STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. Building B. Wing	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Lowell	30 Princeton Boulevard Lowell, MA 01851

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40928 Based on observation, interview and policy review, the facility failed to ensure a dignified experience during meals for 4 Residents (#11, #16, #23, #113) out of a total sample of 27 residents. Findings include: Review of the facility policy titled NSG270 Meal Service, revised 6/01/21 indicated the following: - Sit next to patient while assisting to eat; do not stand over her/him. 1. Resident #11 was admitted to the facility in January 2018 with diagnoses including dementia and protein/calorie malnutrition. Review of Resident #11's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) and required assistance with care activities. On 7/2/21 at 9:01 A.M., Resident #11 was observed in bed being fed by a Certified Nursing Assistant (CNA). The CNA was standing while feeding the Resident. On 7/7/21 at 8:20 A.M., Resident #11 was observed being fed in bed. The staff member was standing while feeding the Resident. 2. Resident #16 was admitted to the facility in March 2014 with diagnoses including dementia and rheumatoid arthritis. Review of Resident #16's MDS dated [DATE] indicated the resident was severely cognitively impaired and scored a 3 out of 15 on the BIMS. Resident #16's MDS further indicated that he/she required extensive assistance with eating. On 6/30/21 at 9:21 A.M., Resident #16 was observed being fed by a Certified Nursing Assistant (CNA). The CNA was standing while feeding the Resident. 3. Resident #23 was admitted to the facility in April 2021 with diagnoses including dementia and falls. (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 - Some	Review of Resident #23's MDS dated [DATE] indicated the Resident was severely cognitively impaired and scored a 3 out of 15 on the BIMS. Further review of Resident #23's MDS indicated the Resident requires extensive assistance with one person physical assist for eating. On 6/30/21 at 9:31 A.M., Resident #23 was observed lying in bed being fed by a staff member. The staff member was standing while feeding Resident #23 breakfast. 4. Resident #113 was admitted to the facility in June 2021 with diagnoses including acute respiratory failure and adult failure to thrive. Review of Resident #113's MDS dated [DATE] indicated the resident was severely cognitively impaired and scored a 3 out of 15 on the BIMS. Resident #113's MDS further indicated that he/she requires assistance with care activities. On 7/2/21 at 8:40 A.M., Resident #113 was observed lying in bed being fed by a hospice aide. The aide was standing while feeding him/her. During an interview on 7/02/21 at 9:15 A.M., CNA #4 said the expectation is that staff will sit while feeding residents. During an interview on 7/2/21 at 9:21 A.M., Unit Manager #1 said that staff should sit while feeding residents and should not be standing.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37349 Based on observation, interview and policy review, the Facility failed to accommodate the needs of two Residents (#45 and #16) out of a total sample of 27 Residents, related to 1) the availability of slipper socks and 2) having a call light within reach. Findings include: 1) For Resident #45 the Facility failed to accommodate the need for slipper socks. Resident #45 was admitted to the facility in 7/2020 with arterial wounds to his/her lower legs and feet requiring dressings. Review of the most recent Minimum Data Set (MDS), dated [DATE] indicated that Resident #45 was cognitively intact, scoring a 14 out of 15 on the Brief interview for Mental Status and required extensive assistance from staff for hygiene and dressing. On 6/30/21 at 10:07 A.M., Resident #45 was observed sitting in a wheelchair with his/her feet on the ground. He/She was not wearing socks and his/her wound dressings were directly on the floor and visibly soiled. During an interview at this time, Resident #45 said that the facility had been looking for slipper socks for 2 days. On 7/1/21 at 1:00 P.M., Resident #45 was observed sitting in a wheelchair with no socks or wound dressings on. During an interview at this time Resident #45 said that the dressings had just fallen off. Resident #45 also said the facility still had not found slipper socks for him/her. During an interview on 7/6/21 at 9:54 A.M., Unit Manager (UM) #1 said that the Facility provides slipper socks for Resident #45. UM #1 said slipper socks are kept in the clean utility room. UM #1 and the surveyor observed the clean utility room together and UM #1 was unable to locate any slipper socks. UM #1 said she would then contact laundry to see if there were any available there. During an interview on 7/6/21 at 10:00 A.M., the laundry person said that she had already sent laundry to the units and did not have socks for Resident #45. During an interview on 7/6/21 at 10:15 A.M., the Administrator and Director of Nursing failed to identify any additional areas where socks may be in the facility. Review of the purchase orders indicated that a case of slipper socks had been ordered each month February, March and April of 2021, but none had been ordered for the past 2 months of May or June. 40928 2) For Resident #16, the facility failed to ensure a call light was within reach. Review of facility policy titled NSG101 Call Lights with a revision date of 6/2/21 indicated: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All Genesis HealthCare patients will have a call light or alternative communication device within their reach at all times when unattended. Resident #16 was admitted in March 2020, with diagnosis of Dementia and Rheumatoid Arthritis. Review of Resident #16's Minimum Data Set (MDS) dated [DATE] indicated that the Resident is able to make self-understood and able to understand others. During multiple observations throughout the day on 6/30/21, 7/1/21 and 7/2/21, Resident #16 was observed in a wheelchair in the center of the room with no call light or alternative