STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225440	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations, interviews and record review, the facility failed to provide a dignified environment for two Residents (#33 and #27) out of a sample of 25 residents. Specifically, 1. For Resident #33, the facility staff referred to the Resident by their level of assistance. 2. For Resident #27, the facility staff assisted the Resident with a meal while standing and referred to the Resident by their level of assistance. Findings include: A review of the facility policy titled 'Dignity' with a revision date of 8/1/23 indicated the following: -Each resident shall be cared for in a manner that promotes and enhances his/her sense of well being, level of satisfaction with life, and feelings of self-worth and self-esteem. -Residents are treated with dignity and respect at all times. -Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not 'labeling' or referring to the resident by his or her room number, diagnosis, or care needs. 1. Resident # 33 was admitted to the facility in August 2019 with diagnoses including dementia. A review of the most recent Minimum Data Set (MDS), dated [DATE], did not indicate a Brief Interview for Mental Status (BIMS) score because the Resident is rarely/never understood. During an interview on 2/25/25 at 8:59 A.M., Certified Nurse's Assistant (CNA #1) was in the dining room with residents. The surveyor asked her if Resident #33 was done eating. She said Resident #33 was done eating, he/she is a feeder. During an interview on 2/27/25 at 8:22 A.M., CNA #1 said residents should not be referred to by their level of assistance. During an interview on 2/27/25 at 8:50 A.M., the Director of Nurses said staff should not be addressing residents by their care level needs. (continued on next page)

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	2. Resident #27 was admitted to the facility in November 2019 with diagnoses including adult failure to thrive. Review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 11 out of a possible 15 indicating moderate cognitive impairment. On 2/26/25 at 8:38 A.M., the surveyor observed a hospice staff member assisting the Resident with breakfast while standing. During an interview on 2/27/25 at 8:27 A.M., CNA #1 was in the hallway assisting with breakfast trays. CNA #1 was in the earshot of other residents. She said all staff, including hospice staff, should not assist residents with meals while standing. CNA #1 said Resident #27 is a feeder and staff should assist with meals while seated. CNA #1 said she should not be referring to Resident #27 based on his/her care needs. During an interview on 2/27/25 at 8:50 A.M., the Director of Nurses said all staff, including hospice staff, should not assist residents with meals while standing. She said they should be seated at eye level. She said staff should not refer to residents based on their level of care.

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F 0578 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) for two Residents (#11 and #95), out of a total sample of 25 residents were consistently documented in the medical record. Findings include: Review of facility policy titled Advance Directives, dated as updated [DATE], indicated the following: -The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. -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 advanced directives. -If the resident does not have an advance directive: -1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline the assistance. 1 a. Resident #11 was admitted to the facility in [DATE] with diagnoses that include chronic kidney disease stage 3, dysphagia, gout and muscle weakness. Review of Resident #11's most recent Minimum Data Set (MDS) Assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 2 out of a possible 15 indicating severe cognitive impairment. The MDS further indicated that the Resident does not have a pressure ulcer but is at risk for developing one. The MDS indicated that the Resident is a full code. Review of the paper record indicated a MOLST (Massachusetts Medical Orders for Life Sustaining Treatment) form, signed and dated [DATE], indicating Do Not Resuscitate and Do Not Intubate signed by both the Health Care Proxy (HCP) and the physician. Review of Resident #11's physician's orders, dated [DATE], indicated the following: -Do not Intubate. -Do not resuscitate . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's active advanced directives care plan, dated as revised [DATE], indicated Advanced Directives: MOLST reads as full code with an intervention that indicates to uphold and respect my wishes and healthcare proxy wishes. [sic] Review of a social services progress note, dated [DATE], indicated in part, we honor [his/her] MOLST and HCP (healthcare proxy) is invoked. During an interview on [DATE] at 8:26 A.M., Unit Manager #1 said that once a MOLST form is filled out and signed, then an order is entered into the medical record. He further said that advanced directives and code status are discussed at care plan and quarterly meetings with the resident and or their HCP. He said that advanced directives should be consistently documented throughout the medical record including physician's orders, care plan and MDS assessment. During an interview on [DATE] at 9:29 A.M., the Director of Nurses said that she would expect that advanced directives are documented consistently throughout the medical record. She said she would expect that advanced directives are discussed at care plan meetings and that changes in resident status are updated in the moment. 1 b. Resident #95 was admitted to the facility in [DATE] with diagnoses that included sepsis and acute respiratory failure with hypoxia. Review of Resident #95's most recent Minimum Data Set (MDS) Assessment, dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the Resident had intact cognition. The MDS further indicated that the Resident was a full code. Review of Resident #95's care plan failed to indicate a plan of care regarding advanced directives. Review of Resident #95's physician orders failed to indicate an order for advanced directives. Review of uploaded documents into the Electronic Medical Record (EMR) failed to indicate a MOLST (Massachusetts Medical Orders for Life Sustaining Treatment) form was uploaded. Review of the paper medical record indicated a blank MOLST form, not filled out or signed by the Resident or physician. Review of Resident #95's Progress notes indicated the following: -a social services progress note, dated [DATE], indicated a 48-hour care plan meeting was held. The progress note failed to indicate that advanced directives were discussed at this time. -A social Services progress note, dated [DATE], indicated a 48-hour care plan meeting was held. The progress note failed to indicate that advanced directives were discussed at this time. -A review of all progress notes since admission failed to indicate a discussion around advanced directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:33 A.M., Resident #95 said that no one at the facility had discussed advanced directives or his code status with him/her. Resident #95 said that if he/she were to pass naturally, they would not want to receive CPR (Cardiopulmonary Resuscitation) and would want to be a do not resuscitate. During an interview on [DATE] at 8:26 A.M., Unit Manager #1 said that if a resident is admitted without a valid MOLST form then the staff will complete one with the resident and or the healthcare proxy. If the Resident or healthcare proxy do not complete one, then the resident is a full code and that is communicated to the resident or healthcare proxy. He said once the code status is determined it is entered into the medical record as a physician's order. During an interview on [DATE] at 9:29 A.M., the Director of Nurses said that a MOLST form should be completed or attempted to be completed on every resident. She said that if a resident or their designee decline to fill out the form she would expect documentation of that in the medical record and education provided to the resident or designee that a full code would be implemented.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50338 Based on record review and interview the facility failed to inform each resident of services available in the facility and the charges for those services not covered under Medicare/Medicaid or by the facility's per diem rate. Specifically, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notices (SNF/ABNs) to two out of two applicable records reviewed. During an interview on 2/26/25 at 2:00 P.M., Social Worker #2 said she had never issued an ABN before. She said that it was the business office that issued the ABNs. During an interview on 2/27/25 at 10:54 A.M., the Administrator said the facility is not issuing the ABNs, but they should be.

