STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225002	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holden Rehabilitation & Nursing Center	32 Mayo Road Holden, MA 01520

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review, the facility failed to determine if the practice for self-administration of medications was clinically appropriate for one Resident (#119) out of a total sample of 20 residents. Specifically, the facility failed to assess Resident #119's ability to self-administer medications before the Resident was allowed to have three bottles of Aspercreme (topical anesthetic medication), one prescription Ventolin (fast-acting bronchodilator medication) inhaler, one unit dose dropper of Systane Ophthalmic Solution (eye lubricant and irrigation medicine), and one bottle of prescription Latanoprost (medication used to treat high intraocular pressure) eye drops in his/her possession for the purpose of self-administration which increased the Resident's risk for improper medication administration. Findings include:Review of the facility's Self-Administration of Medications Policy, undated, indicated the following: -Purpose- To establish a standardized process for evaluating, authorizing, monitoring, and documenting resident self-administration of medications. -This policy promotes resident autonomy while ensuring medication safety. -Residents of the facility may self-administer medications only when: -A physician, nurse practitioner (NP), or physician assistant (PA) agrees with self-administration. -The interdisciplinary team (IDT) determines the practice is clinically appropriate and safe. -The resident demonstrates the physical ability to safely self-administer medications. -Eligibility Criteria- -Demonstrate safe administration technique. -Maintain medications safely. -Comply with storage requirements. - . licensed nursing staff shall complete a Self-Administration Assessment . The assessment shall be reviewed by the attending provider and incorporated into the care plan. -Provider authorization - medications approved for self-administration. -The comprehensive care plan shall include resident goals/preferences, medications approved for self-administration. Resident #119 was admitted to the facility in May 2026 with diagnoses including Adult Failure to Thrive (AFTT), Weakness, Chronic Obstructive Pulmonary Disease (COPD), and Osteoarthritis (OA). Review of Resident #119's May 2026 Physician orders indicated: -Aspercreme Lidocaine External Cream 4% (percent), apply to affected areas topically every 24 hours as needed for pain, ordered 5/13/26. -Latanoprost Ophthalmic Solution 0.005%, instill one drop in both eyes at bedtime for Glaucoma, ordered 5/13/26. -Systane Ophthalmic Solution 0.4-0.3%, instill two drop [sic] in both eyes every eight hours as needed for dry eyes, ordered 5/13/26. -Ventolin HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT [sic] (Albuterol Sulfate), two puff [sic] inhale orally every four hours as needed for wheezing/sob (shortness of breath), ordered 5/13/26. Further review of Resident #119's May 2026 Physician orders did not include an order for self-administration of medication. Review of Resident #119's clinical record failed to include evidence that: -An assessment for self-administration of medication was completed with the Resident. -A Physician/NP/PA agreed with the self-administration of any medication. -The IDT determined self-administration of medication was clinically appropriate and safe. -The assessment was reviewed by the Attending Provider and incorporated into the Resident's care plan. -The Provider authorized Aspercreme, Systane, Latanoprost, and Ventolin medications for self-administration by the Resident. On 5/17/26 at 9:10 A.M., the surveyor observed the following in Resident #119's room: -Resident #119 was lying in bed with the head of bed slightly elevated. -The Resident's bedside table was located next to the right side of the Resident's bed, within reach of the Resident. -The surveyor observed (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	three bottles of Aspercreme, one bottle of prescription Latanoprost eye drops in an open box, one unit dose dropper of Systane Ophthalmic Solution, and one prescription Ventolin inhaler in an open box. During an interview at the time, Resident #119 said staff allowed him/her to keep the Aspercreme, Latanoprost eye drops, Systane eye drops, and Ventolin inhaler at his/her bedside for self-administration. Resident #119 said facility staff insisted on administering his/her other medications and that he/she was allowed to self-administer the Aspercreme, Latanoprost eye drops, Systane eye drops, and Ventolin inhaler. The Resident said he/she was able to use the Ventolin inhaler whenever he/she was feeling SOB and the eye drops whenever he/she needed to treat his/her dry eyes. Resident #119 said facility staff had not instructed him/her on medication storage requirements. On 5/18/26 at 4:42 P.M., the surveyor observed Resident #119 in his/her room with a bottle of prescription Latanoprost eye drops and Ventolin inhaler, both out of the boxes. During an interview at the