communication method within reach. Resident #16's call light was observed on his/her bed, not in reach of the Resident. During an interview on 7/1/21 at 1:00 P.M., Resident #16 indicated if he/she needed help he/she would get a staff member, and would do so by yelling. Resident #16 indicated he/she does have a call light/button he/she can press for assistance but he/she was not able to locate it. During an interview on 7/2/21 at 9:21 A.M., Unit Manager #1 acknowledged that residents should be positioned to have access to call lights and that if they are unable to reach the call light than an actual bell would be given to the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36797 Based on observation and interview, the facility failed to maintain all resident care areas of the building in good repair and in a clean manner. Findings include: A) On 7/7/21 the surveyor observed the following on the first floor resident care unit: 100- The vertical blinds were missing multiple sections, the orange wall had a yellowing substance dripping, the bathroom ceiling was peeling and the toilet paper holder rod was missing. 101- The closet door was off the tracks and a handle was missing, the headboard of bed A had brown smears across it, the Bed B privacy curtain was soiled, a blue arm chair seat was stained, the yellow arm chair seat was stained, the over the toilet commode was rusty. 102- The closet doors were off their tracks, the bathroom ceiling had brown stains, the ceiling light was falling down, the towel rod was missing, a wall in the room had 2 holes, the wall behind the bed was gouged, the wall next to the thermometer had the outline of something that was no longer affixed to the wall and the surface behind it had peeled off. 103- The closet door was missing, walls had a brown substance spattered on them, the wall behind Bed A was gouged, the vertical blinds had sections missing, the walls were dirty, scuffed and peeling. 104- The closet door was off the tracks, the over the bed commode was rusty. 105- The closet door was off the tracks, the ceiling above the closet doors was black, the bathroom ceiling had a cracked patch with a hole in it, behind Bed B the baseboard trim was falling off. 106-The wall by the window was patched without paint. 107- The closet door was off the tracks, the toilet bowl was stained with rust and was continuously running, the shower curtain was dirty with brown spots. 108- There was a hole in the wall to the left of the over the bed light for Bed A, there was a hole in the wall behind the bed, and the closet door was rusted.There was foul odor in the room that was noticeable in the hallway. 109- The toilet paper holder rod was missing, the bathroom ceiling was stained brown, the sink had brown rust stains, and the closet door was off it's tracks. 110- The wall was patched in 3 places without paint, the toilet tank cover was missing, Bed A's headboard and footboard was peeling, The closet door was off the tracks, the walls were scuffed and gouged, and the over the bed commode was rusty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	111- The closet door was off the tracks, the ceiling above the closet doors was black, the bathroom door jamb was rusted, the toilet paper holder rod was missing, the wall next to Bed A was spattered with a brown substance, the over the toilet commode was rusted. 112- The closet door was missing a knob, the radiator was rusted, the bathroom wall had multiple small holes, the walls in the room were scuffed and gouged throughout, the room ceiling near the window and above Bed A had a large brown stains. 113- The wall above the baseboard on the corner out side of the bathroom was broken and rusted, the wall next to Bed A was peeling and gouged, the closet door was off the tracks with one knob missing, and the walls in the room were scuffed and gouged throughout. 114- The closet door was off the tracks, the bathroom door jamb was rusted, 3/4 of the front of the bathroom radiator was missing with the remaining piece held on with a silver colored tape, the radiator was rusted. The towel rod in the bathroom was missing, the bathroom ceiling was stained brown and there were several broken wall tiles. The Bed A privacy curtain was dirty with brown spots, the wall around Bed A were peeling and gouged. 115- All of the walls in the room had white patches that had not been sanded or painted and the vertical blinds had sections missing. In the bathroom a towel rod was missing and the ceiling had brown stains. 116- The closet doors were off the tracks, the vertical blinds were dirty and missing sections and the toilet paper holder rod was missing. 117- The closet doors were off the tracks, a towel rod was missing and the ceiling had brown stains around the light fixture, the over the toilet commode was rusty, the wall next to Bed A was gouged and the privacy curtain around Bed B had brown stains. 118- The closet doors were off the tracks, and the toilet paper holder rod was missing. 119- The bathroom ceiling had brown stains. 120- The closet doors were off the tracks, the wall to the left of the bathroom door was gouged, the toilet paper holder rod was missing, the bathroom ceiling around the light fixture had brown stains and the ceiling above the window had brown stains. The first floor hallway had multiple areas of the walls with white patching without paint and areas where wall paper had been removed. The first floor Dayroom had multiple areas of peeling wallpaper, as well as scuffed walls and door jambs. The radiator was scuffed and the chair rail had peeling paint. B) On 7/7/21 the surveyor observed the following on the second floor resident care unit: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	200- the floor had multiple brown spot stains, the wall had a brown substance smeared on it, the vertical blinds had missing sections with some on the floor and the edges of the over the bed table edges were chipped and peeling. The bathroom door jamb was rusted with peeling paint, the toilet was continuously running, and the soap dispenser had fallen off of the wall and onto the floor. 