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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** 45763 Based on observations, record review and interviews, the facility failed to implement care plans for three Residents (#56, #46 and #32), out of a total of 25 sampled residents. Specifically: 1. For Resident #56, who has a history of putting non-food items into his/her mouth, the facility failed to implement the Resident's care plan of removing potentially hazardous items from the Resident's tray. 2 a. For Resident #46, the facility failed to implement supervision during meals as part of his/her Activities of Daily Living care plan. 2 b. For Resident #32, the facility failed to implement supervision during meals as part of his/her nutritional and Activities of Daily Living care plan. Findings Include: Review of the facility policy titled Activities of Daily Living (ADL), last revised 8/23, indicated the following: Policy Statement -Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Policy Interpretation and Implementation -Appropriate care and services will be provided for residents who are unable to carry out ADL's 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 #56 was admitted to the facility in January 2024 and had diagnoses of Picks dementia (a form of dementia that can cause changes in diet or mouth-centered behaviors) and PICA (an eating disorder in which a person compulsively eats or craves non-food items). Review of the most recent Minimum Data Set (MDS) assessment, dated 1/3/25, indicated that a Brief Interview for Mental Status could not be completed as the Resident was rarely or never understood. Review of Resident #56's care plans indicated the Resident was at risk for potential injury due to placing non-edible items into his/her mouth, with the following intervention: - Resident will not have paper items on his/her food trays or table, revised on 7/2/24. Further review of Resident #56's care plans indicated the Resident had PICA with a history of putting non-food items in his/her mouth, with the following interventions: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Food tray should not have packets, plastic wrap, or tops to containers left within arms reach, revised 8/29/24. On 2/25/25 at 11:54 A.M. the surveyor observed Resident #56 with his/her lunch tray. There was a singe serve packet of tartar sauce, a plastic lid from a bowl, the paper tray ticket, and a paper bag containing a cookie on the tray. A nurse was assisting Resident #56 with his/her lunch but at 12:09 P.M. the nurse got up and left. The surveyor then observed Resident #56 pick up the tartar sauce packet, which was opened and had the foil lid pulled back but still attached; as the Resident placed the foil lid into his/her mouth the nurse returned and intervened. On 2/25/25 at 3:12 P.M. the surveyor observed a staff member bring the Resident cookies on a paper towel and place them on the resident's table. On 2/25/25 at 5:03 P.M. the surveyor observed Resident #56 eating dinner, the dinner tray had a paper tray slip and a plastic bowl lid. On 2/26/25 at 8:25 A.M., the surveyor observed Resident #56 eating breakfast, the breakfast tray had a paper tray ticket, plastic covering from a disposable cereal container, and paper straw wrapper. On 2/26/25 at 4:49 P.M. the surveyor observed Resident #56 eating dinner, the dinner tray had a mustard packet, ketchup packet, and two single serve cookie packages. The surveyor then observed a staff member walk by and remove the condiments and cookies. On 2/26/25 at 5:11 P.M., the surveyor observed a staff member assisting Resident #56 with a nutritionally fortified supplemental shake, the staff member left the small white plastic cap of the shake on the Resident's dinner tray. During an interview on 2/27/25 at 9:05 A.M. certified Nursing Aide (CNA) #2 said Resident #56 still had a behavior of placing inedible items in his/her mouth. CNA #2 said the Resident's tray should not have condiment packages as he/she will place them in his/her mouth; the CNA said prohibited items should be removed from the Resident's tray before the Resident receives the tray. During an interview on 2/27/25 at 9:07 A.M. Nurse #4 said Resident #56 still puts inedible items into his/her mouth. Nurse #4 said there should not be condiments or paper products on the Resident's tray and that these items, such as tartar sauce and the paper bag cookies came in, should be removed from the tray before the Resident received the tray. During an interview on 2/27/25 at 10:31 A.M., the Director of Nursing (DON) said that if Resident #56 was still placing objects into his/her mouth that she would expect the care plan interventions to be followed. The DON said that nurses checked resident trays before the trays were delivered and that she would expect the nurse to remove any prohibited items from Resident #56's tray before the tray was delivered. 2 a) Resident #46 was admitted to the facility in September 2023 with a diagnosis of dementia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 11/15/24, indicated that Resident #46 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 2 out of 15. Further review of the MDS indicated that the Resident required supervision or touching assistance with eating. Review of Resident #15's care plans indicated Resident #46 was unable to perform ADLs (activities of daily living) independently due to the effects of dementia with agitation, dementia with psychotic features, rheumatoid arthritis, cognitive communication deficit, leukemia with weakness and impaired mobility with the following intervention: - Assist with meals as needed, initiated 4/11/24. Review of Resident #46's Kardex indicated the following: - Assist with meals as needed. Review of Resident #46's most recent occupational therapy evaluation, dated 10/25/24, indicated the Resident required set-up and supervision with eating and that the Resident does not allow staff to provide physical assistance with