time, Resident #119 said he/she was allowed to keep the Latanoprost eye drops and Ventolin inhaler on his/her table. During an interview on 5/19/26 at 9:10 A.M., Nurse #2 said when a resident expresses the desire to self-administer medications, the resident needs to be assessed for their ability to self-administer and an order must be obtained from the Physician for self-administration. Nurse #2 said she was not sure whether Resident #119 had been assessed and an order obtained for self-administration of medications. Nurse #2 said she did not know if Resident #119 was authorized to self-administer medications. On 5/19/26 at 9:20 A.M., the surveyor observed Resident #119 in his/her room, sitting up in his/her wheelchair with the bedside table in front of him/her and eating breakfast. The surveyor observed two bottles of Aspercreme on the table to the left of the Resident's breakfast tray. During an interview on 5/19/26 at 10:45 A.M., Unit Manager (UM) #2 said Resident #119 had not been assessed for self-administration of medications prior to allowing the Resident to maintain possession of medications at his/her bedside for self-administration.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record review, the facility failed to adhere to professional standards of practice relative to arranging for follow-up dermatology services, for one Resident (#12) out of a total sample of 20 residents.Specifically, the facility failed to arrange a follow-up dermatology appointment recommended by the Dermatologist for Resident #12, when the Resident had been assessed by the Dermatologist and treated for a skin condition of the upper lip, increasing the Resident's risk for unresolved upper lip/skin conditions. Findings include:Resident #12 was admitted to the facility in May 2022 with diagnoses including mild cognitive Impairment, Dementia, and need for assistance with personal care. Review of the Minimum Data Set (MDS) Assessment, dated 4/23/26, indicated Resident #12: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15 total possible points. -has clear speech. -understands and was understood. Review of Resident #12's Dermatology Visit Note, dated 3/2/26, indicated: -A focused skin exam was performed. -Upper lip with scaly, erythematous papules and plaques. -The Resident's differential diagnosis was irritant contact dermatitis versus allergic contact dermatitis versus fungal overgrowth . -Treatment recommended was Hydrocortisone one (1) percent (%) cream, mix 50-50 with Ketoconazole cream and apply to upper lip twice a day for two to three weeks. -Return in about one month (around 4/2/26) for recheck rash. Review of Resident #12's March 2026 Treatment Administration Record indicated Hydrocortisone External Cream 1% (Topical) and Ketoconazole External Cream 2% (Topical) were applied to the Resident's upper lip every day and evening shift for lesion from 3/3/26 through 3/16/26. Review of Resident #12's clinical record failed to include any evidence the Resident had a follow-up appointment with dermatology as recommended. Review of Resident #12's Nursing Progress Note dated 4/5/26, indicated the Resident's lip had multiple scabbed areas. On 5/17/26 at 9:32 A.M. and 5/18/26 at 9:38 A.M., the surveyor observed a scabbed area above Resident #12's upper lip. During an interview on 5/18/26 at 9:38 A.M., Resident #12 said he/she was told the area above his/her upper lip was cancer. During an interview on 5/18/26 at 11:34 A.M., Unit Manager (UM) #2 said she was responsible to ensure recommended follow-up consults were scheduled for residents on the Unit. UM #2 said Resident #12 was supposed to have a follow-up appointment with the Dermatologist on 4/2/26, and she did not see any evidence that the follow-up appointment was scheduled for the Resident. UM #2 said she would look into whether the Resident had been to see the Dermatologist since 3/2/26. During an interview on 5/18/26 at 4:00 P.M., UM #2 said that the follow-up dermatology appointment recommended by the Dermatologist had not been scheduled by the facility, so the Resident had not been seen by the Dermatologist relative to his/her upper lip skin lesion since 3/2/26.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interviews, and record reviews, the facility failed to provide care and services consistent with professional standards of practice for an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body) for one Resident (#13) of five applicable residents for urinary catheters, out of a total sample of 20 residents.Specifically, for Resident #13, the facility failed to accurately monitor the Resident's urinary output and secure the Resident's suprapubic catheter (small incision in the lower abdomen to drain urine directly from the bladder, bypassing the urethra) with a leg strap as ordered by the Physician, increasing the Resident's risk for indwelling urinary catheter complications. Findings include: Review of the Centers for Disease Control (CDC) guidelines for the Prevention of Catheter Associate Urinary Tract Infections (CAUTI). Retrieved from: https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html, revised 3/25/24, indicated the following: -Need for accurate measurements of urinary output in critically ill patients.-Properly secure indwelling catheters after insertion to prevent movement and urethral traction. Review of the facility policy titled Facility Catheter Output Monitoring Policy, undated, indicated:-to ensure accurate monitoring and reporting of urinary output for residents with indwelling urinary catheters in order to promote resident safety, prevent complications, identify changes in condition promptly, and maintain compliance with infection prevention standards.-Nursing staff will.verify physician orders for catheter care and monitoring.-Foley catheter output will be measured.-Documentation will include: total urine output in milliliters (ml). Resident #13 was admitted to the facility in December 2025 with diagnoses including Quadriplegia, retention of urine and neuromuscular dysfunction of bladder. Review of Resident #13's care plan for impaired urinary elimination, last revised 1/5/26, indicated: -catheter strap at all times - change weekly on bath days. -measure output Q (every) shift. -supra-pubic catheter care per facility protocol Q shift. Review of Resident #13's recent Minimum Data Set (MDS) Assessment, dated 3/14/26, indicated: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 12 out of a total possible score of 15. -has an indwelling urinary catheter. -was dependent for all activities of daily living (ADLs). Review of Resident #13's May 2026 Physician's orders indicated: -Urinary Catheter size: 30 FR (French: size)/30 cc (cubic centimeters measurement) ˆballoon, change every three months for suprapubic care, start date 3/26/26. -Secure suprapubic catheter with leg strap to avoid pulling. Check site every shift. Check skin site every shift. Every shift document placement and skin integrity, start date 2/21/26. -Document output every shift. Call MD (Doctor of Medicine) for urinary output of less than 100 ml. Supra pubic care. Every shift, monitor urinary color and odor, start date 2/22/26. Review of Resident #13's Treatment Administration Record (TAR), for March 2026, April 2026 and May 2026 indicated: -the suprapubic catheter was secured daily every shift with a leg strap. -no urinary output documentation for March 2026 as follows:>Day Shift: 3/1/26, 3/4/26, 3/17/26, 3/24/26, 3/29/26, 3/31/26>Evening Shift: 3/2/26, 3/7/26, 3/12/26, 3/15/26, 3/24/26, 3/26/26>Night Shift: 3/15/26, 3/16/26, 3/17/26, 3/24/26, 3/29/26, 3/30/26-no urinary output documentation for April 2026 as follows: >Day Shift: 4/17/26 >Evening Shift: 4/5/26, 4/13/26, 4/16/26, 4/23/26, 4/30/26 >Night Shift: 4/2/26, 4/6/26, 4/7/26, 4/12/26, 4/13/26, 4/16/26, 4/20/26, 4/23/26, 4/27/26, 4/30/26-no urinary output documentation for May 2026 as follows: >Day Shift: 5/2/26 >Evening Shift: 5/6/26, 5/7/26, 5/17/26 >Night Shift: 5/2/26, 5/4/26, 5/7/26, 5/13/26, 5/14/26, 5/17/26 On 5/18/26 at 9:47 A.M., the surveyor and Unit Manager (UM) #1 observed Resident #13's urinary catheter. While the urinary catheter tubing was being checked, the Resident said Ow, ow, ow, ow! The surveyor did not observe a securement device/leg strap to be in place. During an interview at the time, UM #1 said that the securement strap was important so that a Resident cannot pull out the catheter and to prevent the potential for pain when the urinary catheter is pulled. During an interview on 5/18/26 at 12:59 P.M., Nurse #1 said that she documents residents' (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary output in the TAR for the residents with catheters on the unit. During an interview on 5/18/26 at 11:45 A.M., UM #1 said that it is important for nursing staff to document the urinary output for residents with urinary catheters to ensure that the residents' kidneys are functioning properly. During an interview on 5/18/26 at 1:40 P.M., UM #1 said that the Nurses should have been documenting the urinary output for Resident #13 as ordered and they were not. UM #1 also said that Resident #13 should have had the securement device in place as ordered by the Physician and did not, even though it was documented in the TAR that it was in place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to adhere to Transmission Based Precautions (TBPs) and Standard Precautions for two Residents (#79 and #24), out of a total sample of 20 residents, increasing the risk for transmission of infection. Specifically, the facility failed to ensure its staff adhered to Contact Plus Precautions and Standard Precautions when: -Resident #79 was symptomatic and being treated for Clostridioides difficile (C. diff: highly contagious bacterium that infects the colon causing severe diarrhea and painful intestinal inflammation) and placed on Contact Plus Precautions. -Resident #24 did not have a C. diff infection and was not placed on TBPs. -Nurse #3 entered Resident #79's room without donning a gown and gloves, used bare hands to adjust the Resident's legs, exited Resident #79's room without performing any hand hygiene, then proceeded to Resident #24's room, entered his/her room without performing any hand hygiene, and used bare hands to adjust Resident #24's sheets while the Resident