201- The bathroom floor had tiles missing. 202- The baseboard on the corner outside of the bathroom was missing. 203- The baseboard on the corner outside of the bathroom was crumbling and scuffed and the towel holder rod was missing. 204- The towel holder rod was missing and both privacy curtains were dirty. 205- The bathroom toilet was continuously running, two toilet paper holder rods were missing, the tiles above the sink were broken, the soap dispenser had fallen off of the wall and was on top of the toilet tank cover, the tile behind the bathroom radiator was broken and the vertical blinds were missing multiple sections. 206- The baseboard on the corner outside of the bathroom was crumbling and scuffed, the wall behind Bed B was gouged and the privacy curtain around Bed A had brown stains on it. 207- The privacy curtain around Bed A was dirty and the wall behind Bed A was gouged. 208- An electrical cover plate on the wall was broken and the closet door was off it's track. 209- The inside of the bathroom door was scuffed and stained, 3 ceiling tiles in the bathroom had brown stains, the bathroom light switch had a thick brown substance on it, the bathroom radiator was rusted, the closet door was off it's track, the baseboard on the corner outside of the bathroom was crumbling and the television for Bed A was stuck on one channel. 210- The baseboard on the corner outside of the bathroom was crumbling, the bathroom ceiling light/fan was falling down, a bathroom ceiling tile was stained brown, the walls below the over the bed lights on both Beds A and B had multiple patches and were not painted, Bed B the television volume did not work and to the right of the door the wall had a patch that was not painted. 211- One closet door was missing and the other one was off of it's track, the electric box cover on the wall near Bed A was broken and held together with tape, One wall had a large area that was patched and not painted, the walls below the wallpaper border were scuffed, the wall behind Bed B was gouged, one wall had multiple small holes and the vertical blinds had multiple[le broken pieces that were lying on top of the windowsill. 212- One wall had large gauges and peeling paint and the Bed B television wall had multiple holes in it. 213- The floor surrounding the toilet was stained brown and the toilet continuously runs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	214- There was a brown substance on the wall next to the door and the vertical blinds were broken with broken pieces lying on the window sill. 215- The closet door was off of it's track, the wall behind the dresser was scuffed and there were multiple vertical blind pieces missing. 216-The trim in the bathroom was missing paint, there was approximately a 1.5 foot area of a yellow substance dripping on the walls, the wall between the beds was scuffed, the wall behind Bed B was gouged and the wall with the outside window was gouged. 217- The wall beneath the bathroom sink had an approximately 6x 3 hole, the tiles around the toilet were stained brown, the walls of the room were gouged in multiple areas and the vertical blinds were broken with broken pieces lying on the window sill. 218- The light above the bathroom sink not working, the wall across from the bed had multiple yellow drip marks and the vertical blinds were missing multiple pieces. 219- The closet door was off of it's tracks. 220- The baseboard on the corner outside of the bathroom was crumbling, the closet door was off of it's tracks, the Bed A privacy curtain had brown and orange stains on it and the vertical blinds were missing multiple pieces. During an interview on 7/07/21 at 11:30 A.M., the Center Executive Director said that the building needs new paint and wallpaper.The Center Executive Director said there was no formal work plan in place for the environment on the resident care units. The Center Executive Director said there are widespread environmental issues throughout the facility.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review and interview the facility failed to ensure 2 Residents (#30 and #59) were assessed to determine if the use of devices acted as a restraint out of a total sample of 27 residents. Findings include: Review of the facility policy titled Restraints: Use Of and dated revised 6/1/21, indicated that if the device cannot easily be removed by the patient and/or restricts freedom of movement or normal access to his/her body, the Restraint Evaluation/ Reduction will be completed. Further review indicated that an order from the physician is to be obtained as well as consent from the responsible party prior to the initiation of the restraint. 1. Resident #30 was admitted to the facility in July 2020 with diagnoses including repeated falls, muscle weakness and schizophrenia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #30 required an extensive assist of one person to walk and transfer out of bed. On 6/30/21, at 7:45 A.M., Resident #30 was observed in bed sleeping on a bolster mattress (a mattress with raised sides used to prevent a person from being able to get out of bed. On 7/1/21, at 1:17 P.M., Resident #30 was observed to be sleeping in bed with a bolster mattress on his/her bed. Review of the medical record failed to indicate that Resident #30 was assessed to determine if the use of a bolster mattress acted as a restraint. Further review failed to indicate a doctor's order for the use of a restraint or a careplan for the use of a restraint. During an interview on 7/1/21, at 7:50 A.M., Certified Nurse's Aide (CNA) #2 said that the bolster mattress helps to prevent Resident #30 from getting out of bed. She then said that Resident #30 gets confused sometimes and tries to get up without help and he/she falls a lot. 2. Resident #59 was admitted to the facility in June 2021 with diagnoses including Parkinson's disease, dementia and hallucinations. On 7/01/2, at 7:30 A.M., the surveyor observed Resident #59 lying in bed on his/her right side with a pillow wedged under the fitted sheet below the siderail