STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075335	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beechwood Health & Rehabilitation Center	31 Vauxhall Street New London, CT 06320

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on review of clinical records, facility documentation, facility policy, and an interviews for 30 of 52 sampled residents (Resident #1, #3, #4, #5, #6, #8, #13, #14, #15, #18, #23, #24, #26, #28, #29, #30, #33, #35, #39, #42, #44, #58, #500, #501, #502, #503, #504, #505, #506, and #507) reviewed for personal funds, the facility failed to credit interest earned to each resident's personal funds account. The findings include: Interview and facility documentation review with Director of Revenue #1 on 6/25/2025 at 2:10 PM, identified that Resident #33 had personal funds held by the facility in an interest-bearing account. Director of Revenue #1 indicated the monthly application of interest earned to an individual resident's account was a manual process. She identified that the facility failed to apply any interest earned to Resident #33's personal funds account from April 2024 to May 2025. Further review of Resident Trust Accounts identified a total of 30 residents with funds held by the facility who did not have interest earned applied to their individual accounts. Current facility residents affected included: Resident #1, #3, #4, #5, #6, #8, #13, #14, #15, #18, #23, #24, #26, #28, #29, #30, #33, #35, #39, #42, #44, and #58. discharged residents affected included: Resident #500, #501, #502, #503, #504, #505, #506, and #507. The Director of Revenue #1 stated that Business Manager #1 had assumed responsibility for managing resident personal fund accounts. She was unsure of why the interest had not been applied to each individual account since April 2024. However, she believed that Business Manager #1 was not properly trained, which resulted in the failure to apply interest as required by federal regulation. Review of the Personal Needs Account Policy and Procedure Policy dated 3/1/2021 failed to include the application of interest to a resident account.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy for 3 of 4 sampled residents (Resident #4, Resident #22, and Resident #33) reviewed for advanced directives, the facility failed to obtain a signed copy of an Advanced Directive form for Resident #4 and Resident #33, and for Resident #22 failed to transcribe the signed Advance Directive form to the electronic medical record. The findings include: 1. Resident #4 was admitted in February of 2020 with diagnoses that included encounter for palliative care, malignant neoplasm of the left breast (breast cancer), chronic systolic (congestive) heart failure, unspecified atrial flutter, cardiomyopathy, and essential hypertension. The admission Minimum Data Set assessment dated [DATE] identified Resident #4 had a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The quarterly Minimum Data Set, dated [DATE] identified Resident#4 had a BIMS score of 99, indicating the resident was unable to complete the Brief Interview of Mental Status evaluation. The Resident Care Plan dated [DATE] identified Resident #4 had an advanced directive for DNR/DNI/DNH (Do not Resuscitate/Do not Intubate/Do not Hospitalize) A medical record review identified a handwritten MD note dated [DATE] on the physician order sheet stating: DNR/DNI/NMP (Nurse May Pronounce). A signed Advanced Directive was not located in the medical record of Resident #4. A review of Resident #4's electronic medical record identified a start date, physician order, on [DATE] for an Advanced Directive indicating DNR/DNI/DNH/NMP/(Nurse May Pronounce)/Comfort Measures A signed copy of the Advance Directive was not located in the electronic medical record. A review of physician note for Resident #4 dated [DATE] at 2:02 PM indicated Resident #4 preference was for a Full Code. A physician note dated [DATE] at 12:40 PM identified that the resident's family member planned to come to the facility to sign the Advanced Directive form. Subsequently, a Progress Note dated [DATE] at 4:47 PM indicated that Resident #4's family member had signed an Advanced Directive to make the resident a DNR. Interview and clinical record review on [DATE] at 12:54 PM with Registered Nurse (RN) #1 identified that Resident #4 did not have a signed Advanced Directive form in the paper chart. She further identified that the nursing supervisor was responsible to ensure a signed copy was placed in the chart. RN #1 stated the physician note in the chart was an extra step but that the signed order is a must. Although RN #1 believed the Advanced Directive form was accidentally removed when the chart was thinned she was unable to locate the form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing Services (DNS) on [DATE] at 10:18 AM identified that her expectation was a signed copy of the Advanced Directive form would be in the resident's chart. She was unable to identify why there was not a copy in Resident #4's chart and stated she would attempt to locate it from medical records; however, this was never located. Further, the DNS expectation was that the Advanced Directive form would be added to the resident chart upon admission and reviewed quarterly. 