STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225680	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Marina Bay	2 Seaport Drive Quincy, MA 02171

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43935 Based on observation, interview, and document review, the facility failed to ensure one Resident (#303) was informed of and actively participated in his/her baseline plan of care within the first 48 hours following admission, out of a total sample of 31 residents. Findings include: Review of the facility's policy titled Baseline Care Plan, dated as revised 8/15/23, indicated but was not limited to: - a baseline care plan is developed within 48 hours of admission to the facility Process: - interview resident, obtain physician orders, complete admission nursing assessment and begin interdisciplinary (IDT) assessment, review transfer information, develop baseline care plan with IDT, continue to gather information - the facility will provide the resident with a summary of the baseline care plan that includes but is not limited to: initial goals of the resident, summary of resident's medications and dietary instructions, any services and treatments to be administered by the facility Resident #303 was admitted to the facility on [DATE] with diagnoses including cerebrovascular disease (illness affecting the blood vessels of the brain) and diabetes mellitus. Review of the Admission assessment for Resident #303, dated as completed on 9/16/24, indicated but was not limited to the following: - Resident is cooperative with clear speech and adequate hearing and vision - Resident is alert, verbal and comprehensible (easy to understand), and oriented to person, place and time (continued on next page)

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/24 at 8:50 A.M., Resident #303 said he/she was admitted to the facility a couple days prior and that he/she did not know what the plan was for their short-term stay, but they were supposed to have a meeting to discuss the plan and his/her goals and they were waiting for that to occur. The Resident said the staff were not answering any of their questions to let them know what the plan was for care or their individual goals for discharge and they were frustrated. The Resident said they had not yet had a meeting with the IDT or been offered a summary of their care plan or initial goals while at the facility. Review of the medical record for Resident #303 failed to indicate a baseline care plan summary had been completed or that the Resident had been offered or provided a copy of their medications and care activities to be performed while at the facility. During an interview on 9/18/24 at 8:22 A.M., Resident #303 said he/she was aware of their medication changes, but they had not been explained to him/her and he/she had still not had a meeting or been offered any information on their care and what services they would receive while at the facility for their short-term stay. The Resident said he/she was concerned that the facility was not collaborating with him/her regarding their personal goals for their stay and what needed to be accomplished for him/her to return to the community as soon as possible. Resident #303 said he/she was going to self-advocate and request the information today since he/she has their mind and has not been offered any information yet. During an interview on 9/18/24 at 9:17 A.M., the Case Manager said the process for new admission residents and baseline care plans is for the IDT to meet with each resident within two days of admission. She said the meeting includes the resident and the IDT and is collaborative to review the resident's individual goals and plans and create a tentative plan for them to reach those goals prior to the comprehensive plan being made. She said after the meeting the resident is asked to sign a copy of the baseline plan of care summary and is offered and provided a copy to ensure they are aware of the plan and a copy is kept in the medical record. During an interview on 9/18/24 at 12:28 P.M., Unit Manager (UM) #4 reviewed Resident #303's medical record with the surveyor and said the Resident did not have a signed baseline plan of care summary in their record and she was unsure of when the meeting took place or where the summary was but she would look for it and provide it to the surveyor. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 9/18/24 at 12:42 P.M., the Surveyor observed UM #4 bringing a care plan summary form to Resident #303's room and followed the UM to the room. The Resident was in the room with Social Worker (SW) #2 when the UM and surveyor arrived. The form was handed to Resident #303 and SW #2 informed the Resident that he/she forgot to sign the form from the meeting held on 9/16/24. The Resident insisted he/she did not have a meeting on 9/16/24 and the meeting was being held now. The Resident was becoming increasingly frustrated with the insistence on the part of SW #2 that he/she had forgotten they had a meeting and said, You're trying to bamboozle me and You're trying to make me think I'm crazy and I don't know stuff but I know that we did not have a meeting on Monday. Upon the surveyor intervening, SW #2 said the Resident is alert and oriented and she did not attend the meeting on Monday (9/16/24) but that is the process and she is sure he/she had one. The Resident said there was no meeting and he/she had met with