eating. Review of Resident #46's most recent rehabilitation screening, dated 11/12/24, completed by a speech language pathologist, indicated the Resident required close supervision/physical assistance with eating and that the Resident had severe cognitive impairments and poor awareness. Further review of the screening form indicated the Resident talked with food in his/her mouth increasing the Resident's risk for aspiration. On 2/25/25 at 9:10 A.M. the surveyor observed Resident #46 eating breakfast in his/her room. The Resident was alone, not within eyesight of staff and coughing. On 2/25/25 at 2:53 A.M., the surveyor observed a staff member bring Resident #46 a bowl of potato chips, the staff member then left the resident alone in his/her room and not within eyesight of staff. On 2/25/25 at 5:11 P.M. the surveyor observed Resident #46 eating dinner alone in his/her room. The Resident was alone and not within eyesight of staff. On 2/26/25 at 8:14 A.M., the surveyor observed Resident #46 eating breakfast alone in his/her room. The Resident was alone and not within eyesight of staff. On 2/26/25 at 8:26 A.M. the surveyor observed Resident #46 eating breakfast in his/her room. The Resident was alone, not within eyesight of staff and coughing; there was juice spilled on the Resident's tray. On 2/27/25 at 8:13 A.M., the surveyor observed Resident #46 eating breakfast in his/her room. The Resident was alone and not within eyesight of staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/25 at 8:47 A.M., the Director of Rehab (DOR) said that Resident #46 required close supervision with eating due to cognitive issues. The DOR said that if a resident required close supervision that he would expect a staff member to be with the resident providing supervision throughout the entire meal period. During an interview on 2/27/25 at 8:51 A.M. the Registered Dietitian said Resident #46 required supervision with eating. During an interview on 2/27/25 at 9:01 A.M., Certified Nursing Aide (CNA) #2 said Resident #46 required supervision with eating. During an interview on 2/27/25 at 9:07 A.M., Nurse #4 said Resident #46 takes a long time to eat and needed encouragement to do so. During an interview on 2/27/25 at 10:31 A.M., the Director of Nursing (DON) said she would expect Resident #46 to be supervised while eating. 45343 2b. Resident #32 was admitted to the facility in September 2024 with diagnoses that included Type 2 Diabetes Mellitus, acute kidney failure, acute and chronic respiratory failure with hypoxia, and dysphagia (difficulty swallowing) oropharyngeal phase. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident had Brief Interview for Mental Status (BIMS) exam score of 14 out of a possible 15 indicating that he/she is cognitively intact. Further review of the MDS indicated that Resident #32 currently requires supervision/touching assistance for eating. On 2/25/25 at 8:18 A.M., Resident #32 was observed sitting upright in bed eating his/her breakfast with food spilled on his/her shirt with a right-hand tremor noted. There were no staff observed providing supervision or assistance with self-feeding. On 2/25/25 at 12:16 P.M., Resident #32 was observed seated in his/her wheelchair in their room eating lunch with a right-hand tremor noted. There were no staff observed providing supervision or assistance with self-feeding. On 2/25/25 at 12:21 P.M., Resident #32 was observed seated in his/her wheelchair eating lunch in their room with a noted right-hand tremor. There were no staff observed providing supervision or assistance with self-feeding. On 2/26/25 at 8:21 A.M., Resident #32 was observed sitting upright in bed eating his/her breakfast with food spilled on his/her sheet covering their chest and a right-hand tremor noted. There were no staff observed providing supervision or assistance with self-feeding. On 2/26/25 at 8:33 A.M., Resident #32 was observed sitting upright in bed eating his/her breakfast with food spilled on his/her sheet covering their chest and a right-hand tremor noted. There were no staff observed providing supervision or assistance with self-feeding. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 12:24 P.M., Resident #32 was observed sitting in his/her wheelchair in their room eating lunch with food spilled on his/her vest and a right-hand tremor noted. There were no staff observed providing supervision or assistance with self-feeding. On 2/26/25 at 12:28 P.M., Resident #32 was observed sitting in his/her wheelchair in their room eating lunch with food spilled on his/her vest and a right-hand tremor noted. There were no staff observed providing supervision or assistance with self-feeding. On 2/27/25 at 8:35 A.M., Resident #32 was observed sitting upright in bed eating his/her breakfast with a right-hand tremor noted. There were no staff observed providing supervision or assistance with self-feeding. Review of Resident #32's ADL and nutrition care plans indicated the following: Eating: Supervise and/or assist resident during meals, initiated 10/4/24. Nutrition: Monitor resident during meals and report s/sx (signs and symptoms) of choking and/or swallowing difficulty, initiated 10/7/24. Review of the speech therapy discharge summary dated 11/25/24 indicated the following: Supervision for Oral Intake: Close supervision. Review of Resident #32's medical record failed to indicate Resident #32 refused assistance with meals. During an interview on 2/26/25 at 4:48 P.M., Nurse #1 said staff setup Resident #32's meal and he/she can eat on his/her own. Nurse #1 said Resident #32 used to eat in the dining room but doesn't any longer because of his/her hand tremor. During an interview on 2/27/25 at 8:36 A.M., the Activities Director said Resident #32 does not require assistance with self-feeding. During an interview on 2/27/25 at 9:12 A.M., the Director of Nursing said she would expect Resident #32 would be provided with the level of assistance indicated on his/her care plan for self-feeding.