2. Resident #22 was admitted in [DATE] with diagnoses that included multiple sclerosis, disorder of bone density and structure, and hypertension. The Resident Care Plan dated [DATE] identified Resident #22 had an Advanced Directive that directed staff for a Do Not Resuscitate (DNR) status. The admission Minimum Data Set assessment dated [DATE] identified Resident #22 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, required set up assistance for personal hygiene, and required maximal assistance for chair-bed-to chair transfers. An Advanced Directive form signed by Resident #22 and the physician, dated [DATE] identified that Resident #22 had provided consent for a DNR status. Interview and clinical record review on [DATE] at 11:46 AM with Licensed Practical Nurse (LPN) #2 identified that Resident #22 did not have a code status order within his/her electronic medical record. LPN #2 further identified an Advanced Directive form was to be signed by residents upon admission, or within 24 hours of admission, with the admitting nurse. After the Advanced Directive form was signed, the form would be sent to the physician to sign the order, and the nurse supervisor was responsible to enter the advanced directive status order into the electronic health record. Interview and clinical record review on [DATE] at 12:54 PM with Registered Nurse (RN) #2 identified Resident #22 did not have a code status order within his/her electronic medical record. RN #2 further identified that it was her responsibility to enter the order into the electronic medical record as she was the nurse who acknowledged the advance directive code status order. RN #2 was unable to identify why the code order was not entered into the electronic medical record. Interview with the Director of Nursing Services (DNS) on [DATE] at 1:33 PM identified that she had the expectation for Resident #22's code order to be entered into the electronic health record no later than [DATE]. The DNS further identified the missing advance directive code order in the electronic health record could have resulted in Resident #22 receiving Cardiopulmonary Resuscitation (CPR) against his/her wishes in an emergency situation. Subsequent to surveyor inquiry, on [DATE] at 2:01 PM a code status order was entered into the electronic health record for Resident #22 by RN #2 that directed DNR. 3. Resident #33's diagnoses included dementia, anxiety, and dysphagia. The New admission Evaluation dated [DATE] identified Resident #33 was oriented to person and was cognitively confused at the time of the evaluation. Resident #33 required both a walker and a wheelchair for mobility, maximal assistance from staff with personal hygiene, bed mobility and transfers, and required assistance with meal set up when eating. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Care Plan dated [DATE] identified Resident #33's care plan failed to include an advance directive plan of care. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had a Brief Interview of Mental Status (BIMS) score of 7 indicating cognition was severely impaired. A physician's order dated [DATE] indicated Resident #33 was a Do not Resuscitate (DNR). A physician's order that was still in effect, dated [DATE] indicated Resident #33 was a full code. Review of the clinical record on [DATE] at 2:15 PM identified the facility failed to obtain a signed copy of Resident #33's advance directive. Interview and clinical record review with RN #1 on [DATE] at 1:02 PM identified the facility did not have a signed copy of Resident #33's advance directive. RN #1 stated she did not know why this was not there, but it was the responsibility of the nursing supervisor to ensure that the form was completed and signed. RN #1 stated that per the facility policy, the advance directive must be signed and completed within 24 hours of admission to the facility. Interview with Corporate RN #1 on [DATE] at 1:16 PM identified it was the facility's policy for the RN supervisor on duty to ensure a resident's advance directive was signed and a hard copy placed in the physical chart. The RN supervisor must complete this task within 24 hours of admission without exception. While she was unsure of why it had not been completed, she believed it was an oversight on the part of the nursing supervisor. Review of the facility's Advanced Directive policy identified, in part, that information of whether or not a resident has executed an advanced directive shall be displayed prominently in the medical record and any revocations of the advance directive must be submitted, in writing, to the Administrator. Further, the policy identified that the Director of Nursing Services or designee will notify the Attending Physician of advanced directives so that appropriate orders can be documented in the resident's medical record.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record, interviews, facility documentation, and facility policy, for 1 of 3 sampled residents (Resident #28) reviewed for abuse and for the only sampled resident (Resident #30) reviewed for grievances the facility failed to report an allegation of abuse to the State Agency per the requirement. The findings include: 1. Resident #28's diagnoses included bipolar disorder, morbid obesity, and chronic congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had a Brief Interview of Mental Status (BIMS) score of 9 indicating cognition was moderately impaired, required a wheelchair for mobility, and was dependent on staff for bed mobility, and all transfers. The Resident Care Plan (RCP) dated 5/12/2025 identified Resident #28 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to immobility and physical limitations. Interventions directed staff to converse with Resident #28 when providing care, provide 1 to 1 bedside visits, and to escort the resident to activities of his/her choice. Review of the Grievance/Concern form dated 6/5/2025 identified Resident #28 stated NA #7 was often in a bad mood and told Resident #28, This is just a job. In addition, Resident #28 felt as though NA #7 talked about him/her being overweight and that NA #7 was angry 90% of the time. Although there was a signature line for the staff member who completed the form to sign, no staff member had signed the intake portion of the grievance form. Interview with Resident #28 on 6/23/2025 at 10:35 AM identified Resident #28 reported that NA #7 was