the case manager individually and then on separate occasions and different days some other people but no one had offered him/her a copy of the summary or asked them for their individual goals. The Resident said he/she would sign the paper and asked what the date was, the UM said the facility had already dated the form for Monday and the Resident said again that they did not meet and questioned why they would back date the paper and reminded the staff no one offered him/her the summary on that day and a meeting was not held. During an interview on 9/18/24 at 12:46 P.M., SW #2 provided the surveyor with a copy of the baseline care plan summary dated 9/16/24 signed by herself and the Resident. She said she pre-signed the paper when she was completing her piece and when the team came to have the meeting with the Resident they were not available and she was pulled away and did not attend the meeting and couldn't speak to who was at the meeting or when it occurred since she was not there. Review of the baseline care plan summary dated as completed 9/16/24 indicated the Resident had the information reviewed with them, but the form was unsigned until the Resident signed it, as observed by the surveyor on 9/18/24. During an interview on 9/18/24 at 12:52 P.M., Resident #304, who is Resident #303's roommate and alert and oriented, said he/she was in the room most of the day on 9/16/24 and had met with the IDT. The Roommate said Resident #303 was correct when he/she said he/she was not seen by the IDT and did not have a baseline plan of care summary signed on Monday 9/16/24 because Resident #303 was out of the facility early in the morning and did not return until later in the day. The Roommate said the IDT team returned to see Resident #303, but he/she was unavailable until late afternoon. During an interview on 9/18/24 at 1:02 P.M., the Director of Nurses (DON) and Consultant #1 were made aware of the concerns and surveyor's observations regarding Resident #303. The DON said the expectation is that the IDT hold a meeting with the resident and the meetings are held within 48 hours. She said the Resident was admitted on a Sunday and therefore their meeting would have had to be completed by the end of day Tuesday. She said the staff do complete sections of the form prior to meeting with the residents but in this instance the dates on the form should have been corrected to indicate the date the Resident participated in the care plan and was offered the summary. Consultant #1 said the staff should have adjusted the dates on the form to reflect the accurate date of the meeting and information sharing and allowed the Resident to sign and date the form for today (9/18/24) and the process for completing the baseline care plan and offering the Resident a copy was not followed within the 48-hour time frame or to expectation. Both the DON and the Consultant said the baseline care plan process did not work as it should have for this Resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/24 at 1:52 P.M., UM #4 said she should not have dated the baseline care plan summary for 9/16/24 and should have dated it for 9/18/24 since that was the first time any of the information had been discussed with the Resident and the Resident was offered a copy. She said she was not present at a meeting for the Resident on 9/16/24 and she cannot say whether one actually took place. She said the form did not reflect the correct date or information as it should and the Resident should have been allowed to date it correctly when he/she signed it. During an interview on 9/18/24 at 2:02 P.M., Nurse #5 said on 9/16/24 Resident #303 left the facility at approximately 8:00 A.M., for an appointment and did not return to the facility until about 2:30 P.M., she said she did see a few IDT members go to the Resident's room after he/she returned but no meeting was held for the Resident on that date because the Resident was not available in the facility and the form in the record was inaccurate based on the date of completion. She said the team did meet and discuss the Resident on 9/16/24 but the Resident was not involved and the summary was not offered to him/her. During an interview on 9/19/24 at 7:45 A.M., the Administrator said she was made aware of the situation that occurred with Resident #303 and their baseline care plan. She said since the information was inaccurate, she had staff meet with the Resident again on 9/18/24 and offer to correct the information and the form, which the Resident was appreciative of, and provided the Resident with a new copy of their baseline care plan summary dated as complete on 9/18/24. She said this meeting and the summary was not provided to the Resident within 48 hours as it should have been per the policy and regulation; the process was not followed as expected. Review of the Baseline plan of care for Resident #303, dated as completed 9/18/24, indicated the Residents preferences for sleep and individual goals and was signed and dated by the Resident, UM #4, Case manager, Director of Rehabilitation, MDS Nurse and SW #2 on 9/18/24. During a follow up interview on 9/19/24 at 9:28 A.M., Resident #303 said he/she feels good about the facility taking his/her input and correcting the baseline care plan to be collaborative and include his/her personal goals and preferences and was happy that the facility allowed him/her to have the form dated appropriately.