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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. 49880 Based on record review and interview, the facility failed to ensure care and services are provided according to accepted standards of clinical practice for one Resident (#306) out of a total sample of 25 residents. Specifically, for Resident #306, the facility failed to obtain daily weights as indicated in physician's orders. Findings include: Review of the facility policy titled Weight Assessment and Intervention, dated as updated 8/1/23, indicated Residents are weighed upon admission and at intervals established by the interdisciplinary team. Resident #306 was admitted to the facility in February 2025 with diagnoses that include acute respiratory failure with hypoxia and retention of urine Review of Resident #306's physician's orders, dated 2/15/25, indicated daily wts (weights) if >3lbs. (pounds) in one day or >5 lbs. in one week call MD/NP (Medical Doctor/ Nurse Practitioner). Review of the weights portal in the electronic medical record (EMR) indicated the following weights: 2/14/25 192.0 Lbs. 2/16/25 192.9 Lbs. 2/21/25 192.0 Lbs. 2/22/25 191.9 Lbs. Review of the February 2025 Medication Administration Record (MAR) failed to indicate that the Resident refused to be weighed and failed to indicate that daily weights were obtained as indicated in physician's orders. Review of Resident #306's nursing progress notes failed to indicate refusal to be weighed, or that the physician was notified that the Resident was not weighed Review of the Nutrition Assessment, dated 2/17/25, indicated the following: Resident admitted for STR s/p (short term rehab status post) hospitalization . Resident with significant weight loss PTA r/t (prior to admission related to) acute illness and decreased appetite as evidenced by resident interview. Per resident interview, he wants to maintain current weight and happy with recent weight loss. Resident also reports good appetite, likes all foods and happy with meals provided. Diet appropriate for optimal intake at meals. Resident agreeable to diet. Recent labs not available. Anticipate stable weight if meal intake remains good overall. Plan- Continue diet a/o (as ordered). Follow for unplanned weight changes. [sic] (continued on next page)

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Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/25 at 8:39 A.M., Unit Manager #1 said that daily weights should be completed at 6:00 A.M. every day as indicated in the physician's orders. He said that if a resident refuses to be weighed it should be documented, however, he said that Resident #306 doesn't refuse care. Unit Manager #1 said that he would expect that the staff are carrying out physician's orders as indicated. During an interview on 2/27/25 at 9:03 A.M., the Director of Nurses said that she would expect that nurses are following physician's orders as it is the standard of practice.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45763 Based on interview and record review the facility failed to ensure that one Resident (#65), out of a total sample of 25 residents, received proper treatment to maintain vision ability. Specifically, the facility failed to refer Resident #65 to a retina specialist for further evaluation as recommended by the optometrist. Findings Include: Review of the facility policy, titled Ancillary Services, updated 8/1/23, indicated, but was not limited to, the following: - Residents will be offered ancillary services including, but not limited to, ophthalmology, audiology, podiatry and psych services. If resident chooses services outside of ancillary services provided at the facility all efforts will be made to ensure they are seen. (sic.) - Schedule of services will be provided with as much information as possible, in a timely fashion as possible. - Nursing staff will be responsible for reviewing any and all recommendations from the ancillary services and communicate that to the attention of the attending MD (medical doctor)/NP (nurse practitioner)/PA (physician assistant) for approval or refusal of recommendations. Resident #65 was admitted to the facility in January 2024 with a diagnosis of coronary artery disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/27/24, indicated that Resident #65 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Further review of the MDS indicated that the Resident utilizes corrective lenses. Review of Resident #65's care plan indicated that the Resident's HCP (health care proxy) was activated in January 2024. Review of Resident #65's signed but undated consent form indicated the Resident consented to being seen by an optometrist. During an interview on 2/25/25 at 8:25 A.M. Resident #65 said he/she needed new lenses for his/her glasses as he/she could not see clearly. The Resident said being able to see clearly was very important because he/she was an avid reader; the surveyor observed several books and reading materials on Resident #65's bed. Review of the NP #1's (Nurse Practitioner) progress note, dated 1/29/25, indicated the following: - During this visit Resident #65 was concerned about needing new glasses. He/she is followed by health drive and awaiting recommendations. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #65's optometrist evaluation, dated 6/12/24, indicated the Resident had a presumed macular hole in his/her right eye and suspected glaucoma in both eyes with the following plan/recommendation: - Monitor; follow-up 3-4 months; referral: ophthalmology consult (retina specialist); Patient requires further evaluation with retina specialist with macular OCT (a noninvasive imaging method that uses reflected light to create pictures of the back of your eye which helps eye care providers diagnose and manage common eye diseases such as glaucoma) to further assess macula and rule out macular hole. Spoke with patient on all findings, patient wishes to see retain specialist for further evaluation. Review of Resident #65's optometrist evaluation, dated 9/23/24, indicated the Resident had a maculopathy, cellophane with possible pseudo hole in his/her right eye and suspected glaucoma in both eyes with the following plan/recommendation: - Monitor; follow-up 3-4 months; referral: ophthalmology consult (retina specialist); patient requires further evaluation with macular OCT to assess ERM (epiretinal membrane) grade in more detail. Review of Resident #65's optometrist evaluation, dated 1/28/25, indicated the Resident had maculopathy in his/her right eye and suspected glaucoma in both eyes with the following plan/recommendation: - Monitor; follow-up: referral: ophthalmology consult (retina specialist); patient requires further evaluation and potential treatment with retina specialist due to bothersome ERM affecting vision. Please refer patient for further evaluation. Review of Resident #65's medical record failed to indicate the Resident was evaluated by a retina specialist. Review of the scheduling book failed to indicate the Resident had an appointment scheduled with a retina specialist. During a follow-up interview on 2/26/25 Resident #65 said he/she had not attended, or had been asked by facility staff about, an appointment with a retina specialist. During interviews on 2/26/25 at 10:51 A.M. and 12:02 P.M., Social Worker (SW) #2 said if the routine optometrist can't meet a resident's needs that the facility will reach out to the family to facilitate an alternative. During an interview on 2/26/25 at 3:39 P.M. Resident #65's HCP said she was not aware that the Resident needed a retina specialist and that she would like the Resident to see the specialist. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 1:37 P.M., Nurse #5 said the Resident had a physician order, dated 1/22/25, to be seen by ophthalmology but that this order was in reference to the routine optometrist who evaluated Resident #65 on 1/28/25, not a retina specialist. Nurse #5 said that when a resident is seen by an ancillary service that the nurses will receive a printout of the evaluation which the MD or NP will review and that if a follow-up was required that the NP or MD would write an order. Nurse #5 said Resident #65 has not been seen by a retina specialist, and that there was no discussion or upcoming appointment for a retina specialist. Nurse #5 said that nursing will facilitate making an appointment if needed. Review of Resident #65's active and discontinued physician orders failed to indicate an order to be seen by a retina specialist. During an interview on 2/26/25 at 2:30 P.M. NP #1 said nursing provides her with ancillary service evaluations/recommendations for review. NP #1 said if a referral was needed, she could place the referral online. NP #1 said Resident #65 was having issues with vision, so she asked the unit manager to sign the Resident up to be seen by the routine optometrist as the Resident already had a consent form signed. NP #1 said she was unaware of the optometrist recommendation for a referral to a retina specialist and that she would not have disagreed with that recommendation. During an interview on 2/27/25 at 8:40 A.M. MD #1 said she did not know about the optometrist's recommendation for a referral to a retina specialist. During an interview on 2/27/25 at 10:39 A.M., the Director of Nursing (DON) said that previously the Assistant Director of Nursing (ADON) was printing out ancillary service evaluations/recommendations but that the ADON left last September. The DON said that she had provided NP #1 Resident #65's optometrist recommendations for a referral to the retina specialist yesterday, after the surveyor had brought the concern to the attention of the facility.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49880 Based on observation, record review and interview the facility failed to ensure one Resident (#95) with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing out of a total sample of 25 residents. Specifically, the facility failed to ensure recommendations from the consulting wound physician were implemented and that physician's order were in place for an air mattress. Findings include: Review of facility policy titled Ancillary Services, dated as updated 8/1/23, indicated that nursing staff will be responsible for reviewing any and all recommendations from the ancillary services and communicate that to the attention of the attending MD/NP/PA (Medical Doctor/ Nurse Practitioner/ Physician Assistant) for approval or refusal of recommendations. Review of facility policy titled Support Surface Guidelines, dated as updated 8/1/23, indicated support services alone are not effective in preventing pressure ulcers, but studies indicate that the use of appropriate support surfaces with interventions such as turning, repositioning, and moisture management can assist in reducing pressure ulcer development. Resident #95 was admitted to the facility in January 2025 with diagnoses that included sepsis, type 2 diabetes mellitus and acute respiratory failure with hypoxia. Review of Resident #95's most recent Minimum Data Set (MDS) Assessment, dated 1/31/25, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the Resident had intact cognition. The MDS further indicates that the resident had two unstageable pressure ulcers that were present upon admission to the facility. Further, the MDS indicates that the Resident is at risk for the development of pressure ulcers. MDS failed to indicate that the resident exhibits refusal of care. Review of the most recent weekly skin assessment, dated 2/25/25, indicated a DTI (deep tissue injury) to the left heel as well as the right big toe. Review of the Norton Assessment (an assessment to determine the risk for skin breakdown and development of pressure ulcers), dated 1/26/25, indicated a risk score of 10, indicating high risk for skin breakdown. Review of Resident #95's active skin breakdown care plan, dated as 2/7/25, indicated that the Resident has actual skin breakdown to 1. Left heel DRI and 2. right great toe DTI. [sic] 1 a. Review of Resident #95's wound consultant notes dated 2/13/25 and 2/20/25 indicated recommendations regarding the treatment of the unstageable wound of the left heel that included to off-load the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #95's active physician's orders failed to indicate an order to off-load the wound to the left heel. -On 2/25/24 at 7:56 A.M., the surveyor observed the resident lying in bed with his/her heels directly on the mattress. -On 2/26/25 at 7:00 A.M., the surveyor observed the resident lying in bed with his/her heels directly on the mattress. -On 2/27/25 at 7:18 A.M., the surveyor observed the resident lying in bed with his/her heels directly on the mattress. During an interview on 2/27/25 at 8:31 A.M. Unit Manager #1 and the Infection Preventionist said that after the consulting wound physician rounds, notes are uploaded into the system on the same day and all recommendations are reviewed with the facilities Nurse Practitioner (NP) and then put into place. The Infection Preventionist rounds with the consulting wound physician and relays the recommendations to the NP. They said that staff should be elevating Resident #95's heels and staff should have obtained orders for off-loading the wound to promote healing. Unit Manager #1 said that Resident #95 is cooperative with care and would not refuse having the wound off-loaded. During an interview on 2/27/25 at 9:34 A.M., the Director of Nurses said that she would expect that recommendations from the consulting wound physician are implemented in the facility. She said skin can worsen fast, especially in residents who have other complications such as diabetes. 