rude and belittling toward him/her. Resident #28 stated NA #7 told him/her, this is just a job. Resident #28 said that hearing such a statement from a healthcare worker was upsetting. Interview with Social Worker (SW) #1 on 6/24/2025 at 3:02 PM identified she was made aware, on 6/6/2025, of the concern that had occurred between Resident #28 and NA #7. The DNS had informed her of the concern during morning report stating that NA #7 had been reassigned off of Resident #28's care. SW #1 reported her role in the allegation was limited to just speaking with Resident #28 after the complaint had already been addressed by the DNS. She described herself as, just a messenger, reported that standard grievance follow-up is expected within 48 hours, and the matter had been viewed as more of a nursing customer service issue. Further, the situation fell under the DNS's responsibility to report and investigate concerns. SW #1 stated the comments made by NA #7 were not appropriate or caring statements for a healthcare worker to say to a resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility documentation with the DNS on 6/24/2025 at 3:41 PM identified that she had spoken to Resident #28 following a request from the surveyor for documentation. She indicated that Therapeutic Recreation Director (TRD) #1 had brought the concern to her attention regarding Resident #28 immediately upon being reported on 6/5/2025. On the grievance form it was alleged that NA #7 entered the room in a bad mood when providing care to Resident #28 stating, This is just a job, and also made comments about Resident #28 being overweight. The DNS discussed the matter with Social Worker #1 the following morning during the staff morning meeting and reported that NA #7 had been reassigned and would not be taking care of Resident #28 any longer. The DNS was unable to identify who completed the intake portion of the grievance form or who had crossed off the resident's last name and wrote anonymous. She indicated she felt as though the resident wished to remain anonymous due to the cross off and that was the reason she had not reported the allegation of verbal abuse to the State Agency and reassigned NA #7. When she spoke with Resident #28 he/she expressed feeling upset about the just a job comment and stated that such remarks should not come from a healthcare worker. The DNS identified that she did not inquire about the weight related comment when she spoke to Resident #28. She also indicated she spoke to NA #7 after speaking with Resident #28, and that NA #7 stated she had made the just a job comment not directly to Resident #28, but to a colleague, in the hallway, toward the end of a stressful day. NA #7 indicated that Resident #28 may have overheard the comment but denied saying anything directly to the resident. The DNS stated that such comments were inappropriate, in hindsight the situation had potential for verbal abuse and should have been reported to the State Agency at the time the allegations were first brought to her attention on 6/5/2025. The DNS subsequently took NA #7 off the schedule on 6/24/2025 pending the outcome of the investigation and per the facility abuse policy and filed a Facility Reported Incident (FRI) dated 6/24/2025 which identified that on 6/5/2025 Resident #28 reported a staff member said to him/her this is just a job and made comments about him/her being overweight. Re-interview with Resident #28 on 06/25/25 at 9:20 AM identified the incident occurred when Resident #28 asked for assistance to be boosted up in bed. Resident #28 reported the request irked NA #7, and she appeared visibly irritated. Resident #28 recalled NA #7, saying this is just a job in a dismissive tone. Although Resident #28 could not recall the exact words, he/she stated NA #7 was making fun of his/her weight. Additionally, Resident #28 reported overhearing NA #7 make fun of his/her weight to other residents. Resident #28 recalled NA #7 telling his/her roommate they were easy to boost, which Resident #28 found hurtful. Interview with TRD #1 on 6/26/2025 at 8:42 AM identified that she could not recall how she learned of the allegation or the specific details of the event but that she did inform the DNS of the allegation that NA #7 said something about it being just a job and something about Resident #28 being overweight. She did not recall completing the grievance form and could not explain why it was not signed. TRD #1 stated she was aware of the abuse policy and if a healthcare worker suspected or saw something, then the allegations must be reported immediately. TRD #1 did report the allegations to the DNS, she did not feel the comments made by NA #7 to Resident #28 fell under verbal abuse, and she believed NA #7 was an excellent nursing assistant but did not have great bedside manners. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #7 on 6/26/2025 at 12:26 PM identified NA #7 reported that she was walking down the hallway at the end of the stressful shift and said out loud, this is just a job. She stated she was not directly speaking to anyone. She acknowledged she may have been near Resident #28's room when she commented, and Resident #28 may have overheard the comment. NA #7 explained she was tired and overwhelmed with multiple call lights going off at once. She also stated that when providing care to Resident# 28, it typically requires 3 or 4 staff members because 2 people are not enough to safely move Resident #28 and Resident #28 needed to be boosted, like every 5 minutes. NA #7 denied saying anything to Resident #28 about his/her weight. 2. Resident #30's diagnoses include dementia without behaviors, muscle weakness and reduced mobility. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #30 had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment and required set-up or clean-up assistance with Activities of Daily Living (ADL), able to transfer independently, and was frequently incontinent of urine and bowel. The Resident Care Plan dated 2/7/2024 identified an incontinence as an area of concern. Interventions included to provide toileting and incontinent care. Physician's orders dated 4/1/2024 directed to provide the assistance of 1 staff for transfers, mobility, and ADL's. A grievance form completed by Resident #30's responsible party dated 4/8/2024 identified that Resident #30 was in his/her pajamas at 10:30 AM in a very soiled pull up (incontinent brief) with a strong order. Also on the grievance form, the social worker indicated the resolution was to re-educate staff on performing rounds for toileting. There was no further documentation attached to the grievance form which was signed by the social worker and Administrator and the signatures were undated. A review of social work and nursing notes from 4/8/2024 through 4/30/2024 failed to indicate information with regard to the grievance form dated 4/8/2024 filed on Resident #30's behalf of an alleged incident of an overly soiled and odorous brief. Interview with the Director of Nursing Services (DNS) on 6/25/2025 at 12:30 PM identified that she was unaware of the grievance filed on Resident #30's behalf dated 4/8/2025. The DNS was unable to locate any investigation or education provided to staff for toileting rounds. The DNS indicated that if she was aware of the grievance she would have reported the allegation to the State Agency. She indicated that she was usually responsible for nursing grievance resolution and was unsure why this grievance was not brought to her attention. The staff members who were involved with the grievance form, social worker, nurse aide, and Administrator were no longer employed at the facility. An attempt to interview all 3 former staff members was unsuccessful. Subsequent to surveyor inquiry, the allegation of neglect was reported to the State Agency on 6/25/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Grievance/Complaint policy dated 6/7/24 directed, in part, any issue determined to be a potential allegation of abuse, neglect, misappropriation of property, exploitation, or injuries of unknown origin will immediately be reported and investigated following the abuse protocol/policy. A review of the Abuse Prohibition policy dated 4/12/2025 directed, in part, all allegations of abuse/neglect will be reported within time periods for reasonable suspicion of a crime and depends on the seriousness of the event that leads to the reasonable suspicion. Results in serious bodily injury or not, the individual shall report immediately, but not later than 2 hours after forming the suspicion.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record, interviews, facility documentation, and facility policy, for 1 of 3 sampled residents (Resident #28) reviewed for abuse and for the only sampled residents (Resident #30) reviewed for grievances the facility failed to investigate an allegation of abuse per the facility policy. The findings include: 1. Resident #28's diagnoses included bipolar disorder, morbid obesity, and chronic congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had a Brief Interview of Mental Status (BIMS) score of 9 indicating cognition was moderately impaired, required a wheelchair for mobility, and was dependent on staff for personal hygiene, bed mobility, and all transfers. The Resident Care Plan (RCP) dated 5/12/2025 identified Resident #28 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to immobility and physical limitations. Interventions directed staff to converse with Resident #28 when providing care, provide 1 to 1 bedside visits, and to escort the resident to activities of his/her choice. Review of the Grievance/Concern form dated 6/5/2025 identified Resident #28 stated NA #7 was often in a bad mood and told Resident #28, This is just a job. In addition, Resident #28 felt as though NA #7 talked about him/her being overweight and that NA #7 was angry 90% of the time. Although there was a signature line for the staff member who completed the form to sign, no staff member had signed the intake portion of the grievance form. Interview with Resident #28 on 6/23/2025 at 10:35 AM identified Resident #28 reported that NA #7 was rude and belittling toward him/her. Resident #28 stated NA #7 told him/her, This is just a job. Resident #28 said that hearing such a statement from a healthcare worker was upsetting. Interview with Social Worker (SW) #1 on 6/24/2025 at 3:02 PM identified she was made aware, on 6/6/2025, of a concern that had occurred between Resident #28 and NA #7. The DNS had informed her during morning report stating that NA #7 had reassigned off of Resident #28's care. SW #1 reported her role in the allegation was limited to just speaking with Resident #28 after the complaint had already been addressed by the DNS. She described herself as, just a messenger, reported that standard grievance follow-up is expected within 48 hours, and the matter had been viewed as more of a nursing customer service issue. Further, the situation fell under the DNS's responsibility to report and investigate concerns. SW #1 stated the comments made by NA #7 were not appropriate or caring statements for a healthcare worker to say to a resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility documentation with the DNS on 6/24/2025 at 3:41 PM identified that she had spoken to Resident #28 following a request for documentation. She indicated that the Therapeutic Recreation Director (TRD) #1 had brought the concern to her attention regarding Resident #28 immediately upon being reported on 6/5/2025. On the grievance form it was alleged that NA #7 entered the room in a bad mood when providing care to Resident #28, stated, This is just a job, and also