on the left side of the bed. Review of the medical record failed to indicate that Resident #59 had been assessed to determine whether or not the use of the pillow under the fitted sheet acted as a restraint. Further review failed to indicate a doctor's order for the use of a restraint or a careplan for the use of a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/01/21, at 7:30 A.M., Certified Nurse's Aide (CNA) #2 said that sometimes they put that pillow like that so Resident #59 can't get out of bed. CNA #2 said that Resident #59 tries to get out of bed sometimes and he/she also shakes a lot so the pillow helps to prevent him/her from falling out of bed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 37349 Based on interview and record review, the Facility failed to implement their policy to prevent the potential for further abuse while investigating an allegation of abuse for 1 Resident (#34) out of a total sample of 15 residents. Findings include: Review of the facility's Abuse Prohibition Policy, revised 4/9/21 indicated the following: *The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. Review of the facility incident report indicated that on 9/2/21 at approximately 8:15 P.M., Resident #34 had called the police and reported to them that he/she was choked. During an interview on 9/14/21 at 10:45 A.M., the Director of Nurses said that he was aware that Resident #34 had called the police on the night of 9/2/21 alleging that he/she had been choked. He said that it is facility policy to suspend alleged abusers while an investigation is being conducted. He said that Resident #34 did not specifically name who the alleged abuser was so he was unable to determine who to suspend pending investigation. He said he received a call from the Department of Public Health on 9/8/21, and at that time suspended 3 staff members who worked the night of 9/2/21, 6 days after the allegation. Review of the investigation file indicated that on 9/5/21, no time indicated, the Social Worker had interviewed Resident #34 who said that he/she was attacked by 2 nurses. The investigation filed also indicated that on 9/5/21 the Social Worker had interviewed the roommate of Resident #34. The roommate said he/she was in the room at the time of the incident and heard Resident #34 say let go, you are choking me. Further review of the investigation file indicated that on 9/9/21 at 4:00 P.M., the Social Worker spoke with Resident #34 who reiterated that it was two female staff and he/she did not know their names. Resident #34 still feels that he/she was attacked by these staff but there have been no further incidents. During an interview on 9/16/21 at 12:33 P.M., the Social Worker said that she was not in the building at the time of the allegation and did not return until 9/7/21. She said 9/5/21 was written in error and Resident #34 and the roommate were not interviewed until 9/7/21. She said she informed the leadership team verbally and in writing of the interviews on 9/7/21. During an interview on 9/16/21 at 9:17 A.M., the Director of Nurses said that he was unaware of the interviews with Resident #34 and his/her roommates. He said that had he been aware he would have suspended the staff members pending an investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40928 Based on observation, interview and record review, the facility 1) failed to implement care plan interventions related to a fall for 1 Resident (#2), 2) failed to ensure hand orthotics were applied as ordered for 2 Residents (#5 and #28), and 3) failed to develop and implement a care plan for behaviors of fecal smearing for 1 Resident (#19) out of a total sample of 27 residents. 1) For Resident #2, the facility failed to implement fall care plan interventions. Resident #2 was admitted to the facility in 12/2019 with diagnoses including weakness, cognitive communication deficit and depression. Review of Resident #2's Minimum Data Set (MDS) dated [DATE] indicated the Resident had severe cognitive impairment and scored a 4 out of 15 on the Brief Interview for Mental Status. Further review of Resident #2's MDS indicated the Resident required extensive assistance with transfers and had a history of falls. Review of Resident #2's care plans included a care plan initiated 12/26/19 for risk for falls with the following intervention: - Bed/mattress perimeter reminder (bed rolls, scoop/concave mattress, etc.) Review of Resident #2's medical record indicated the Resident had a fall on 6/27/21 and was found on the floor with his/her head at the edge of the bedside table. On 6/30/21 at 10:58 A.M., Resident #2 was observed in bed on a regular mattress, no bolster or scoop mattress noted. On 7/01/21 at 1:35 P.M., Resident #2 was observed lying in bed on a regular mattress, no bolster or scoop mattress noted. On 7/01/21 at 3:30 P.M., Resident #2 was observed lying in bed on a regular mattress, with no bolster or scoop mattress noted. During an interview on 7/01/21 at 3:46 P.M., Unit Manager #1 said Resident #2 has had a few falls. Unit Manager #1 said there is a care plan intervention for a mattress with higher sides to help keep the Resident from rolling. Unit Manager #1 said if an intervention is ordered it should be implemented and that this intervention had not been implemented for Resident #2. 