1 b. On 2/25/24 at 7:56 A.M., the surveyor observed the resident lying in bed, an air mattress was in place, set at 240 pounds. -On 2/26/25 at 7:00 A.M., the surveyor observed the resident lying in bed, an air mattress was in place, set at 240 pounds. -On 2/27/25 at 7:18 A.M., the surveyor observed the resident lying in bed, an air mattress was in place, set at 240 pounds. Review of Resident #95's current weight as documented in the electronic medical record was 200.2 pounds. Review of Resident #95's physician's orders failed to indicate an order for an air mattress. Review of Resident #95's care plan failed to indicate use of an air mattress. Review of Resident #95's consulting wound physician progress notes failed to indicate a recommendation for an air mattress. During an interview on 2/27/25 at 8:31 A.M., Unit Manager #1 and the Infection Preventionist said that Resident #95 did not have a physician's order for an air mattress but should have so that staff can monitor the mattress for appropriate settings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/25 at 9:34 A.M., the Director of Nurses said any resident with an air mattress should have a physician's order for use.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49880 Based on observations, interviews and record review, the facility failed to maintain professional standards in the management and care for urinary catheter devices for one Resident (#306) out of a total sample of 25 residents. Specifically, the facility failed to ensure the urinary catheter drainage bag was not placed directly on the floor. Findings include: Resident #306 was admitted to the facility in February 2025 with diagnoses that include acute respiratory failure with hypoxia and retention of urine Review of Resident #306's physician's orders indicated the following: -Secure to thigh, keep foley (urinary catheter) bag below bladder and provide privacy bag every shift, dated 2/14/2025. -Record foley catheter output every shift, dated 2/14/25. -Irrigate foley with 60ml normal saline as needed for blockage daily, dated 2/14/2025. -On 2/26/25 at 6:57 A.M., the surveyor observed the resident lying in bed. His/her urinary catheter drainage bag was resting on the floor. -On 2/26/25 at 7:17 A.M., Resident #306 was heard yelling for help from his/her room. Three nurses entered the room to assess the resident and then exited the room. After the staff exited the room, the surveyor observed that the urinary drainage bag was still resting on the floor. Review of Resident #306's active care plan, initiated 2/25/25, indicated Indwelling foley (urinary) catheter placement: resident at risk for complications related to insertion of indwelling foley catheter, urinary retention. [sic] During an interview on 2/26/25 at 2:08 P.M., the Infection Preventionist said that the urinary catheter bag should not be resting on the floor as it poses an increased risk for infection. During an interview on 2/27/25 at 9:41 A.M., the Director of Nurses said that a urinary catheter bag should be positioned up off the floor and should not be in contact with the floor.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations, interviews, and record review, the facility failed to ensure that respiratory care and services consistent with professional standards of practice were provided for four Residents (#27, #21, #13 and #93) out of sample of 25 residents. Specifically, 1. For Resident # 27, the facility failed to include an oxygen physician's order in the medical record and have oxygen set at the right flow rate. 2. For Resident #21, the facility failed to routinely change and date oxygen tubing for one Residents. 3. For Resident #13, the facility failed to properly store the nebulizer tubing and mask. 4. For Resident #94, the facility failed to properly store and label the nebulizer tubing and mask. Findings include: A review of the policy titled 'Oxygen Administration' with a revision date of 8/1/23 indicated the following: -The purpose of this procedure is to provide guidelines for safe oxygen administration. -Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. -Turn on the oxygen, unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. A review of the facility policy titled Maintenance of O2 (Oxygen) Tubing/Nebulizer Tubing and Supplies, dated 8/23, indicated the following: Purpose: The purpose of the policy is to address infection prevention with regards to O2/Nebulizer tubing. Preparation: -Review MD orders for accuracy of use of oxygen/nebulizer General Guidelines: -All oxygen use should have orders to change tubing weekly and as needed for being soiled or dirty. -Nursing will be responsible for ensuring weekly O2 tubing is labeled with the appropriate date of being changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-O2 tubing/nebulizer tubing when not in use should be stored in a plastic bag or other non-permeable material to keep from infection. 1. Resident #27 was admitted to the facility in November 2019 with diagnoses including adult failure to thrive. A review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status score of 11 out of a possible 15 indicating moderate cognitive impairment. On 2/25/25 at 9:17 A.M., the surveyor observed the Resident in bed wearing a nasal cannula and oxygen set at 1.5 liters. On 2/26/25 at 7:30 A.M., the surveyor observed the Resident in bed wearing a nasal cannula and oxygen set at 1.5 liters. During an interview, medical record review and observation on 2/26/25 at 10:43 A.M.,, Nurse #2 and the surveyor observed the Resident in bed wearing the nasal cannula with oxygen set at 1.5 liters. Nurse #1 said the Resident is on continuous oxygen. She said the oxygen should be set at 2 liters. Nurse #1 reviewed the medical record and said there were no current physician's orders in place for how many liters of oxygen the Resident should be on and how often the Resident should be on oxygen. She said a physician's order for oxygen should be in place. During an interview on 2/27/25 at 8:52 A.M., the Director of Nurses said, for safe oxygen administration, a physician's order should be in place. She said Resident #27 started using oxygen continuously on 10/14/24. She said his/her oxygen should be set at 2 liters. 45343 2. Resident #21 was admitted to the facility in October 2023 with diagnoses including acute and chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD), and hypertensive heart disease without heart failure. Review of Resident #21's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she had a Brief Interview for Mental Status (BIMS) exam score of 12 out of a possible 15, indicating he/she has intact cognition. Further review of the MDS indicated Resident #21 requires partial/moderate to dependent assistance for daily self-care activities and is on oxygen therapy. Review of Resident #21's physician orders indicated the following: -Replace and date O2 (Oxygen) tubing on Sundays 11:00 P.M. to 7:00 A.M. shift, every night shift, every Sunday, initiated 10/23/24. On 2/25/25 at 8:53 A.M., 12:05 P.M., and 2:40 P.M., Resident #21 was observed lying in bed wearing oxygen at 2 liters per minute (L/min) via nasal cannula. The oxygen tubing was labeled 1/27/25. Review of the Treatment Administration Record (TAR) for February 2025 indicated that the oxygen tubing was changed on 2/2/25, 2/9/25, 2/16/25, and 2/23/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 4:43 P.M., Nurse #1 said the oxygen tubing should be changed weekly and stored in a plastic bag when not in use. Nurse #1 said nurses should follow the physician's