was in bed, increasing the risk of contamination and spread of infection. Findings include: Review of the facility's Contact Plus Precautions Policy, undated, indicated: -The purpose was to prevent and control the transmission of infectious organisms requiring Contact plus Precautions within the facility and to ensure the safety of residents, staff, visitors, and vendors. -Residents identified or suspected of having infections requiring Contact Plus Precautions shall be managed according to Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS) and state infection prevention guidelines. -Appropriate personal protective equipment (PPE), hand hygiene, ., and TBPs will be implemented . -Examples of conditions requiring Contact Plus Precautions included C. diff. -Appropriate signage shall be placed outside the resident room. -All staff entering the resident [room]: -Perform hand hygiene before entering and upon exiting the room. -Wear gloves and isolation gown. -PPE must be removed and discarded prior to exiting room. -Soap and water handwashing is required after caring for residents on Contact Plus Precautions, especially for . confirmed C. diff . -Alcohol-based hand sanitizer may be used before entering the room if hands are not visibly soiled, however, soap and water is preferred upon exit. Resident #79 was admitted to the facility in April 2026 with need for assistance with personal care and Enterocolitis due to C. diff. Review of Resident #79's Lab Result Report with a sample collection date of 5/1/26 indicated the Resident tested positive for C. diff. Review of Resident #79's May 2026 Physician Orders indicated: -Maintain Contact Plus Precautions to rule out C. diff every shift . (5/4/26). -Vancomycin (antibiotic medication) HCl Oral Capsule 125 milligrams (mg), give 125 mg by mouth four times a day for C. diff for 10 days (start date 5/4/26). -Maintain Contact Plus Precautions related to C. diff every shift . (5/11/26). -Vancomycin HCl Oral Capsule 125 mg, give one capsule by mouth four times a day for C. diff for four days (start date 5/14/26). -Vancomycin HCl Oral Capsule 125 mg, give one capsule by mouth two times a day for C. diff for seven days (start date 5/18/26). Review of Resident #79's May 2026 Medication Administration Record (MAR) indicated Vancomycin was being administered to the Resident for C. diff, as ordered. Review of Resident #79's May 2026 Certified Nurse Aide (CNA) Flow Sheets indicated the following relative to the Resident's bowel movements: -Two large bowel movements on 5/16/26 at 1:53 A.M. and 2:59 P.M.: consistency indicated as loose, diarrhea. -One large bowel movement on 5/17/26 at 6:40 P.M.: consistency indicated as mucus. On 5/17/26 at 8:06 A.M., the surveyor observed Resident #79 lying in bed in his/her room. The surveyor observed Contact Plus Precautions signage posted outside the Resident's door and a plastic bin outside of the Resident's room which included but was not limited to disposable gowns and gloves. Resident #24 was admitted to the facility in April 2026 with diagnoses including Congestive Heart Failure (CHF), Prediabetes, and need for assistance with personal care. Review of Resident #24's clinical record indicated the Resident did not require TBPs. On 5/17/26 at 8:10 A.M., the surveyor observed Resident #24 in bed in his/her room. The surveyor observed that there was no signage posted outside the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident's door to indicate that any TBPs were required. On 5/17/26 at 4:56 P.M., the surveyor observed Nurse #3 speaking with Resident #79 in his/her room. Nurse #3 was not wearing a gown and gloves. The surveyor observed Nurse #3 tuck her clipboard under one arm and use her hands to manipulate the Resident's right leg. Nurse #3 then exited Resident #79's room, did not perform hand hygiene and walked directly to Resident #24's room. Nurse #3 was observed entering Resident #24's room without performing hand hygiene, approach the Resident who was in bed, said that she needed to look at his/her legs and lifted the Resident's covers up from his/her legs with bare hands. Nurse #3 then exited Resident #24's room. During an interview on 5/17/26 at 5:05 P.M., Nurse #3 said she did not wear a gown and gloves in Resident #79's room and that she did not perform hand hygiene when she exited Resident #79's room and entered Resident #24's room. Nurse #3 said not implementing Contact Plus Precautions for Resident #79 and not performing hand hygiene prior to coming in contact with Resident #24 increased the risks for transmitting C. diff to herself and to residents. During an interview on 5/19/26 at 12:10 P.M., the Infection Preventionist (IP) said Nurse #3 should have read the signage for Contact Plus Precautions posted outside of Resident #79's room and followed the instructions prior to room entry. The IP said Nurse #3 should have performed hand hygiene after touching Resident #79 and before entering Resident #24's room and handling Resident #24's sheets. The IP said when staff do not follow the instructions posted on precaution signs, there is a serious risk for infection transmission for residents and staff.