2 - a) For Resident #5, the facility failed to ensure a palmar guard was applied as ordered. Resident #5 was admitted to the facility in 5/2015 with diagnoses including cognitive communication deficit, hemiplegia and hemiparesis and depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's Minimum Data Set assessment dated [DATE] indicated short and long term memory problems. Further review of Resident #5's MDS indicated the Resident was totally dependent with dressing and further indicated impairment on one side of the upper and lower extremity. Review of Resident #5's medical record indicated a physician's order dated 3/26/21 for a left palmar guard to be worn daily, on after AM care, off for nighttime. Review of Resident #5's care plan indicated the Resident is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to CVA with an intervention dated 3/31/21 for a left palmar guard worn daily, on after AM care and off for bedtime, check skin daily. On 6/30/21 at 9:45 A.M., Resident #5 was observed lying in bed, with his/her left hand closed tightly in a fist position. There was no palmar guard in place. The surveyor observed a hand orthotic on the floor under the Resident's bed. On 6/30/21 at 1:13 P.M., Resident #5 was observed in bed, fully clothed. Resident #5 was not wearing a palmar guard. On 7/01/21 at 9:50 A.M., Resident #5 was observed in bed and was not wearing a palmar guard . The surveyor observed a hand orthotic on the floor under the Resident's bed. During an interview on 7/01/21 at 12:37 P.M., Certified Nursing Assistant (CNA) #1 said that generally the CNAs are responsible for applying any splints or equipment and that nursing will check that they are applied correctly. During an interview on 7/01/21 at 12:52 P.M., Unit Manager #1 said the CNA should put the splint on, and the nurse will double check and sign off on the Treatment Administration Record. Unit Manager #1 said if there was an order for a splint then it should have been applied. During an interview on 7/01/21 at 4:15 P.M., the Director of Rehabilitation (DOR) said if a resident has a contracture, the therapy department will trial different pieces of equipment or positioning devices to see what works best for the resident. The DOR will obtain an order from the physician for the equipment and the responsibility will be for nursing to implement. The DOR said that if there was an order for a hand splint then it should have been implemented. During an interview on 7/01/21 at 4:58 P.M., the Director of Nursing said that physician orders for application of the [NAME] guard should have been implemented. 2 - b) For Resident #28, the facility failed to ensure a resting hand splint was applied as ordered. Resident #28 was admitted to the facility in 6/2017 with diagnoses including cerebellar stroke syndrome, hemiplegia and contracture of the right hand. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident#28's Minimum Data Set (MDS) dated [DATE] indicated the resident had short and long term memory problems. Further review of Resident #28's MDS indicated the resident required extensive assistance with care activities and that the resident had functional impairment on one side of the upper extremity and lower extremity. Review of Resident #28's medical record indicated a physician's order dated 2/24/21 for a right resting hand splint on after AM care, off for nighttime with daily skin checks. On 6/30/21 at 9:44 A.M., Resident #28 was observed lying in bed and his/her right hand was in a closed fist position. There was no splint to his/her hand. On 6/30/21 at 1:13 P.M., Resident #28 was observed lying in bed, there was no splint noted to his/her right hand. On 7/01/21 at 9:45 A.M., Resident #28 was observed in bed, there was no hand splint noted to his/her right hand. Review of Resident #28's care plan indicated a care plan revised 5/29/19 that the Resident is dependent for ADL (Activities of Daily Living) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to CVA with an intervention to apply orthotic device (resting hand splint) to right hand daily in the morning after care and remove at bedtime. During an interview on 7/01/21 at 12:52 P.M., Unit Manager #1 said typically a Certified Nursing Assistant (CNA) will put the splint on the resident and the nurse will double check and sign off on the Treatment Administration Record. Unit Manager #1 said if there was an order for a splint then it should have been applied. During an interview on 7/01/21 at 4:15 P.M., the Director of Rehabilitation (DOR) said if a resident has a contracture, the therapy department will trial different pieces of equipment or positioning devices to see what works best for the resident. The DOR will obtain an order from the physician for the equipment and the responsibility will be for nursing to implement. The DOR said that if there is an order for a hand splint then it should be implemented. During an interview on 7/01/21 at 4:58 P.M., the Director of Nursing said that physician orders to apply the resting hand splint should have been implemented. 37349 3) For Resident #19 the Facility failed to develop and implement a plan of care related to the behavior of fecal smearing. Resident #19 was admitted to the Facility in 7/2014 with diagnoses which included vascular dementia with behavioral disturbance and psychosis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) dated [DATE], indicated that Resident #19 had a severe cognitive impairment scoring a 3 out of 15 on the Brief Interview for Mental Status and required extensive assistance for personal hygiene and toileting and was dependent on staff for bathing. There were no behaviors indicated in the MDS. On 6/30/21 at 10:05 A.M., the surveyor observed Resident #19 lying in bed. There was a brown substance smeared on the wall next to the bed. On 7/2/21 at 9:30 A.M., the surveyor and Nurse #3 observed Resident #19 lying in bed. There was a brown substance smeared on the wall next to the bed. During an interview with Nurse #3 at this time, she said that the brown substance was feces and had been there for at least 3 weeks. Nurse #3 said that she had told the aides and housekeeping, but it was still there. Review of Resident #19's medical record failed to include a plan of care related to the fecal smearing to ensure Resident #19's dignity and infection control standards were maintained.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, interview and record review the facility failed to ensure that 1 Resident's (#30) fingernails were clean and trimmed out of a total sample of 27 residents. Findings include: On 6/30/21, at 7:49 A.M., the surveyor observed Resident #30 to have long, dirty fingernails. On 7/1/21, at 10:00 A.M., the surveyor observed Resident #30 in the hallway with long fingernails. During an interview on 6/30/21, at 10:00 A.M., Resident #30 said that he/she would like his/her nails to be cut. Resident #30 said his/her fingernails were too long. Review of the care plan dated 5/24/21, indicated that Resident #30 required an extensive assist of 1 for activities of daily living, including grooming. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #30 required an extensive assist for personal hygiene. During an interview on 7/1/21, at 7:50 A.M., Certified Nurse's Aide (CNA) #2 said that it was the CNA's responsibility to assist residents with cutting their nails.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on interview and record review, the facility failed to ensure 1 Resident (#16) out of a total sample of 27 residents received treatment for vision maintenance as ordered by the physician. Findings include: Resident #16 was admitted to the facility in March 2014 with diagnoses including dementia and hypertension. Review of Resident #16's Minimum Data Set (MDS) dated [DATE] indicated the Resident is severely cognitively impaired and scored a 3 out of 15 on Brief Interview for Mental Status (BIMS). Review of Resident #16's medical record indicted a physician's order dated 6/11/20 for an Ophthalmology/vision exam for glasses. Further review of Resident #16's medical record failed to indicate the Ophthalmology exam had been completed as ordered. During an interview on 6/30/21 at 11:19 A.M., Resident #16 indicated he/she could not see out of his/her glasses and he/she was not sure if they were his/hers. Resident #16 said he/she had not seen an eye doctor. During an interview on 7/1/21 at 3:28 P.M., Unit Manager #1 reviewed Resident #16's physician order for an Ophthalmology exam and said that Resident #16 did not receive the vision evaluation for glasses as ordered.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, record review, and interview, the facility failed to prevent a worsening contracture for 1 Resident (#62) out of a total sample of 27 residents. Findings include: Resident #62 was admitted in June 2013 with diagnoses including Cerebral Vascular Accident (CVA). Review of Resident #62's Minimum Data Set Assessment(MDS) dated [DATE], indicated that Resident #62 was unable to complete the Brief Interview for Mental Status and his/her cognitive skills were assessed as severely impaired. The MDS also indicated that Resident #62 was dependent on staff for all mobility and activities of daily living. On all days of survey, Resident #62 was observed lying in bed and unable to communicate with the surveyor. Resident #62's right foot was turned in towards his/her body with no observable splint or brace in place. Review of Resident #62's physician orders indicated the the following order dated 1/5/21: -Wear right foot/ankle splint at all times except for hygiene and skin inspection. Every shift for ROM (range of motion) check skin and splint for placement. Review of Resident #62's Progress Notes indicated, - A progress note dated 2/25/2021-splint use was documented as, was not available. - This documentation for the prescribed brace was documented as not available or pending 72 times from 2/25/21 until 7/1/2021 -A note dated 7/2/21 which indicated the brace had been discontinued. Review of Resident #62's Physical Therapy Evaluation dated 12/31/2020, indicated the following: *Resident #62 has developed worsening range of motion in right ankle and great toe after not wearing the prescribed device. *Goals for treatment for Resident #62 were to increase PROM (passive range of motion) of right great toe and right ankle for facilitation of slowing progression of contractures. During an interview on 07/01/21 04:01 P.M., Nurse #4 said that Resident #62 was missing the ordered right foot/ankle splint. Nurse # 4 could not say how long the splint had been missing but said Rehab was aware. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/1/21 and 7/2/21, the Director of Rehabilitation (DOR) said that Resident #62's contracture had worsened. The DOR said orthotic devices are prescribed for a purpose and should be applied as ordered. The DOR said the expectation for missing orthotics is Nursing would inform Rehab and/or put in an order. The DOR said she was unaware of Resident #62's missing orthotic.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37349 Based on interview and record review, the Facility failed to provide adequate supervision to prevent an elopement for 1 Resident (#25) out of a total sample of 27 residents, resulting in a fall down a flight of stairs and a left clavicle fracture. Findings include: Resident #25 admitted to the Facility in 1/2019 with diagnoses which included Alzheimer's Disease, dementia with behavioral disturbance, psychotic disorder with delusions. Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated that Resident #25 used a wheelchair and required limited assistance to move both on and off the nursing unit. Review of the most recent Elopement Evaluation, completed 1 year and 5 months prior on 2/4/20, indicated that Resident #25 had a history of actual elopement or attempted elopement, and had a history of wandering that places the patient at significant risk of getting to a potentially dangerous place, e.g., stairs, outside facility. Review of Resident #25's plan of care for risk for elopement related to cognitive loss/dementia and Health Care Proxy's concern for elopement indicated an intervention was initiated on 4/9/21 to check on Resident #25 frequently to make sure he/she is not attempting to leave. Review of the nurses note written on 7/6/21 at 12:13 A.M., indicated that Resident #25 had been agitated since the morning of 7/5/21, saying somebody stole his/her child. Reassurance and redirecting done with little or no effect. He/she eloped through the back door and had an unwitnessed fall. Transferred out to the hospital for further evaluation. During an interview on 7/7/21, at 12:35 P.M., Unit Manager #1 said that 15 minute checks were initiated whenever Resident #25 became agitated. The checks were documented on 15 minute check forms and kept in the resident record. She reviewed the medical record with the surveyor and was unable to