orders for changing and labeling oxygen tubing. During an interview on 2/27/25 at 9:17 A.M., the Director of Nursing said any resident on oxygen or nebulizer should have the tubing changed and labeled weekly on Sundays 11:00 P.M. to 7:00 A.M. shift and stored in a plastic bag. 3. Resident #13 was admitted to the facility in December 2024 with diagnoses including chronic obstructive pulmonary disease (COPD), and influenza due to identified novel influenza A virus with other respiratory manifestations, other forms of dyspnea (difficulty breathing or shortness of breath). Review of Resident #13's most recent Minimum Data Set (MDS) Assessment, dated 12/20/24, indicated a Brief Interview for Mental Status (BIMS) exam score of 11 out of 15, indicating he/she has moderate cognitive impairment. Further review of the MDS indicated Resident #13 requires partial/moderate assistance to supervision/touching assistance for self-care activities. Review of physician's orders indicated the following order, dated 2/23/25: - Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML, 3 ml (milliliter)-inhale orally every 6 hours as needed for SOB (shortness of breath) or wheezing via nebulizer. On 2/25/25 at 8:31 A.M., the surveyor observed a nebulizer machine with tubing and a mask on the Resident's nightstand. The nebulizer tubing was not labeled with a date, and the mask and tubing was not stored in a bag and no bag was present. On 2/25/25 at 10:31 A.M., the surveyor observed a nebulizer machine with tubing and a mask on the Resident's nightstand. The nebulizer tubing was not labeled with a date, and the mask and tubing was not stored in a bag and no bag was present. On 2/26/25 at 7:27 A.M., the surveyor observed a nebulizer machine with tubing and a mask on the Resident's nightstand. The nebulizer tubing was not labeled with a date, and the mask and tubing was not stored in the bag now attached to the nightstand drawer. During an interview on 2/16/25 at 4:43 P.M., Nurse #1 said that the nebulizer mask and tubing should be changed weekly, labeled with the date, and stored in a plastic bag when not in use. During an interview on 2/27/25 at 9:17 A.M., the Director of Nursing (DON) said any resident on oxygen or nebulizer should have the tubing changed weekly on Sundays on 11:00 P.M. to 7:00 A.M. shift and stored in a plastic bag. 50338 4. Resident #93 was admitted to the facility in June 2024 with diagnoses including neurocognitive disorder with Lewy bodies (a form of dementia) and Parkinson's Disease. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 12/27/24, indicated that Resident #93 had severe cognitive impairment as evidenced by rarely/never understood and a staff assessment for Brief Interview for Mental Status (BIMS). Review of Resident #93's physician's order, dated 1/28/25, indicated Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters (ml). 3 ml inhale orally every 6 hours as needed for shortness of breath/wheezing via nebulizer. Review of Resident #93's physician's order, dated 2/4/25, indicated Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters (ml). 1 vial inhale orally two times a day for cough/congestion. (Nebulizer). Review of Resident #93's physician's active orders as of 2/25/25, failed to indicate any orders to change nebulizer tubing and mask. Review of Resident #93's Medication Administration Record (MAR) and Treatment Administration Record (TAR) as of 2/27/25, failed to indicate any orders to change nebulizer tubing and mask. Review of Resident #93's physician's progress note, dated 1/29/25, indicated Patient has auditory inspiratory wheezing, staff nurse at bedside, staff reported today that [he/she] does that sometimes, I had a telephone conversation with patient's daughter today and she stated that it happens when it is cold and [he/she] went outside yesterday for a doctor's appointment, she stated that DuoNebs (combination medication of ipratropium and albuterol) as needed helps, added DuoNeb every 6 hours as needed, patient is in no acute distress. [sic] Review of Resident #93's physician's progress note, dated 2/8/25, indicated Added DuoNeb twice daily scheduled as requested by [his/her] daughter, continue as needed, [sic] On 2/25/25 at 7:58 A.M., the surveyor observed nebulizer on Resident #93's nightstand, the tubing was attached and undated and the mask was laying in the drawer of the nightstand, not in a bag. On 2/26/25 at 8:03 A.M., the surveyor observed nebulizer on Resident #93's nightstand, the tubing was attached and undated and the mask was laying in the drawer of the nightstand, not in a bag, On 2/26/25 at 12:18 P.M., the surveyor observed nebulizer on Resident #93's nightstand, the tubing was attached and undated and the mask was laying in the drawer of the nightstand, not in a bag. On 2/27/25 at 7:08 A.M., the surveyor observed nebulizer on Resident #93's nightstand, the tubing was attached and undated and the mask was laying in the drawer of the nightstand, not in a bag. During an interview on 2/27/25 at 7:10 A.M., Nurse #3 said nebulizer tubing and masks are changed every seven days and should be dated when changed. During an interview on 2/27/25 at 8:41 A.M., Nurse #4 said nebulizer tubing and masks get changed weekly and they should be labeled when changed and stored in bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 9:18 A.M., the Director of Nursing (DON) said nebulizer tubing and mask should be stored in a bag when not in use. Tubing should be changed weekly and there should be a physician's order to change tubing on oxygen and nebulizers weekly.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on observation, record review, and interview, the facility failed to maintain an accurate medical record for one Resident (#21) out of a total sample of 25 residents. Specifically, the nurses documented in the Treatment Administration Record (TAR) that oxygen tubing was replaced when it was not. Findings Include: Review of the facility policy titled charting and Documentation, dated 8/23, indicated the following: Policy Statement -All services provided to the residents, progress toward the care plan goals, and any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care Policy Interpretation and Implementation -Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Resident #21 was admitted to the facility in October 2023 with diagnoses including acute and chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD), and hypertensive heart disease without heart failure. Review of Resident #21's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she had a Brief Interview for Mental Status (BIMS) exam score of 12 out of a possible 15, indicating he/she has intact cognition. Further review of the MDS indicated Resident #21 requires partial/moderate to dependent assistance for daily self-care activities and is on oxygen therapy. Review of Resident #21's physician orders indicated the following: -Replace and date O2 (Oxygen) tubing on Sundays 11:00 P.M. to 7:00 A.M. shift, every night shift, every Sunday, initiated 10/23/24. On 2/25/25 at 8:53 A.M., 12:05 P.M., and 2:40 