made comments about Resident #28 being overweight. The DNS discussed the matter with Social Worker #1 the following morning during the staff morning meeting and reported that NA #7 had been reassigned and would not be taking care of Resident #28 any longer. The DNS was unable to identify who completed the intake portion of the grievance form or who had crossed off the resident's last name and wrote anonymous. She indicated she felt as though the resident wished to remain anonymous due to the cross off and that was the reason she had not interviewed any staff or investigated the incident. When she spoke with Resident #28 he/she expressed feeling upset about the just a job comment and stated that such remarks should not come from a healthcare worker. The DNS identified that she did not inquire about the weight related comment when she spoke to Resident #28. She also indicated she spoke to NA #7 after speaking with Resident #28, and that NA #7 stated she had made the just a job comment not directly to Resident #28, but to a colleague, in the hallway, toward the end of a stressful day. NA #7 indicated that Resident #28 may have overheard the comment but denied saying anything directly to the resident. The DNS subsequently took NA #7 off the schedule on 6/24/2025 pending the outcome of the investigation and per the facility abuse policy began an investigation into Resident #28's concern. Re-interview with Resident #28 on 06/25/25 at 9:20 AM identified the incident occurred when Resident #28 asked for assistance to be boosted up in bed. Resident #28 reported the request irked NA #7, and she appeared visibly irritated. Resident #28 recalled NA #7, saying this is just a job in a dismissive tone. Although Resident #28 could not recall the exact words, he/she stated NA #7 was making fun of his/her weight. Additionally, Resident #28 reported overhearing NA #7 make fun of his/her weight to other residents. Resident #28 recalled NA #7 telling his/her roommate they were easy to boost, which Resident #28 found hurtful. Interview with TRD #1 on 6/26/2025 at 8:42 AM identified that she could not recall how she learned of the allegation or the specific details of the event but that she did inform the DNS of the allegation that NA #7 said something about it being just a job and something about Resident #28 being overweight. She did not recall completing the grievance form and could not explain why it was not signed. TRD #1 stated she was aware of the abuse policy and if a healthcare worker suspected or saw something, then the allegations must be reported immediately. TRD #1 did report the allegations to the DNS, she did not feel the comments made by NA #7 to Resident #28 fell under verbal abuse, she believed NA #7 was an excellent nursing assistant but did not have great bedside manners. Interview with NA #7 on 6/26/2025 at 12:26 PM identified NA#7 reported that she was walking down the hallway at the end of the stressful shift and said out loud, this is just a job. She stated she was not directly speaking to anyone. She acknowledged she may have been near Resident #28's room when she commented, and Resident #28 may have overheard the comment. NA #7 explained she was tired and overwhelmed with multiple call lights going off at once. She also stated that when providing care to Resident# 28, it typically requires 3 or 4 staff members because 2 people are not enough to safely move Resident #28 and Resident #28 needed to be boosted, like every 5 minutes. NA #7 denied saying anything to Resident #28 about his/her weight. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #30's diagnoses include dementia without behaviors, muscle weakness and reduced mobility. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #30 had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment and required set-up or clean-up assistance with Activities of Daily Living (ADL), able to transfer independently, and was frequently incontinent of urine and bowel. The Resident Care Plan dated 2/7/2024 identified an incontinence as an area of concern. Interventions included to provide toileting and incontinent care. Physician's orders dated 4/1/2024 directed to provide the assistance of 1 staff for transfers, mobility, and ADL's. A grievance form completed by Resident #30's responsible party dated 4/8/2024 identified that Resident #30 was in his/her pajamas at 10:30 AM in a very soiled pull up (incontinent brief) with a strong order. Included on the grievance form, the social worker indicated the resolution was to re-educate staff on performing rounds for toileting. There was no investigation attached to the grievance form which was signed by the social worker and Administrator and the signatures were undated. A review of Resident #30's flow sheets (record of care provided) dated 4/8/2024 identified that Resident #30 was incontinent of urine on the 7:00 AM to 3:00 PM shift. A review of social work and nursing notes from 4/8/2024 through 4/30/2024 failed to indicate information with regard to the grievance form dated 4/8/2024 filed on Resident #30's behalf of an alleged incident of an overly soiled and odorous brief. Interview and review of facility documentation with the Director of Nursing Services (DNS) on 6/25/2025 at 12:30 PM identified that she was unaware of the grievance filed on Resident #30's behalf dated 4/8/2025. The DNS was unable to locate any investigation or education provided to staff for toileting rounds. The DNS indicated that if she was aware of the grievance she would have initiated an investigation per the facility policy. She indicated that she was usually responsible for nursing grievances and was unsure why this grievance was not brought to her attention. The staff members who were involved with the grievance form, social worker, nurse aide, and administrator were no longer employed at the facility. An attempt to interview all 3 former staff members was unsuccessful. Subsequent to surveyor inquiry, an investigation into the allegation of neglect was started on 6/25/2025. A review of the Grievance/Complaint policy dated 6/7/24 directed, in part, any issue determined to be a potential allegation of abuse, neglect, misappropriation of property, exploitation, or injuries of unknown origin will immediately be reported and investigated following the abuse protocol/policy. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Abuse Prohibition policy dated April 12, 2025, directed, in part, a thorough investigation of reports of alleged resident abuse or neglect would be conducted by the Administrator or DNS to determine if the conduct of the individual is in violation of any standard of care. The resident(s) involved in a case of suspected abuse will be protected from potential harm during the investigation procedure.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility policy, and interviews for the only sampled resident, (Resident #33) reviewed for care planning, the facility failed to ensure the Resident Care Plan was reviewed and revised on a quarterly basis with participation from an interdisciplinary team and Resident #33's representative. The findings included: Resident #33's diagnoses included dementia, anxiety, and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 had a Brief Interview of Mental Status (BIMS) score of 4 indicating Resident #33 was severely cognitively impaired, and required set-up and clean-up assistance when eating, and extensive assistance with bed mobility, toileting, and transfers. Review of the Resident Care Conference (RCC) quarterly meeting documentation on 4/24/2024 at 2:44 PM identified Person #1 was responsible for Resident #33. A note indicated an interdisciplinary RCC meeting took place with Person #1, social services and the MDS coordinator. Resident #33's plan of care was discussed, however, there was no documentation that indicated a multidisciplinary team reviewed or provided input to Resident #33's care needs. Review of the RCC documentation dated 7/31/2024 identified a care plan meeting was held however, there was no documentation Person #1 attended. In addition, there was no indication this was an interdisciplinary meeting with input or review from any other facility staff, and only Social Services and the MDS coordinator were present. Further review of the clinical record failed to identify that documentation of a RCC meeting took place from August 2024 through January 2024. Review of the clinical record on 2/5/2025 identified an RCC meeting was held and Person #1, Social Services and the MDS Coordinator attended, but there was no indication this was an interdisciplinary meeting that included other facility departments. Review of the clinical record from March to June 2025 failed to identify documentation that a RCC meeting was held. Interview with Person #1 on 6/23/2025 at 1:54 PM identified that Person #1 was responsible for Resident #33 and while he/she had participated in RCC's in the past, Person #1 had not been invited or attended an RCC meeting in a while. Person #1 stated he/she assumed the facility had stopped scheduling the meetings but would have liked to attend. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Worker (SW) #1 on 6/24/2025 at 2:33 PM identified that she was new to the facility and had only started in May 2025. She reported that Resident #33 did not have an RCC meeting as he/she should have in May. SW #1 did not know why Resident #33 was not scheduled. Additionally, SW #1 reported that only the facility personnel that were invited and attended RCC meetings were herself and the MDS coordinator. Other departments, such as nursing, dietary, therapy, or recreation were not made aware of the meetings and, therefore, did not attend or provide input on the Resident #33's status or needs. Interview with Corporate RN #1 on 6/24/2025 at 3:11 PM identified that the expectation is that the RCC is held at least quarterly or sooner if the resident's status changes. Additionally, an interdisciplinary team must review and update the RCP quarterly. Corporate RN#1 was unable to explain the lack of input, attendance, or scheduling for RCC's. Subsequent to surveyor inquiry, Person #1 was contacted, and an RCC was scheduled for June. Review of the Care plan, Comprehensive Person-Centered Policy dated 12/2016, directed, in part, the interdisciplinary team, in conjunction with the resident and/or his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The interdisciplinary team must review and update the care plan. when there is a significant change, when desired outcomes are not met, when a resident has been readmitted , and at least quarterly.

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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** Based on observation, review of clinical record, facility policy, and staff interviews, the facility failed to ensure fingernail care was provided to Resident #4. The findings include: Resident #4 was admitted in February 2020 with diagnoses including encounter for palliative care, malignant neoplasm of the left breast (breast cancer), chronic systolic (congestive) heart failure, and unspecified atrial flutter. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #4 had a Brief Interview of Mental Status (BIMS) score of 99, indicating inability to complete the Brief Interview of Mental Status, and was dependent for personal hygiene. The Resident Care Plan dated 6/15/2025 identified Resident #4 had an ADL self-care performance deficit. Interventions indicated: requires extensive assist by (1) staff with personal hygiene, and with a terminal prognosis with comfort focused care, and with adjustments to the provision of ADLs to compensate for changing abilities. Observations on 6/23/2025 at 11:26 AM and 6/25/2025 at 10:00 AM, and 6/25/2025 at 2:52 PM identified Resident #4's fingernails were noted to be lengthy and soiled with brownish debris under the fingernail. A physician order dated 11/1/2024 directed skin inspection every week Wednesday on the 7:00 AM to 3:00 PM. A review of the NA Task Care card for Resident #4 directed bathing/bed bath on Wednesday on the 7:00 AM to 3:00 PM. A review of the flow sheet for Resident #4 identified that NA #5 had signed off Resident #4 indicating completion of bathing bed bath on 6/25/2025 at 1:55 PM. Attempts to speak with NA#5 were unsuccessful. Interview with NA #6 identified that although she did not provide care for Resident #4, she would expect washing of hands and trimming and cleaning of nails, if needed, to occur during a bed bath. Additionally, NA #6 identified that nail care would occur even if it was not a scheduled bath day but nails needed to be cleaned. Interview with Licensed Practical Nurse (LPN) #1 on 6/26/2025 at 11:52 AM identified that on a resident bath/shower day the NA will let them know when bathing is being done so a skin check can be done. LPN #1 further identified that the same would be true for a resident receiving a bed bath. LPN #1 stated the expectation for a bed bath would include a full body wash and a neat and tidy overall appearance. Further, LPN #1 stated that it was the recreation lady that usually would take care of them but otherwise the NA or nurse could. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Corporate Nurse #1 identified that her expectation for a bed bath would include a head to toe wash and rinse including a clean and trim of fingernails. Corporate Nurse #1 identified that it was the responsibility of the NA to provide fingernail care during AM & PM care. Further, Corporate Nurse #1 indicated that the facility has a regular supply of emery boards and orange sticks for NA's to utilize for nail care. Review of the Activities of Daily Living (ADLs), Supporting policy directed, in part, residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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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** Based on observations, review of the clinical record, and facility policy for 3 residents identified during the initial screening of residents (Resident # 51, Resident #48 and Resident #21) the facility failed to ensure medications were not at bedside and alcoholic beverages were not stored in the medication refrigerator in 1 of 2 medication refrigerators. The findings include: 1.a. Resident #21's diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and sleep apnea. The Resident Care Plan dated 2/7/2025 identified COPD as an area of concern. Interventions included providing aerosol or bronchodilators as ordered, monitor for side effects of medication, monitor for acute respiratory insufficiency, and administered oxygen therapy as ordered. Resident #21's quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 as being moderately cognitively impaired as the result of a Brief Interview for Mental Status (BIMS) assessment score of 9. Physician's orders dated 6/23/2025 directed to administer, Trelegy Ellipta Inhalation Activated 200-62-5-25 microgram (MCG) 1 puff inhale one time a day for COPD and Ketoconazole External Cream 2% apply to scalp 2 times a day for fungal rash. Observation on 6/23/25 at 11:39AM during the initial resident screening identified that Resident #21 had the Ketoconazole cream 2% and Trelegy inhaler on the over the bed table. Resident #21 indicated that the nurse leaves the medications there. Observation on 6/23/25 at 1:09 PM identified the Ketoconazole 2% cream and Trelegy inhaler were no longer at the bedside. Interview with LPN#1 on 6/23/25 at 1:12PM indicated the facility was working on getting an order to self-administer the medications as Resident #21 did not have an order to self-administer and there was not a self-administration evaluation completed. LPN #1 stated that she left inhaler at bedside by accident. b. Resident # 51's diagnoses included dysphagia, constipation, and adjustment disorder with mixed anxiety. Furthermore, the care plan identified impaired vision related to Hyperopia (impaired vision of close objects) as an area of concern. Interventions included keep personal items within reach, assist with glasses, orient to surroundings and notify MD of any visual problems The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #21 as being severely cognitively impaired indicated by a Brief Interview of Mental Status (BIMS) score of 7 and required limited assistance with activities of daily living. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders dated 5/29/2025 directed to administer Aspercream 10% every 8 hours to knees as needed and gas relief chewable tabs 80 mg (milligrams) give 2 tabs as needed every 8 hours for gas/bloating. Observation on 6/23/25 at 10:15AM during initial resident screening identified Resident #51 with a bottle of Nuvoflex collagen joint support caps that were opened and missing capsules, a bottle and a box that contained Gas-X soft gel 80 mg, and (2) 3-ounce (oz) tubes of Aspercream all opened and stored on his/her over the bed table. Resident #51 stated he/she takes these medications whenever he/she felt the need. A review of the clinical record on 6/23/2025 with LPN #1 identified that Resident #51 had orders for Gas-X and Aspercream. Resident #51 did not have a physician order or an evaluation to self-administer medications, and did not have a physician order that prescribed Nuvoflex collagen joint support caps to be taken. Observation with LPN #1 on 6/23/2025 at 11:30 AM identified that Gas-X, Aspercream, and Nuvoflex were in Resident #51's room on his/her over the bed table. LPN #1 stated