locate a 15 minute check sheet for 7/5/21. During a phone interview on 7/7/21, at 1:30 P.M., Certified Nursing Assistant (CNA) #2 said that on 7/5/21, Resident #25 had been agitated the entire 3-11 shift, attempting to get on the elevator to leave. She said no one was assigned to watch Resident #25, but everyone knows he/she can't be left alone when he/she is agitated like that. CNA #2 said that just after 9:30 P.M. she needed to provide care to another resident and left Resident #25 being supervised by Nurse #2. CNA #2 said that when she came out of the room she could hear Resident #25 yelling for help so she began searching room to room and was not able to locate him/her. CNA #2 said she finally looked in the stairway next to room [ROOM NUMBER] and saw Resident #25 at the bottom of the stairs and yelled for help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 7/7/21, at 1:12 P.M., Nurse #2 said that on 7/5/21 at approximately 9:30 P.M., the nurse that was caring for Resident #25 let her know that she would be taking her break off the unit. She said that Resident #25 had been pacing back and forth the entire shift attempting to get on the elevator to leave the unit. She said there was no one assigned to specifically supervise Resident #25, but everyone knew that Resident #25 could not be left alone when he/she was agitated like that. Nurse #2 said that she needed to give medications to another resident down the hallway and left Resident #25 being supervised by CNA #2. Nurse #2 said that when she came out of the other resident's room, CNA #2 was yelling for help and Resident #25 was found at the bottom of the stairs in the stairway outside of room [ROOM NUMBER]. She said Resident #25 was then transferred to the hospital to be evaluated. Review of the hospital discharge summary, dated 7/6/21, indicated a left shoulder x-ray result that showed a transverse fracture mid to distal clavicle with minimal displacement and mild to moderate angulation.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 36797 Based on observation, record review and interview the facility failed to ensure a resident maintained acceptable parameters of nutritional status for 1 Resident (#4), out of a total sample of 27 residents. Findings include: Review of the facility policy titled Weights and Heights, reviewed 12/20/19, indicated the following: 1. Weights will be obtained on admission, then weekly for four weeks and monthly thereafter. 2. If the body weight is not what is expected then re-weigh the resident. 3. Significant weight changes will be reviewed by the licensed nurse for assessment. 4. For a significant weight change the licensed nurse will notify the physician/nurse practitioner and the dietician. 5. The licensed nurse will notify the physician/nurse practitioner of the dietician recommendations. Resident #4 was admitted to the facility in September 2016 with diagnoses including Alzheimer's disease, type II diabetes and anxiety. Review of Resident #4's medical record indicated that the Resident had a usual body weight of 140-145 pounds (lbs). Review of the Resident #4's medical record indicated the Resident weighed 130 lbs on 2/21/21. Further review of Resident #4's medical record indicated physician orders dated 3/16/21 to reduce the house supplement to one time per day. Further review of the medical record indicated that the next weight obtained wasn't until 4/15/21, at which time Resident #4 weighed 120.6 lbs., a significant weight loss of 9.4 lbs. or 7.23 percent in less than 2 months (a significant weight loss is defined as 5% in one month, 7% in three months and 10% in six months). Review of the medical record failed to indicate a dietician note or a dietary intervention to prevent further weight loss. Review of the medical record indicated that on 5/27/21, Resident #4 lost another pound with a weight of 119 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Dietician note dated 5/27/21, indicated a recommendation to increase the house supplement back to two times per day. Review of the doctor's orders dated May 2021, June 2021 and July 2021 failed to indicate that the Dietician's recommendation was implemented. Review of the medical record failed to indicate a weight had been obtained in June 2021. Review of the medical record failed to indicate that Resident #4 refuses to be weighed. During an interview on 7/6/21, at 9:35 A.M., Unit Manager (UM) #2 said that Resident #4 is able to be weighed and doesn't know why there are not weights on him/her weekly. UM #2 then ambulated Resident #4 to the scale in the dining room and obtained a weight of 110 lbs., a significant weight loss of 9 lbs. or 7.56 percent in less than 2 months. During an interview on 7/6/21, at 11:00 A.M., the Dietician said that he was aware of the weight loss and the lack of the Resident being weighed weekly. He further said that he had spoken with the Unit Managers and the Director of Nursing but that nothing had changed. The Dietician also said that he wasn't sure why no further interventions had been implemented to prevent further weight loss. During an interview on 7/6/21, at 11:21 A.M., the surveyor asked UM #2 how the doctor or nurse practitioner is informed about a resident's weight. UM #2 responded that the nurse practitioner looks in Point Click Care (PCC) (the computer medical record) and the weights are listed there. During an interview on 7/6/21, at 1:39 P.M., Nurse Practitioner (NP) #1 said that she is supposed to be informed by nursing if a resident has had a significant weight loss. NP #1 then said that she had not been informed of Resident #4's weight loss. NP #1 also said that she was not aware to look in PCC for the weights. NP #1 then said that if the surveyor looked in her notes that the surveyor would not see any mention of Resident #4 having had a weight loss because she didn't know about it. Review of NP #1's notes dated 12/14/20, 2/12/21, 3/5/21, and 3/9/21 failed to indicate a mention of weight loss.