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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 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. 43935 Based on observation, interview, and document review, the facility failed to ensure professional standards of care were met for two Residents (#145 and #14), out of a total sample of 31 residents. Specifically, the facility failed: 1. For Resident #145, to administer care (one to one (1:1) assist during intake by mouth (PO)) in accordance to physician's orders; and 2. For Resident #14, to follow the standard of medication preparation and administration and document missed or refused medications that were ordered by the physician. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility's policy titled Physician Services, dated as revised on 11/14/2022, indicated but was not limited to the following: - Therapeutic diets are prescribed and precise as to the specific dietary requirements or limitations - Physician (MD) orders will be followed by staff as appropriate until the order has been discontinued or changed 1. Resident #145 was admitted to the facility in August 2024 with diagnoses including pneumonitis (an inflammation of the lung) due to inhalation of food and vomit, dysphagia (difficulty swallowing), and epilepsy. Review of the active Physician's Orders for Resident #145, dated 9/18/24, indicated but were not limited to the following: - 1:1 assist with all PO intake. Fully upright with all meals. Pt active with speech language pathologist (SLP) for dysphagia eval and treatment. Every shift (8/30/24) During an observation on 9/18/24, the surveyor observed Resident #145 at the following times: - 8:31 A.M., in room sitting on the edge of the bed consuming breakfast consisting of a muffin, scrambled eggs, hot cereal and juice, no staff was present in the room to assist the Resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8:33 A.M., Certified Nurse Assistant (CNA) #2 enters the room and encourages the Resident to continue to eat his/her meal, leaving the Resident alone at 8:37 A.M., to continue eating and not providing the ordered 1:1 assist - 8:43 A.M., CNA #2 reenters the room and asks the Resident if they are doing okay and exits the room, leaving the Resident alone at 8:43 A.M., to continue eating their breakfast without the ordered 1:1 assist - 8:49 A.M., the Resident has consumed the majority of their scrambled eggs and is pulling a muffin apart with his/her hands, they remain without the ordered staff present to provide a 1:1 assist - 9:02 A.M., CNA #3 enters the room, asks the Resident if they have finished and then removes the breakfast tray from the room During an interview with observation at 8:51 A.M., the SLP observed the Resident eating breakfast alone in their room, she said there is an order currently in place for 1:1 assist with all intake, but the Resident was being discharged from SLP services today and would only require their food to be cut up small once the discharge paperwork was complete but she had not completed it at that time. During an interview on 9/18/24 at 9:02 A.M., CNA #3 said the Resident used to require 1:1 for meals and intake but she didn't think that was required any longer and was unaware of the physician order in place. During an interview on 9/18/24 at 9:04 A.M., Unit Manager #4 reviewed the active physician's orders for Resident #145 with the surveyor and said the Resident should have been provided the 1:1 assist in accordance with the physician order and was not. She said the expectation is for all staff to follow MD orders as written. Review of the activities of daily living (ADL) and mobility flow sheet for Resident #145 from 9/1/24 through 9/18/24, indicated but was not limited to the following: - 37 of 54 potential opportunities for eating ability were documented - 3 of 37 documented opportunities indicated the Resident required set up or clean up assistance (helper sets/cleans up; resident completes activity) - 34 of 37 documented opportunities indicated the Resident was independent (completes the activity by themselves with no assistance from a helper) Review of the CNA care card, undated, for Resident #145 indicated but was not limited to the following: - Diet: regular chopped thin - Independent with set up - No aspiration precautions (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SLP therapy documentation for Resident #145 indicated but was not limited to the following: 8/30/24 Evaluation and plan of treatment: - Current referral reason: Patient (Pt) with diagnosis (dx) of aspiration pneumonia. admitted with soft ground/thin diet. At the time of the evaluation nothing by mouth (NPO) was recommended due to continued aspiration risk, but decision was made to continue ground/thin diet despite continued risk of aspiration. Question safety with PO intake, question least restrictive diet. Aspiration precautions; Pt requires supervision at mealtime 76-90% of the time. Summary of skilled service notes: - 8/30/24: Silent aspiration cannot be ruled out; Pt to continue on soft/thin diet at this time with 1:1 supervision - 9/6/24: Pt able to self-feed liquids, banana and sausage with set up. Pt accepted 100% of morning (A.M.) meal from CNA without signs and symptoms of reflexive aspiration. - 9/11/24: Pt assessed with regular texture all cut up and small portions presented; max cues to alternate liquids and solids, no overt signs of aspiration - 9/17/24: Pt continues to benefit from food being cut up to assist with decreased bite size; exhibits mildly extended mastification (process of chewing food); barriers impacting treatment include moderate cognitive impairment, nursing care required and difficulty learning new information 9/18/24 Discharge Summary: - Set up/cut up all meals; alternate liquids and solids; upright posture during meals; regular textures thin liquids diet During an interview on 9/18/24 at 12:18 P.M., Unit Manager #4 said she contacted the physician for Resident #145 and received orders to discontinue to 1:1 assist with meals today, after the surveyor inquired, and also updated the care plan today to reflect these changes, but dated back to 9/12/24 when the diet order was changed as recommended by the SLP. Review of the care plans for Resident #145 indicated but were not limited to the following: Problem: 9/3/24: Resident requires mechanically altered diet related to dysphagia and difficulties chewing and requires sufficient feeding assistance 9/18/24: Diet upgrade on 9/12/24 and independent eating per SLP and MD approval (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/24 at 12:25 P.M., Nurse #5 said she received the recommendations from SLP on 9/12/24 and contact the physician for new orders. She said on 9/12/24 she received orders from the physician to change the diet to Regular texture. She said she probably should have addressed the Resident's order for 1:1 assist at that time but did not and that is why the order remained active. She said the order for 1:1 assistance with all PO intake was active at the time the surveyor observed the Resident on 9/18/24 and should have been followed as ordered by the physician and was not. Review of the SLP Physician orders request forms for Resident #145 indicated, but were not limited to the following: 8/30/24: 1:1 assist with PO intake; fully upright with all meals 9/12/24: Discontinue mechanical soft/ground diet; house regular diet - cut up The SLP recommendations did not include the discontinuation of 1:1 assist. During an interview on 9/19/24 at 8:33 A.M., the Director of Nurses (DON) and SLP said the Resident was self-feeding and doing well with their skilled SLP services up to the time of discharge from SLP, which was completed yesterday, 9/18/24. The SLP said she never put in a recommendation to discontinue to 1:1 assistance for the Resident and that is likely the reason the order remained active at the time of the 9/18/24 observation. The DON said the expectation is that staff are following all active MD orders as written until the order is discontinued in accordance with the standard of nursing practice. 49425 2. Review of the facility's policy titled Administration Procedures for All Medications, dated as last revised 2024, indicated but was not limited to the following: -Review 5 rights 3 times -Check Medication Administration Record (MAR) for order -Check the label against the order on the MAR -After administration, return to cart, document administration in the MAR -If resident refuses medication, document refusal on MAR. -Notification of Physician/Prescriber for persistent refusals Resident #14 was admitted to the facility in November 2023 with diagnoses which included seizure disorder, joint replacement of the right shoulder, Chronic Obstructive Pulmonary Disease (COPD) (a group of lung diseases that block airflow) and anxiety. On 9/18/24 at 10:18 A.M., the surveyor observed Nurse #1 prepare and administer Resident #14's scheduled 9:00 A.M. medications including: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Buspar 5 milligrams (mg) (for anxiety) one tablet -Neurontin 600 mg (for seizures or nerve pain) two tablets -Tylenol Extra Strength 500 mg (for mild/moderate pain) one tablet Review of Resident #14's active Physician's Orders indicated the following: -Buspar 10 mg once a day, dated 5/15/24 -Neurontin 600 mg one tab three times a day, dated 1/25/24 -Tylenol Extra Strength 500 mg give two tabs = 1000 mg three times a day, dated 1/25/24 -Anoro Ellipta 62.5-25 micrograms (mcg) (inhaler for lung conditions) one inhalation once a day, dated 1/25/24 -Fluticasone Propionate 50 mcg (inhaler for lung conditions) one spray in nostrils once a day, dated 1/25/24 -Ipratropium Bromide 0.02% (aerosol for lung conditions), inhalation three times a day, dated 2/15/24 -Lidocaine adhesive patch 4% (local anesthetic for pain management), apply two patches to right shoulder once a day, dated 1/25/24 The surveyor did not observe Nurse #1 follow the 5 Rights and 3 Checks when administering the incorrect doses of Buspar, Neurontin and Tylenol Extra Strength and failed to document that Resident #14 was not administered the Anoro Ellipta, Fluticasone Propionate, Ipratropium Bromide, and Lidocaine patches as ordered by the physician. Review of the Medication Administration Record (MAR) indicated the Anoro Ellipta, Fluticasone Propionate, Ipratropium Bromide, and Lidocaine patches to the right shoulder were signed off as administered on 9/18/24 at 10:18 A.M. During an interview on 9/18/24 at 2:14 P.M., Nurse #1 said Resident #14 has a nighttime dose of Buspar 5 mg, and she administered the nighttime dose by accident. She also said she administered the incorrect dose of Neurontin. Nurse #1 said when preparing the Tylenol, she dropped one tablet on the medication cart and disposed of it and forgot to put another tablet into the medication cup. She said Resident #14 refuses the Anoro Ellipta, Fluticasone Propionate, Ipratropium Bromide all the time, so she does not administer it. Nurse #1 said she cannot apply the Lidocaine patches to Resident #14's right shoulder, because the Resident is wearing a brace. She said she signed all of the missed medications off as administered on the MAR by mistake. During an interview on 9/18/24 at 3:47 P.M., the Assistant Director of Nursing (ADON) said her expectation is for the nurse to administer medications as ordered by the doctor. She said the nurse should not have documented any medication as administered if it was not. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/19/24 at 12:52 P.M., the Director of Nursing (DON) said her expectation is for medications to be administered per the Physician's orders. She said the Physician is to be notified of incorrect or omitted medications, and a medication error form must be completed. DON said the medications omitted should have been documented as not given in the medical record, and the nurse should have documented the reason for not administering the medications in a nursing note. Refer to 759

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49425 Based on observation, interview, and record review, the facility failed to ensure it was free from a medication error rate of greater than five percent when one of two nurses made seven errors out of 40 opportunities, totaling a medication error rate of 17.5%. These errors impacted one Resident (#14), out of three residents observed. Specifically, the nurse administered the wrong dose of Buspar (for anxiety), Neurontin (for seizures or nerve pain), and Tylenol (for mild to moderate pain), and failed to administer Anoro Ellipta (inhaler for lung conditions), Fluticasone Propionate (inhaler for lung conditions), Ipratropium Bromide (aerosol for lung conditions), and Lidocaine patches (local anesthetic for pain management) as ordered. Findings include: Review of the facility's policy titled Administration Procedures for All Medications, dated as last revised 2024, indicated but was not limited to the following: -Review 5 rights 3 times -Check Medication Administration Record (MAR) for order -Check the label against the order on the MAR Review of the facility's policy titled Physician Services, dated as revised 11/14/22, indicated but was not limited to the following: -MD orders will be followed by staff as appropriate until the order has been discontinued or changed. Resident #14 was admitted to the facility in November 2023 with diagnoses which included seizure disorder, joint replacement of the right shoulder, Chronic Obstructive Pulmonary Disease (COPD) (a group of lung diseases that block airflow), and anxiety. On 9/18/24 at 10:18 A.M., the surveyor observed Nurse #1 prepare and administer Resident #14's scheduled 9:00 A.M. medications including: -Buspar 5 milligrams (mg) one tablet -Neurontin 600 mg two tablets -Tylenol Extra Strength 500 mg one tablet Review of Resident #14's active Physician's Orders indicated the following: -Buspar 10 mg once a day, dated 5/15/24 -Neurontin 600 mg one tab three times a day, dated 1/25/24 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tylenol Extra Strength 500 mg give two tabs = 1000 mg three times a day, dated 1/25/24 -Anoro Ellipta 62.5-25 micrograms (mcg) one inhalation once a day, dated 1/25/24 -Fluticasone Propionate 50 mcg one spray in nostrils once a day, dated 1/25/24 -Ipratropium Bromide 0.02% inhalation three times a day, dated 2/15/24 -Lidocaine adhesive patch 4% apply two patches to right shoulder once a day, dated 1/25/24 Nurse #1 administered the incorrect dose of Buspar, Neurontin and Tylenol. Nurse #1 failed to administer Anoro Ellipta, Fluticasone Propionate, Ipratropium Bromide, and Lidocaine patches. During an interview on 9/18/24 at 2:14 P.M., Nurse #1 said Resident #14 has a nighttime dose of Buspar 5 mg and she administered the nighttime dose by accident. She said she administered the incorrect dose of Neurontin. Nurse #1 said when preparing the Tylenol, she dropped one tablet on the medication cart and disposed of it and forgot to put another tablet into the medication cup. She said Resident #14 refuses the Anoro Ellipta, Fluticasone Propionate, Ipratropium Bromide all the time, so she does not administer it. Nurse #1 said she cannot apply the Lidocaine patches to Resident #14's right shoulder, because the Resident is wearing a brace. During an interview on 9/18/24 at 3:47 P.M., the Assistant Director of Nursing (ADON) said her expectation is for the nurse to administer medications as ordered by the doctor.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and document review, the facility failed to ensure all medications used in the facility were stored and labeled in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. Ensure staff properly labeled all medications stored in one of four medication carts reviewed once opened; and 2. Provide a permanently affixed compartment for the storage of a schedule IV (potential for misuse and dependence) controlled substance in one of two medication room refrigerators reviewed. Findings include: Review of the facility's policy titled Medication Storage in the Facility, revised 2024, indicated but was not limited to the following: -Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator. -Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to ensure purity and potency. -Once opened, these will be good to use until the manufacturer's date is reached unless the medication is: a. a multi-dose injectable vial b. an item for which the manufacturer has specified usable life after opening -When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. -The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. 1. Review of a facility document titled Medications with Shortened Expiration Dates, dated [DATE], indicated but was not limited to the following: -Lantus (insulin glargine, treats diabetes) - Vial: once opened, product expires 28 days after first use or removal from refrigerator, whichever comes first. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:14 A.M., the surveyor reviewed the Cityside Unit side 1 medication cart with Nurse #4 and observed the following: -one multidose vial of Lantus (insulin glargine, treats diabetes) stored inside a plastic storage container, not stored in its packaging box, pop top off the vial indicating it had been opened, vial not labeled with the date when opened or the new date of expiration, labeled with a resident's name During an interview on [DATE] at 9:19 A.M., Nurse #4 said she didn't know when the bottle was opened. She said the insulin should have had the date when opened and the discard date to ensure it was not expired. During an interview on [DATE] at 10:15 A.M., the Director of Nursing (DON), Administrator, and Consulting Staff #1 said the Lantus should have been labeled with the date when opened and the new date of expiration. The DON said the Lantus was only good for 28 days once opened and had a short expiration date to stay effective. 2. On [DATE] at 7:55 A.M., the surveyor reviewed the Harborside 1 Unit medication storage room with Nurse #3 and observed one bottle of lorazepam (benzodiazepine/schedule IV-controlled substance, treats anxiety) oral concentrate 2 milligrams (mg)/milliliter (ml) stored inside the packaging box in a clear locked controlled substance box inside the refrigerator. The box was affixed to a shelf; however, the shelf was not affixed to the refrigerator. The surveyor was able to take the shelf out of the refrigerator with the box attached. During an interview on [DATE] at 7:55 A.M., Nurse #3 said the controlled substance box should be permanently affixed and she had asked maintenance five times for it to be fixed but they said they couldn't. During an interview on [DATE] at 10:08 A.M. with the DON, Administrator, and Consulting Staff #1, Consulting Staff #1 said the policy was for the box to be double locked, which it was, but not permanently affixed. She then said the refrigerator was locked to avoid having to permanently affix it because it couldn't be.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48362 Based on resident and staff interviews, observation, and meal test trays on two of three units, the facility failed to prepare and serve meals in a manner conserving flavor, were palatable, and served at safe and appetizing temperatures. Findings include: Review of Resident Council Meeting Minutes, dated 6/26/24, indicated several residents were concerned about food temperatures and receiving cold food. During a Resident Council Meeting held on 9/18/24 at 1:00 P.M. by the survey team, 14 out of 14 residents present at the meeting said there was a concern about cold food temperatures across all mealtimes. On 9/19/24 at 11:30 A.M., the surveyor requested a lunch test tray to the Harborside Two Unit. The food truck left the kitchen at 11:53 A.M. and arrived at 11:55 A.M. on the unit. The test tray was conducted with the Dietitian observing at 12:06 P.M. with the following results in degrees Fahrenheit (F): - Sweet and Sour Chicken: 138.8 F - Mixed Vegetable (Carrots, Broccoli, Cauliflower): 108.7 F: soft, lacking flavor, cold to taste - Rice: 116.5 F: bland tasting, cold to taste - Strawberries: 50.8 F: warm to taste/touch, watery tasting - Milk: 54.2 F: warm to taste/touch Of note, the test tray was delivered to the unit on a pushcart by the dietary aide. An additional resident tray was also observed on the pushcart. All additional resident trays were delivered to the unit in a closed truck. On 9/23/24 at 8:00 A.M., the surveyor requested a breakfast tray to the Cityside Unit. The food truck left the kitchen at 8:20 A.M. and arrived at 8:26 A.M. on the unit. The test tray was conducted with the Dietitian observing at 8:34 A.M. with the following results: - Hard Boiled Egg: 128.0 F: warm to touch/peel, yellow cooked yolk - Oatmeal: 134.1 F: cool temperature, watery, lacking flavor - Muffin: 110.0 F: warm to touch - Milk: 49.1 F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Coffee: 150.6 F During an interview on 9/23/24 at 8:38 A.M., the Dietitian said the meal temperatures observed were not within appropriate ranges: hot items on resident meals should be 140 F when arriving to the resident and the milk temperature was too warm. The Dietitian said she would not expect trays to be delivered on a pushcart to the unit during meal times and that meals should remain in the delivery truck with the door closed to maintain proper temperatures until the tray is ready to be delivered to the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48362 Based on observation, record review, and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to properly label and date food products, and to maintain safe and clean equipment in four of five nourishment kitchenettes. Findings include: Review of the facility's policy titled Food & Nutrition Services, revised 12/5/21, indicated but was not limited to the following: - Food brought in by family or visitors will be in a secure container/bag, dated and will be subject to disposal based on sanitary, safe consumption. - If there are leftovers, the Facility will label the leftovers and store them in accordance with the Facility's policies for use and storage of foods, including but not limited to, policies relating to food sanitation. On 9/17/24 at 9:09 A.M., the surveyor made the following observations on the Cityside Unit nourishment kitchenette: - The inside of the microwave had orange and brown residue and food splatter covering the sides and top portion. - The refrigerator had a gallon size resealable bag with red grapes, dated 9/15/24, but no resident identification. - The refrigerator had two containers of soup wrapped in a plastic bag with no date or resident identification. On 9/17/24 at 3:44 P.M., the surveyor made the following observations on the Harborside One Unit nourishment kitchenette: - The inside of the microwave had brown food residue on the glass plate. The top portion of the microwave had peeling white plastic and burnt/bubbling plastic revealing the metal component underneath. - The refrigerator had a Styrofoam container on the bottom shelf with no date or resident identification. On 9/17/24 at 3:52 P.M., the surveyor made the following observations on the Harborside Two Unit nourishment kitchenette: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The inside of the microwave had a paper towel covering the glass plate with food residue. There was food splatter/stains covering the top and side of the microwave. - The freezer contained a Hershey's candy bar with no date or resident identification. On 9/18/24 at 8:04 A.M., the surveyor made the following observations on the Seaport Unit nourishment kitchenette: - The inside of the microwave had food residue/splatter on the top and sides. The top portion of the microwave had peeling white plastic and burnt/bubbling plastic revealing the metal component underneath. On 9/18/24 at 1:31 P.M., the surveyor made the following observations on the Harborside One Unit nourishment kitchenette: - The inside of the microwave had orange and brown residue and food splatter covering the sides and top portion. On 9/18/24 at 1:35 P.M., the surveyor made the following observations on the Harborside Two Unit nourishment kitchenette: - The inside of the microwave had a paper towel covering the glass plate with food residue. There was food splatter/stains covering the top and side of the microwave. On 9/18/24 at 1:40 P.M., the surveyor made the following observations on the Cityside Unit nourishment kitchenette: - The inside of the microwave had orange and brown residue and food splatter covering the sides and top portion. During an interview on 9/18/24 at 2:08 P.M., Dietary Staff #2 said she was in charge of stocking dietary items, including snacks and drinks, on each of the units nourishment kitchenettes every morning. Dietary Staff #2 said the Housekeeping staff is responsible for keeping nourishment kitchenettes clean, including microwaves and refrigerators. During an interview on 9/19/24 at 9:57 A.M., Housekeeping Staff #1 said she is typically responsible for cleaning the rooms and dining area on the Cityside Unit. Housekeeping Staff #1 said when cleaning the room, she makes sure the floors are clean and equipment like microwaves and refrigerators are also cleaned. During an interview on 9/19/24 at 10:25 A.M., the Dietitian said refrigerators and microwaves in the unit nourishment kitchenettes are to be for resident use only. The Dietitian said the microwaves on each unit should be cleaned appropriately and in good working condition. The Dietitian said food items left in the refrigerators in the unit nourishment kitchenettes should be labeled with the resident name and/or room number and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49425 Based on observation, record review, and interviews, the facility failed to ensure for one Resident (#114), out of a total sample of three residents observed on a medication pass, infection prevention and control measures were implemented to prevent the potential transmission of infections. Specifically, the facility failed to ensure staff followed basic infection control practices, including hand hygiene, resulting in potential cross contamination (transfer of pathogens from one surface to another). Findings include: Review of the facility's policy titled Handwashing/Hand Hygiene, dated as last revised August 2017, indicated but was not limited to the following: When to wash hands (at a minimum) -Before and after direct patient/resident contact -After completing tasks at one patient/resident area before moving to another station -Before procedures, such as administering medications -After contact with items/surfaces in patient/resident areas When to use the alcohol hand sanitizer -After contact with resident intact skin -Before entering the resident rooms -Before exiting the resident rooms Review of the facility's policy titled Administration Procedures for all Medications, dated as revised 2024, indicated but was not limited to the following: -Cleanse hands using antimicrobial soap and water, or facility approved hand sanitizer before beginning a medication pass, before handling medication, and before contact with the resident. -When finished with each resident, wash hands with antimicrobial soap and water or use facility approved hand sanitizer. Review of the facility's policy titled Oral Medication Administration, dated as revised 2024, indicated but was limited to the following: -Wash hands when beginning a medication pass, or when contact with resident is expected or has occurred. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pour or push the correct number of tablets or capsules into the cup, taking care to avoid touching the tablet or capsule, unless wearing gloves -When finished with each resident, wash hands with antimicrobial soap and water or use facility-approved hand sanitizer. Review of the facility's policy titled Injectable Medication Administration, dated as revised 2024, indicated but was not limited to the following: -Equipment required: Examination gloves Review of Centers for Disease Control and Prevention (CDC) guidance titled Infection Control in Healthcare: An Overview, dated 2/7/24, indicated but not limited to the following: Common reservoirs in and on the human body: Skin -Many germs live and grow on healthy skin and normally do not cause harm. -Your skin interacts with the environment daily, especially when you touch things with your hands. -Pathways for germs to spread from skin include: -Touch, especially with your hands. Review of Centers for Disease Control and Prevention titled Infection Control Basics, dated 4/3/24, indicated but not limited to the following: Transmission can happen through activities such as: -Physical contact, like when a healthcare provider touches medical equipment that has germs on it and then touches a patient before cleaning their hands. Resident #114 was admitted to the facility in July 2022 with diagnoses including Type II Diabetes. On 9/18/24 at 9:20 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #114 which included the following: -Nurse #1 had a medication cup with four tablets inside -Nurse #1 spilled two white, round tablets onto the medication cart -Nurse #1 picked up the tablets from the medication cart and placed them back into the cup with her bare hands -Nurse #1 prepared insulin injections at the medication cart as ordered and entered Resident #114 room carrying the medication cup of tablets and capsules and two insulin syringes -Nurse #1 did not perform hand hygiene prior to entering the room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #1 administered all eleven tablets and four capsules to Resident #114 with a cup of water -Nurse #1 cleansed Resident #114's left upper arm with an alcohol swab and injected one syringe of insulin -Nurse #1 cleansed Resident #114's left upper arm, with an alcohol swab and injected the other syringe of insulin. -Nurse #1 did not don (put on) gloves prior to administering the insulin injections -Nurse #1 exited Resident #114's room, disposed of the used needles in the sharps container located on the medication cart, and did not perform hand hygiene -Nurse #1 then began preparing another resident's medication At no time during the observation, did the surveyor observe Nurse #1 perform any type of hand hygiene. During an interview on 9/18/24 at 10:30 A.M., Nurse #1 said she should have discarded the medication she touched with her bare hands and not given it to Resident #114. She said that she usually wears gloves to give an injection, but she forgot to bring them into the room. Nurse #1 said she forgot to use the hand sanitizer before and after giving medications. During an interview on 9/18/24 at 3:35 P.M., the Assistant Director of Nurses (ADON) said her expectation is when medications are contaminated, they need to be wasted and not administered to the resident. She said hand hygiene should be done before and after all medication administrations. The ADON said gloves must be worn for all injections due to the increased risk of coming in contact with bodily fluids. During an interview on 9/19/24 at 12:52 P.M., the Director of Nursing (DON) said her expectation is for infection control guidelines to be maintained at all times, as a standard of practice. She said medications are never touched with bare hands, and if they are they must be disposed of and not given to the resident. She said when giving injections, gloves are worn to decrease the risk of cross contamination. She said hand hygiene should have been performed prior to entering and when exiting Resident #114's room, and after disposal of the dirty needles.