P.M., Resident #21 was observed lying in bed wearing oxygen at 2 liters per minute (L/min) via nasal cannula. The oxygen tubing was labeled 1/27/25. Review of the Treatment Administration Record (TAR) for February 2025 indicated that the oxygen tubing was changed on 2/2/25, 2/9/25, 2/16/25, and 2/23/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 4:43 P.M., Nurse #1 said nurses should accurately document the day the oxygen tubing was changed in the TAR. During an interview on 2/27/25 at 9:17 A.M., the Director of Nursing said any resident on oxygen should have the tubing changed weekly and she would expect it to be accurately documented in the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on observations, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment that prevents the development and transmission of communicable diseases and infections when the facility failed to implement Enhanced Barrier Precautions for three Residents (#306, #95, and #40) out of a total sample of 25 residents and staff wore gloves in the hallways and failed to perform hand hygiene following glove removal. Findings include: 1. Review of facility policy titled Enhanced Barrier Precautions, dated as updated 8/1/23, indicated the following: -Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. -EBPs are targeted gown and glove use during high contact resident care activities when contract precautions do not otherwise apply. -Gloves and gown are applied prior to performing the high contact resident care activity. -Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: -dressing; -bathing/ showering; -transferring; -providing hygiene; -changing linens; -changing briefs or assisting with toileting; -device care or use (central line, urinary catheter, feeding tube, tracheostomy/ ventilator, etc.); and -wound care (any open skin requiring a dressing). -EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. -PPE (personal protective equipment) is available outside of the resident's rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 a. Resident #306 was admitted to the facility in February 2025 with diagnoses that include acute respiratory failure with hypoxia and retention of urine Review of Resident #306's most recent Minimum Data Set (MDS) Assessment, dated 2/14/25 was an Entry MDS, therefore did not indicate a Brief Interview for Mental Status Score. -On 2/25/25 at 8:06 A.M., Resident #306 was observed in his/her room with a urinary catheter in place. There was no signage outside of the room to indicate the need for Enhanced Barrier Precautions (EBPs). There was no personal protective equipment (PPE) outside of the room for use. -On 2/26/25 at 9:05 A.M., staff were observed providing activities of daily living care to Resident #306. Staff were not utilizing EBPs during care. There was no signage outside of the room to indicate the need for EBPs. There was no PPE outside of the room for use. 1 b. Resident #95 was admitted to the facility in January 2025 with diagnoses that included sepsis and acute respiratory failure with hypoxia. Review of Resident #95's most recent Minimum Data Set (MDS) Assessment, dated 1/31/25 indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the Resident had intact cognition. -On 2/25/25 at 7:56 A.M., the surveyor observed Resident #95 in bed. He/she had a cholecystostomy tube (a tube that goes into the gallbladder) in place. There was no signage outside of the room to indicate the need for EBPs. There was no PPE outside of the room for use. -On 2/26/25 at 7:01 A.M., the surveyor observed Resident #95 in his/ her room. There was no signage outside of the room to indicate the need for EBPs. There was no PPE outside of the room for use. 1 c. Resident #40 was admitted to the facility in September 2020 with diagnoses including acute kidney failure. A review of the Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 indicating moderate cognitive impairment. Further review of the MDS indicated that the Resident has an indwelling catheter (including suprapubic catheter and nephrostomy tube). On 2/25/25 at 9:11 A.M., the surveyor observed the Resident awake in bed, he/she had a nephrostomy tube in place (a thin, flexible tube inserted into the kidney to drain urine directly from the organ). There was no signage outside of the room to indicate the need for EBPs. There was no PPE outside of the room for use. On 2/26/25 at 7:39 A.M., the surveyor observed the Resident in the room sleeping. He/she had a nephrostomy tube in place. There was no signage outside of the room to indicate the need for EBPs. There was no PPE outside of the room for use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 at 8:38 A.M., the surveyor observed the Resident in the room, sitting on his/her bed. He/she had a nephrostomy tube in place. There was no signage outside of the room to indicate the need for EBPs. There was no PPE outside of the room for use. During an interview on 2/26/25 at 2:08 P.M., the Corporate Director of Nurses said that anyone with an open area or who is susceptible to infection, such as residents who have urinary catheters, gastrostomy tubes or drains should be on EBPs. During an interview on 2/27/25 at 9:41 A.M., the Director of Nurses said that she would expect that EBPs be in place as appropriate and followed in the facility. 2. Review of facility policy titled Personal Protective Equipment- Using Gloves, dated as updated 8/1/23, indicated the following: -Objectives -1. To prevent the spread of infection -3. To protect hands from potentially infectious material -Miscellaneous -5. Wash hands after removing gloves (Note: gloves do not replace hand washing.) Review of facility policy titled Handwashing/ Hand hygiene, dated as updated 8/1/23, indicated the following: -Use alcohol- based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: -After removing gloves. -On 2/25/25 at 9:17 A.M., the surveyor observed a housekeeping staff member pulling a barrel of trash in the hallway on the first-floor unit. The housekeeping staff member had one glove on one of his hands. He got onto the elevator and using his gloved hand, held open the elevator door for the surveyor to get on. -On 2/26/25 at 9:03 A.M., the surveyor observed a housekeeping staff member in the hallway of the first-floor unit with gloves on bilateral hands. Another staff member stopped him and said that he needed to take his gloves off in the hallway. The housekeeping staff member removed the gloves and threw them away. He did not perform hand hygiene upon removing the gloves. He walked down the hallway to the linen closet, opened the door, potentially contaminating the handle, and got supplies from the closet. During an interview on 2/26/25 at 2:14 P.M., the Corporate Director of Nurses and Infection Preventionist said that staff should be removing gloves before entering the hallways and should perform hand hygiene after removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 at 9:43 A.M., the Director of Nurses said that staff should not be wearing gloves in the hallways and should be sanitizing their hands after glove removal.