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, interview and record review, the facility failed to ensure behavioral health services were provided to meet the needs of 1 Resident (#29) out of a total sample of 27 residents. Findings include: Review of the policy titled OPS106 Consultant Agreements and Responsibilities, revision date 7/24/18 indicated: - In the event that the facility can not employ the specific service of a qualified, professional person arrangements for such are provided by an outside resource. The purpose is to assume that services needed by patient are available through the center. Resident # 29 was admitted in October 2019 with diagnoses including Cerebral Vascular Accident, Major Depressive Disorder and Bipolar Disorder. Review of the Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating Resident #29 is cognitively intact. The MDS further indicated Resident #29's mood was down, depressed and hopeless. During an interview on 06/30/21 at 10:05 A.M., Resident #29 appeared very tearful and he/she said there had been a decreased interest in many things. Resident #29 said he/she had previously had frequent talk therapy sessions, but indicated there was a change in consultants within the facility, and talk therapy was no longer available. Review of Resident #29's Medical Record indicated: - A therapy assessment dated [DATE] as the last recorded therapy session. The assessment indicated termination in treatment would likely exacerbate or return Resident #29's symptoms. Treatment plan recommended continuing therapy treatment. During an interview on 7/2/2021 at 9:07 A.M., Unit Manager #1 said that therapy support services have not been available to residents. During an interview on 7/07/21 at 11:32 A.M., the Center Executive Director said that the current psych services provider was only providing medication management and that there were not currently therapists or psych services providing therapy to residents with behavioral health care needs. The Center Executive Director said that he was unsure how long it had been since therapy services were available to residents. The Center Executive Director further said that there was no current plan in place to manage residents with therapy support needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. Building B. Wing	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Lowell	30 Princeton Boulevard Lowell, MA 01851

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, policy review and interview the facility failed to ensure that food items were accurately labeled and dated to determine an expiration/use by date in 2 out of 2 unit refrigerators and in the main kitchen refrigerator. Findings include: Review of the facility policy titled Food and Nutrition Services Policies and Procedures, revised [DATE], indicated that food and beverages are maintained in a sanitary manner, are covered, labeled and dated with use by dates according to storage policies. On [DATE], at 7:45 A.M., the surveyor observed the following: In the main kitchen refrigerator, the following was observed; 1. 8 cups of a green liquid without a label or date. 2. 5 bowls of salad without a date. 3. 1 crate full of rotten cucumbers. In the main kitchen freezer, the following was observed; 1. 1 box of peas open and exposed to the air. 2. 1 bag of Tater Tots open and without a date. 3. 1 bag of blueberries open and without a date. On [DATE], at 4:45 P.M., the surveyor observed the first floor refrigerator to contain the following: 1. 1 frozen orange in a plastic bag with chunks of ice in the bag and dated [DATE]. 2. 1 half gallon of 2% milk open and without a date opened. 3. 1 half gallon of 2% milk open, frozen and with a date opened of [DATE]. During an interview on [DATE], at 4:48 p.m., Unit Manager #1 said that all the food should be dated and that it was the kitchen's responsibility to clean out expired food. On [DATE], at 4:15 P.M., the surveyor observed the second floor refrigerator to contain the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. Building B. Wing	07/07/2021

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Regalcare at Lowell	30 Princeton Boulevard Lowell, MA 01851

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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 - Many	1. 1 quart of chicken and rice soup open and without a date when opened. 2. 1 cup of milk without a date or label. 3. 1 bowl of salad without a date or label. 4. 1 container of dressing without a date or label. During an interview on [DATE], at 4:28 P.M., Nurse #4 said that all the food is supposed to be labeled and dated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. Building B. Wing	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, interview, and policy review the facility failed to ensure infection control practices for catheter care were maintained in accordance with facility policy for 1 Resident (#28) out of a total sample of 27 residents. Findings include: Review of facility policy titled 'Catheter: Indwelling Urinary- Care of', revised 6/01/21, indicated the following: -Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor. Resident #28 was admitted to the facility in June 2017 with diagnoses including cerebellar stroke syndrome, muscle weakness, and obstructive uropathy. Review of Resident #28's Minimum Data Set assessment dated [DATE] indicated the resident had an indwelling catheter and required extensive assistance with care activities. On 6/30/21 at 9:41 A.M., Resident #28 was observed in bed with his/her catheter bag on the floor of his/her room. On 7/01/21 at 9:46 A.M., Resident #28 was observed in bed with his/her catheter bag on the floor of his/her room. On 7/01/21 at 3:31 P.M., Resident #28 was observed in bed with his/her catheter bag under the bed on the floor of his/her room. During an interview on 7/01/21 at 3:43 P.M., Nurse #1 said that for infection control purposes, a catheter bag should not be on the floor. During an interview on 7/01/21 at 3:52 P.M., Unit Manager #1 said that the catheter bag should not be on the floor. During an interview on 7/01/21 at 4:51 P.M., The Director of Nursing said that the catheter bag should always be off the floor.