she had not seen the medications on the over the bed table and if she had, she would have removed them because Resident #51 did not have an order to self-administer, and the medications were not secured per policy. c. Resident #48's diagnoses included dementia, adjustment disorder and visuospatial deficit with spatial neglect following a cerebral infraction (difficulty processing information about location, orientation, and relationship between objects after an injury to the brain). Resident #48's quarterly Minimum Data Set (MDS) assessment date 5/12/2025 identified Resident #48 as unable to complete a Brief Interview for Mental Status (BIMS) assessment due to cognitive status and required supervision with activities of daily living. Physician's orders dated 5/25/2025 directed to administer Calcium Carbonate (Tums) chewable 500 mg every 6 hours as needed for heartburn. The Resident Care Plan dated 5/29/2025 identified dependency related to transfer, strengthening and medication management related to stroke. Interventions included ensure adaptive equipment that the resident needs are provided and items are within reach. Observation on 6/23/2025 at 10:30 AM during initial resident screening identified Resident #48 with a bottle of Tums 500mg ½ full stored on the over the bed table. Resident #48 indicated she took the Tums when needed for heartburn. A review of Resident #48's clinical record with LPN #1 on 6/23/2025 at 11:40 AM identified there was no physician order to self-administer medications and no self-administration evaluation completed. Observation with LPN#1 on 6/23/2025 at 11:45 AM identified a half full bottle of Tums on Resident #48' over the bed table. LPN #1 stated she had not seen the bottle of Tums and if she had, she would have removed the medication as Resident #48 did not have physician order to self-administer and medications were not stored secure per facility policy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After identification of medication concerns by bedside, medications were removed from Resident # 21, Resident #51 and Resident #48 room. In addition, a Self-Administration of Medication Evaluations were completed on Resident #21, Resident #51 and Resident #48 on 6/23/2025. Subsequent to surveyor inquiry, on 6/23/2025, the facility conducted a facility wide audit to ensure no other residents had medications at their bedside. Interview with DNS on 6/23/2025 at 12:45 PM identified that if medications were at the bedside, it was the charge nurse's responsibility to remove the medications. The DNS indicated that the medications for Resident #21, Resident #51 and Resident # 48 should not have been at the bedside as they did not have an order for self- administration or a self-administration evaluation completed. Furthermore, if a resident has an order to self-administer medications, the medications are kept secured in the resident's room. 2. Observation on 6/25/2025 at 11:00 AM identified that 2 bottles of wine and 8 bottles of beer were being stored in the 2nd floor medication refrigerator with resident medications. Interview with DNS on 6/25/2025 at 12:00 PM indicated that wine and beer should not be stored with medications. She indicated that it is the charge nurses' responsibility to ensure no non-medication items were stored in the medication refrigerator. The DNS indicated that she was unsure of the policy related to medication storage but believed it stated only medications should be stored in the medication refrigerators. Observation on 6/26/2025 at 1:15 PM identified that the wine and beer remained in the 2nd floor medication refrigerator. The Medication Storage policy dated 1/2025 directed, in part, medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Refrigerated medications should be kept in closed and labeled containers with internal medications separated for external medications and all medications segregated from fruit juices, applesauce, and other foods used in administering medications. Any other food such as employee lunches and activity department refreshments should not be stored in this refrigerator. The Self Administration of Medication policy dated 12/2016 directed, in part, that residents have the right to self-administer medications if the interdisciplinary team determines it is clinically appropriate. As a part of the overall evaluation the staff and practitioner will assess each resident's mental and physical abilities to self-administer. Medications for self-administration must be stored in a safe and secure place which is not accessible by other residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, facility documentation, facility policy and staff interviews, the facility failed to ensure the kitchen ice machine was maintained in sanitary condition. During surveyor walk through of the kitchen on 6/23/2025 at 10:30 AM with Director of Dietary (DD) observation was made of a black substance within the ice machine. Interview and observation with the DD on 6/25/2025 at 11:57 AM identified that the ice machine cleaning would be the responsibility of the Maintenance Director but that the facility currently did not currently have a full time Maintenance Director. Additionally, the DD stated he never thought of looking up into the machine for cleanliness. Subsequent to surveyor inquiry the machine was cleaned by DD and the black residue was no longer present. Review of the Beechwood Monthly Preventive Maintenance & Safety Checklist on 6/25/2025 documented a check of the Ice machine cleanliness, function and filters for April 2025 and June 2025. No verification checklist was completed by the facility for May 2025. Review of the Sanitization policy indicates that all equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Further, the policy states ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy.