STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225040	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julian J Levitt Family Nursing Home	770 Converse Street Longmeadow, MA 01106

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record reviews, the facility failed to ensure personal care was provided with respect and dignity, in a manner to maintain and enhance quality of life for one Resident (#539) out of a total sample of 36 residents. Specifically, the facility failed to: -Ensure that Resident #539 was covered/clothed as requested by the Resident when during personal care, staff left the Resident exposed and uncovered in his/her bed, when the Resident required assistance from staff for personal care, resulting in the Resident feeling disrespected and dehumanized. -Ensure a timely response to Resident #539's undignified experience which increased the Resident's risk for further undignified experiences at the facility. Findings include: Resident #539 was admitted to the facility in April 2025 with diagnoses including Osteoarthritis of bilateral knees, muscle weakness, difficulty in walking, need for assistance with personal care, Osteoarthritis of the right shoulder, pain in right shoulder, and pain in right knee. Review of Resident #539's At Risk Care Plan initiated 4/16/25, indicated: -The Resident was at risk for falls, skin breakdown, Activities of Daily Living (ADL) functioning limitations and pain related to a diagnosis of [muscle] weakness. -Staff were to provide assistance with ADL completion. Review of the Physical Therapy (PT) Care Plan initiated 4/17/25, indicated Resident #539: -has generalized weakness. -required assistance with transfers. Review of the Occupational Therapy (OT) Care Plan initiated 4/17/25, indicated Resident #539: -required assistance with upper body and lower body dressing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility's Record of Resident Grievance for Resident #539, dated 4/17/25, indicated: -The Certified Nurses Aide (CNA #5) took the blankets down and took [pulled] the Resident's hospital gown up and left the room to get the supplies. -The Resident felt exposed and felt their dignity was violated. -The outcome, dated 4/18/25, included communication with family and Resident. -The resolution was that CNA #5 was not to enter Resident #539's room. -The Resident's daughter had called and left a message for Unit Manager (UM) # 1. UM #1 had left a return voicemail for the Resident's daughter. The Resident was updated that his/her daughter was called and stated [daughter aware with correction]. Further review of the Record of Resident Grievance Form indicated Resident #539 (who was his/her her own decision maker) did not sign the Grievance outcome. Review of the Minimum Data Set (MDS) Assessment, dated 4/22/25, indicated Resident #539: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. -was able to make him/herself understood and understood others. -demonstrated no behaviors. -required moderate assistance from staff to perform rolling from left to right. -required moderate assistance from staff for completion of toileting. -required moderate assistance from staff for dressing. Review of Resident #539's ADL Care Plan initiated on 4/29/25, indicated: -was unable to perform ADLs independently due to Osteoarthritis of the right knee and right shoulder. -required assistance from staff for bathing and dressing. -required assistance with mobility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 2:32 P.M., Resident #539 said on 4/16/25, during the 11:00 P.M. to 7-00 A. M. (11-7) shift, a CNA was rude and disrespectful to him/her. Resident #539 said that he/she had used the bed pan, and urine had spilled onto the bed and hospital gown that he/she wore at that time. Resident #539 said the while CNA was assisting him/her to change the hospital gown and bedding, the CNA removed the Resident's hospital gown, and while the CNA was changing the bed linen, the CNA left the Resident naked and exposed. Resident #539 said that he/she told the CNA that he/she was cold and asked to be covered. Resident #539 said the CNA did not answer him/her, left him/her exposed, uncovered and cold, and pointed towards the wall (to indicate where Resident #539 needed to turn). Resident #539 said the CNA then left the room. Resident #539 said the CNA made him/her feel very nervous and vulnerable and the CNA was in charge of the situation. The Resident said the CNA was mean and disrespectful by not responding to him/her when he/she asked to be covered, and that being left naked and exposed was a very undignified experience. Resident #539 said that around 7:30 A.M. to 8:00 A.M., (on 4/17/25) he/she told Nurse #4 what had happened and gave Nurse #4 the details of the incident and explained how he/she felt mistreated. Resident #539 said that same day, mid-morning, he/she then told Rehabilitation (Rehab) Staff # 1 in detail about the previous night's events, and Rehab Staff #1 said he/she should not have been treated that way. Resident #539 said around 3:15 P.M. on 4/17/25, CNA #5 entered his/her bedroom to provide care, and he/she told the CNA that he/she had reported the incident from the previous night, did not want care provided from CNA #5 and the CNA exited the room. Resident #539 said later in the evening on 4/17/25 around 6:00 P.M., Unit Manager (UM) #1 came to see him/her, and he/she told UM #1 all the same details, and that he/she felt mistreated, disrespected, undignified, and dehumanized. Resident #539 said UM #1 told Resident #539 that she would talk with CNA # 5 about what happened. During an interview on 4/30/25 at 4:28 P.M., with the Director of Nursing (DON) and Administrator on 4/30/25 at 4:28 P.M., the DON said UM #1 notified her about Resident #539's complaint about CNA #5, and that it was a customer service complaint. The DON said UM #1 handled the Resident's complaint by conducting education with the staff and was not sure if a grievance form had been completed. The DON said she did not know why UM #1 did not speak with Resident #539 until 6:00 P.M on 4/17/25. The DON also said she was not sure why CNA #5 had gone back into Resident #539's room if CNA #5 had been educated by UM #1 to not provide care to Resident #539. During a follow-up interview on 5/2/25 at 9:05 A. M., Resident #539 said the following: -On 4/17/25 around 7:30 A.M., the Resident told Nurse #4 that the CNA on the 4/16/25 (11-7 P.M.) shift made the Resident feel disrespected and undignified, relative to leaving the Resident naked and exposed, and that the CNA was mean and unkind. -Nurse #4 appeared to the Resident to be exasperated that the event had occurred. -Mid-morning, on 4/17/25, Resident #539 told Rehab Staff #1 about the event that occurred on the 4/16/25 (11-7 P.M.) shift with the CNA. -SW #1 came to see the Resident on 4/17/25 between 3:00 P.M. and 3:30 PM at which time the Resident told SW #1 the details of the event that occurred with the CNA during the previous night's 11-7 (P.M.) shift. -The Resident said SW #1 listened to him/her and said, Oh, that's terrible. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #539 said that UM #1 visited him/her around 6:30 P.M. on 4/17/25 and said to Resident #539 that she was going to speak with CNA# 5 about the incident. -Resident #539 said that at no point on 4/17/25 did any staff members he/she spoke with about the 4/16/25 event offer to file a formal complaint or grievance, and that he/she did not put anything in writing. -Resident #539 said no staff member came back to discuss the outcome of his/her reported incident with CNA #5 until 4/30/25, after he/she made the surveyor aware of the situation. -Resident #539 said he/she did not feel like things were handled appropriately and nothing ever came of reporting the event until [the surveyor] came into the facility. During an interview on 5/2/25 at 11:07 A.M., Rehabilitation Staff #1 said she did the Physical Therapy Evaluation for Resident #539 on 4/17/25. Rehab Staff #1 said she recalled the Resident being a little upset about something that happened during the (11-7 P.M.) shift with a staff member, but did not remember the details of what the Resident said. Rehab Staff #1 said she reported the Resident's complaint to UM #1 around 11:00 A.M. on 4/17/25. During an interview on 5/2/25 at 11:42 A.M., Nurse # 4 said that when he went to see Resident #539 on 4/17/25 in the morning, the Resident reported that he/she felt disrespected by a staff member on the prior (11-7 P.M.) shift. Nurse #4 said he could not recall the details of what the Resident had said, but that the Resident was angry about the incident, and that Nurse #4 told UM #1 and SW #1 right away because they were sitting in the office near the Resident's room. Nurse #4 said that anytime a facility receives a complaint from a Resident, the facility process was for a staff designee to complete an investigation right away, and that the incident should be reported to the DON and the Administrator immediately. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/25 at 12:33 P.M., UM #1 said that she and SW #1 were notified by Nurse #4 on 4/17/25 around 7: 30 A.M. that Resident #539 had a concern about staff on the (11-7 P.M.) shift. UM #1 said she was told by SW #1 that SW #1 would go see the Resident. UM #1 said she was unsure of when SW # 1 went to see Resident #539 about the complaint, but that around 3:00 P.M., SW #1 told her that the Resident had a concern involving an (11-7 P.M.) shift CNA and the that the CNA should be educated on customer service. UM #1 said that shortly after 3:00 P.M., CNA #5 had already gone back into Resident #539's room to take vital signs at the beginning of her shift and then CNA #5 came to speak with UM #1 because Resident #539 told CNA #5 that he/she had reported CNA #5 and did not want the CNA to provide care for him/her. UM #1 said she then educated CNA #5 about customer service, obtained a statement about the incident on 4/17/25 from the CNA, and instructed CNA #5 not to go into Resident #539's room. UM #1 said SW #1 completed a Grievance Form, and UM #1 completed education to CNA #5 as an outcome to the grievance. UM #1 said that she was under the impression SW #1 would have followed-up with the Resident right away after the incident had been reported to them at 7:30 A.M. and was not sure why SW #1 did not see the Resident until around 3:00 P.M. UM #1 said she did not speak with the Resident about the 4/16/25 incident until sometime between 5:00 P.M. and 6:00 P.M. on 4/17/25 (9.5 - 10.5 hours after the Resident's report to Nurse #4). UM #1 said the Resident told her that the CNA #5 was unfriendly, had a flat affect, and had left him/her naked and exposed which made him/her feel uncomfortable. UM #1 said Resident #539 was upset to have been left naked and when the Resident asked to be covered, the CNA did not cover him/her and gestured for him/her to roll over leaving him/her exposed. UM #1 said that if a Resident had a complaint or concern, a staff member should have interviewed the Resident as soon as possible and should have informed administration. UM #1 said she though the Resident's concern about CNA #5 was a customer service concern that could be corrected with staff education. During an interview on 5/2/25 at 1:22 P.M., SW #1 said on 4/17/25 between 7:30 A.M.- 8:30 A.M., Nurse #4 told her that Resident #539 that a complaint from the (11-7 P.M.) shift. SW #1 said she went into the Resident's room around 8:30 A.M. but the Resident was working with a therapy staff member at the time, so SW #1 told Resident #539 that she would come back. SW #1 said that her workday got very busy, and she forgot to return to see the Resident until around 3:00 P.M. SW #1 said Resident #539 told her about the incident with CNA #5 at that time. SW #1 said Resident #539 told her that CNA #5 did not introduce herself, did not talk to the Resident, and instead of asking the Resident to roll over in the bed, pointed with her finger. SW #1 said Resident #539 further said that CNA #5 removed the Resident's hospital gown, and the Resident told the CNA that he/she was cold, and asked to be covered up, but the CNA left the room for supplies without covering the Resident as requested. Resident #539 told SW #1 that she thought the situation was undignified. SW #1 said she then returned to the office and told UM #1 that CNA #5 needed to be educated for dignity related to leaving Resident #539 exposed and cold while providing care. SW #1 said the Resident was bothered and saddened by the event on 4/17/25, and that Resident #539 said he/she would never treat a patient the way CNA #5 treated him/her. SW #1 said at the time of her interview with Resident #539 on 4/17/25, CNA #5 had already gone into the Resident's room and the Resident had told the CNA to leave. SW #1 said she completed a Grievance Form on 4/17/25, gave it to UM #1 but it was left on the UM's desk and forgotten about until 4/30/25, when the surveyor inquired about the incident that occurred on 4/16/25. SW #1 said that she should have gone back right away to see Resident #539 in the morning of 4/17/25 but did not because she forgot and got busy. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/25 at 3:26 P.M., the Administrator said a thorough investigation should have been completed immediately after Resident #539 had voiced a complaint to Nurse #4 on 4/17/25 at 7:30 A.M. The Administrator said when the Resident was unavailable to speak with SW #1 in the morning on 4/17/25, SW #1 should have gone back as soon as possible to ask thorough questions about the incident details and to check on how the Resident was doing. The Administrator said she and the DON completed a follow-up investigation after the surveyor brought it to their attention on 4/30/25, and Resident #539 was very clear about feeling intimidated and vulnerable on 4/17/25. The Administrator also said since SW #1 did not go back to interview the Resident right away, there was a several hour delay in the initial investigation. The Administrator said completing a through investigation on 4/17/25 would have prevented CNA #5 from going into Resident #539's room on 4/17/25 in an attempt to provide care.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review, and interview, the facility failed to refer one Resident (#77) for a Preadmission Screening and Resident Review (PASRR- a federal and state-required process that is designed to, among other things, identify evidence of serious mental illness [SMI] and/or intellectual or developmental disabilities [ID/DD] in all individuals [regardless of source of payment] seeking admission to Medicaid-or Medicare-certified nursing facilities) Level II Evaluation (an evaluation conducted to determine if an individual with a newly evident or possible SMI, ID, or a related condition for Level II resident review upon a significant change in status assessment) out of a total sample of 36 residents. Specifically, for Resident #77, the facility failed to refer the Resident for a Level II PASRR Evaluation after receiving a new diagnosis of Psychosis. Findings include: Resident #77 was admitted to the facility in December 2017 with diagnoses including history of alcohol abuse and Depression. Review of the Diagnosis List indicated Resident #77 has the following current diagnoses in part: -Dementia-onset 2/22/24 -Anxiety-onset 2/22/24 -Psychosis-onset 9/26/24 -Delusional Disorder-onset 9/26/24 Review of the PASRR completed 11/12/17, failed to indicate that Resident #77 had a serious mental health disorder that would indicate a Level II Evaluation was required. Review of the H&P (History and Physical) completed on 11/26/17, indicated Resident #77 was diagnosed with alcohol abuse and Depression. Further review of the H&P failed to indicate documented evidence of diagnoses of Psychosis, Anxiety, and Delusional Disorder. Review of the Behavioral Health Note dated 3/29/23, indicated Resident #77 was diagnosed with Dementia, Psychosis, Depression, Anxiety, and Alcohol Abuse. Further review of Resident #77's medical record failed to indicate documented evidence that a PASRR Level II Evaluation was conducted after a newly evident or possible serious mental health disorder was identified on 3/29/23 or 9/26/24. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 12:19 P.M., Social Worker (SW) #2 said that she could not speak to the Behavioral Health Note dated 3/29/23, that indicated Resident #77's Psychosis diagnosis. SW #2 said that the Psychosis diagnosis, as far as she was aware, was added on 9/26/94, and when that new mental health diagnosis was identified, a request for a PASRR Level II Evaluation should have been made to the PASRR office but had not been made, as required.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observations, record review, and interviews, the facility failed to ensure one Resident (#52) received treatment and care in accordance with professional standards of practice, out of total sample of 36 residents. Specifically, for Resident #52, the facility failed to follow-up with a recommendation made by the Ophthalmologist to increase the use of Refresh Optive Ophthalmic (a preservative-free eye drop designed to relieve dry eye symptoms) from two times per day to four times per day. Findings include: Resident #52 was admitted to the facility in September 2024 with diagnoses including Myasthenia Gravis and Dementia. Review of the Provider Encounter Progress Note, dated 1/9/25, indicated the following in part: -Patient had bilateral ectropion (condition in which your eyelid turns outward) with retracted lower lid history of recurrent conjunctivitis (eye infection) . Review of the Ophthalmologist Report of Consultation, dated 3/10/25, indicated the following: -Recommended to use Refresh Optive in both eyes four times a day -Consultant signature -Provider initials Review of Resident #52's active Physician orders as of 5/5/25, indicated the following order: -Refresh Optive Mega-3 Ophthalmic Solution 0.5-1-0.5 %. Instill one drop in both eyes two times a day for eye health, initiated 1/9/25. Review of the March 2025 through May 2025 Medication Administration Records (MARs) indicated: -Refresh Optive Mega-3 Ophthalmic Solution 0.5-1-0.5 % was administered as ordered, two times per day. -the administered frequency failed to reflect the Ophthalmologist's recommendation made on 3/10/25, for four times per day. On 4/30/25 at 3:41 P.M., the surveyor observed Resident #52 seated in his/her wheelchair in his/her room with Health Care Proxy (HCP)/family present. Resident #52 was observed to have red, watery bilateral lower lids, and a yellow crusty substance on the left upper lid. During an interview at the time, Resident #52's HCP said Resident #52 used eye drops and that his/her eyes usually looked that way. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/5/25 at 2:19 P.M., Unit Manager (UM) #2 said the two initials on the Ophthalmologist Consultant Report dated 3/10/25 belonged to the Ophthalmologist and the Provider at the facility. UM #2 said that this indicated that the Provider reviewed and agreed with the recommendations made by the Ophthalmologist. UM #2 said after the recommendations had been reviewed and accepted by the Provider, the Nurse should have changed the order to reflect the new recommendation to increase the Refresh Optive Mega-3 Ophthalmic Solution 0.5-1-0.5 % from two times a day to four times a day and that did not occur.

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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** Based on observation, interview, and record reviews, the facility failed to provide treatment for hearing loss for one Resident (#121), out of a total sample of 36 residents. Specifically, the facility failed to ensure recommendations made from the Audiologist (professional that specializes in diagnosing, treating, and managing hearing loss and balance disorders) were implemented for Resident #121 in order to improve his/her hearing ability. Findings include: Resident #121 was admitted to the facility in October 2021 with diagnoses including need for assistance with personal care and hearing loss. Review of the Cognitive Impairment/Communication Care Plan initiated 5/10/22, indicated Resident #121: -had an alteration in communication due to difficulty hearing, and included the following interventions also initiated 5/10/22: >Audiology Consult as needed. >Use assistive hearing device as needed. >Utilize communication board/paper as needed. Review of the Request for Service Form, signed by Resident #121 on 5/15/23, indicated he/she consented to Audiology Services. Review of the Provider Note dated 1/15/25, indicated Resident #121: -was currently receiving Debrox (medication applied directly inside the ears to loosen and unclog built-up earwax) to his/her ears in anticipation of audiology visit this week . -was receiving communication via white board . Review of the January 2025 Medication Administration Record (MAR) indicated Debrox Otic Solution, 5 drops to both ears twice daily for five days for ear wax removal, initiated 1/10/25 through 1/16/25. Review of the Audiology Consult, dated 1/22/25 indicated Resident #121: -was seen due to increased complaints of newly decreased hearing -communication was via use of a white board -had visibly occluding (obstructed) cerumen (earwax) on the left ear (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had some non-occluding cerumen on the right ear -had perforation of tympanic membrane (ruptured ear drum) present in the right ear -hearing aids were cleaned and checked for fit, Resident was pleased with sound quality of hearing aids -the left hearing aid may need manufacturer repair due to weak sound quality -was unable to complete pure tone testing and speech testing due to visibly occluded cerumen in both ears, the wax was too deep for removal .wax needs removal -Recommendation for Attending Medical Doctor (MD)/Nursing Staff: >wax needs removal in the left ear. >Medical Consult due to: wax removal needed-left ear. >Change (hearing aid) batteries weekly. >Clean hearing aids after use. >Daily use of hearing aids is recommended. >Please contact MD for wax removal orders. >Please open battery door when hearing aids were not in use. -Action to be taken by Audiologist: Re-evaluate Resident after wax removal Review of the Provider Note dated 2/10/25, indicated Resident #121 was very hard of hearing and communicated through a white board. Further review of the Provider Note failed to indicate the results or any mention of the Audiologist's Recommendations from 1/22/25. Review of the Minimum Data Set (MDS) Assessment, dated 2/15/25, indicated Resident #121: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 -required substantial/maximum assistance with personal hygiene, dressing upper body -understands and was understood -had highly impaired hearing and utilized hearing aids Review of the Social Service assessment dated [DATE], indicated: (continued on next page)

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Julian J Levitt Family Nursing Home	770 Converse Street Longmeadow, MA 01106

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident was seen by Audiology with a report that his/her (ear) wax was impacted and to be taken out . Review of the Resident's clinical record failed to indicate documented evidence of the facility follow-up relative to the Audiologist's Recommendations from 1/22/25. On 4/30/25 at 11:00 A.M., the surveyor observed Resident #121 dressed in a hospital gown and lying in bed. When the surveyor attempted to conduct an interview, the Resident said he/she couldn't hear a thing and instructed the surveyor to utilize the white board located in the room. The Resident was also observed with no hearing aids in place during the observation. On 5/2/25 at 11:05 A.M., the surveyor observed the Resident lying in bed, dressed in a hospital gown and watching television with closed captions on and he/she was not wearing hearing aids. During an interview using the whiteboard for communication, the Resident said he/she could not recall having another audiology appointment after the one in January 2025, and could not recall any follow-up from the January 2025 appointment relative to his/her hearing. Resident #121 said he/she had wax in his/her inner ears and that the Audiologist cleaned his/her hearing aids. Resident #121 further said after the hearing aids were cleaned by the Audiologist, they worked better for about three days and then had wax built up on them again and were not helpful with his/her hearing. When the surveyor asked about his/her hearing aids, the Resident said he/she thought the hearing aids may be in a drawer in his/her room but was not sure where they were located. Resident #121 said he/she was not sure anything could be done to help with his/her hearing, but he/she would like to be able to hear better. On 5/7/25 at 9:56 A.M., the surveyor and Unit Manager (UM) #3 reviewed Resident #121's clinical record. During an interview at the time, UM #3 said Resident #121 utilized a white board to communicate because he/she was hard of hearing. UM #3 said she could not recall Resident #121 using hearing aids and would have to look into the Audiologist's Recommendations from January 2025. UM #3 also said she would look into the location of the Resident's hearing aids. During an interview on 5/7/25 at 11:25 A.M., Certified Nurses Aide (CNA) #1 said Resident #121 was very hard of hearing and that facility staff utilized a white board to communicate with him/her. CNA #1 said she was not aware that Resident #121 had hearing aids. During a follow-up interview on 5/7/25 at 10:20 A.M., UM #3 said she was able to locate the hearing aids in the Resident's room. UM #3 said she was unable to verify that the Audiologist's Recommendations from 1/22/25 were implemented and/or reviewed with the Provider for follow-up. UM #3 said when a Consultant evaluates a Resident, the report would be emailed to the facility, printed out and reviewed with the facility Provider. UM #3 said the Provider would initial the Consult Form to indicate it was reviewed and would implement new orders if indicated. UM #3 said the Audiology Consult dated 1/22/25 for Resident #121 was not initialed as reviewed by the Provider. UM #3 further said there was no indication that there was follow-up to the Audiologist's Recommendations, that she had reviewed the Resident's clinical record for orders for wax removal after the 1/22/25 and was unable to find that this was implemented.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on records review, and interviews, the facility failed to obtain laboratory services as ordered by the Physician for one Resident (#143) of five applicable residents, out of a total sample of 36 residents. Specifically, the facility failed to obtain laboratory services as ordered by the Physician, to check Resident #143's Keppra (Levetiracetam: medication used to manage seizures) level, placing the Resident at risk for inadequate medication monitoring and complications related to medication use. Findings include: Review of the facility's policy titled Lab and Diagnostic Test Results - Clinical Protocol, undated, indicated the following: -The physician will identify, and order diagnostic and lab testing based on diagnostic and monitoring needs. -The reason for getting a test often affects the urgency of acting upon the result. Resident #143 was admitted to the facility in May 2024 with diagnoses including Epilepsy. Review of Resident #143's Final Levetiracetam Level Result, drawn 2/27/25 with results obtained on 3/3/25, indicated the Resident's Levetiracetam level was 4.5 ug (microgram)/mL (milliliter), (reference range is 3.0 - 60.0 ug/mL). Review of Resident #143's Physician Assistant (PA) Progress Note, dated 5/2/25, indicated the following: -The Resident was noted with a decline in status and weight loss. -The Resident was a full code (use of all possible medical interventions to be used to sustain one's life) status. -The Resident had a seizure disorder and was maintained on Keppra. -No recent seizure activity. -Obtain Keppra level. Review of Resident #143's May 2025 Physician orders indicated: -Keppra oral tablet 500 milligrams (mg), give one tablet by mouth two times a day for seizure disorder, dated 8/30/24. -An order, dated 5/2/25, for . Keppra level on 5/5/25. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #143's May 2025 Medication Administration Record (MAR) indicated: -Keppra was administered to the Resident as ordered by the Physician. -The box indicating Keppra level on 5/5/25 was blocked off with an x. Review of Resident #143's clinical record failed to include any evidence the Resident's Keppra level was drawn on 5/5/25. During an interview on 5/7/25 at 1:10 P.M. the Director of Nursing (DON) said Keppra level results usually took a couple of days to be communicated to the facility from the lab, so the results may not have been available yet. The DON said she would provide the laboratory requisition slip as evidence the Keppra level was drawn for Resident #143 on 5/5/25. During an interview on 5/7/25 at 3:30 P.M., Unit Manager (UM) #4 said a Keppra level was ordered to be drawn for Resident #143 on 5/5/25. UM #4 said the Keppra level was not drawn for the Resident because no laboratory requisition had been completed by the facility. During a follow-up interview on 5/7/25 at 3:53 P.M., the DON said potential risks for not obtaining lab services to draw Resident #143's Keppra level included an increased risk for seizure activity if the Keppra level was too low and increased risk of toxicity if the level was too high.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to maintain complete and accurate clinical records for three Residents (#155, #533, and #423) out of a total sample of 36 residents. Specifically, 1. For Resident #155, the facility failed to record the Resident's post void residual (PVR: amount of urine remaining in the bladder after one urinates) when PVRs were ordered to monitor the Resident's Kidney Disease, placing the Resident at risk for inadequate monitoring of his/her medical condition. 2.For Resident # 533, the facility failed to document the administration of a newly ordered dose of Lasix (diuretic medication that helps reduce fluid buildup in the body), when the Resident experienced symptoms of Congestive Heart Failure (CHF: type of heart failure that occurs when the heart cannot pump blood as well as it should), placing the Resident at risk for inadequate monitoring of his/her medical condition. 3. For Resident #423, the facility failed to document the administration of PRN (as needed) antipsychotic (medication used to treat psychosis, a mental health condition where individuals experience difficulties distinguishing between reality and what is not real) medication as required, placing the Resident at risk for inadequate monitoring of his/her medical condition. Findings include: 1. Resident #155 was admitted to the facility in September 2024 with diagnoses including Urinary Tract Infection (UTI), Acute Kidney Failure, and Dementia. Review of Resident #155's Physician Progress Note, dated 4/21/25, indicated: -The Resident had a positive urinalysis (UA: urine test often done to check for UTI and/or kidney disease). -The Resident had Acute Kidney Injury (AKI) and Acute Renal Failure. -The Resident had Chronic Kidney Disease. -Bladder scan (non-invasive ultrasound of the bladder used to determine how much urine remains in one's bladder after urination) for [urine] retention issues. Review of Resident #155's April 2025 Physician orders indicated the following: -An order, dated 4/21/25: -PVR every shift for kidney disease for three days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	->(greater than) 350 [milliliters], insert Foley catheter. Review of Resident #155's April Medication Administration Record (MAR) indicated: -PVRs were recorded on the night shift on 4/21/25, 4/22/25, and 4/23/25. -PVRs were recorded on the day shift on 4/22/25, 4/23/25, and 4/24/25. -PVR was recorded on the evening shift on 4/23/25. -No PVRs were recorded on the evening shifts on 4/22/25 and 4/24/25. Review of Resident #155's clinical record failed to include any evidence that the Resident's PVRs were recorded for the evening shifts on 4/22/25 and 4/24/25. During an interview on 5/7/25 at 11:15 A.M., Unit Manager (UM) #2 said Nurse #7 and Nurse #8 were responsible for Resident #155's care for the evening shifts on 4/22/25 and 4/24/25. During an interview on 5/7/25 at 2:01 P.M., Nurse #8 said she did not usually work on the hallway where Resident #155 resided. Nurse #8 said that she was not responsible to provide care for the Resident between 4/22/25 and 4/24/25, when PVRs were to be completed and recorded in the Resident's record. During an interview on 5/7/25 at 2:06 P.M., Nurse #7 said she was familiar with and had provided care for Resident #155. Nurse #7 said if the Resident had an order for PVRs every shift, then the PVRs would be completed. Nurse #7 said if she was the Nurse to have completed the Resident's PVR, she would have written the PVR amount on her resident report sheet and may not have entered the PVR amount in the Resident's record. During an interview on 5/7/25 at 1:10 P.M., the Director of Nursing (DON) said when PVRs were ordered to be completed for a Resident, the Nurses were responsible to record the PVR amounts in the Resident's record when the bladder scan for PVR was completed. The DON said Resident #155 had a UTI at the time the PVRs were ordered and that the Resident had kidney disease. The DON said recording the PVR amounts was an important piece for monitoring the Resident's condition, to ensure the Resident was urinating enough. The DON said the Resident's PVR amount should have been recorded in the Resident's clinical record for the evening shifts on 4/22/25 and 4/24/25. 3. Resident #423 was admitted to the facility in February 2025 with diagnoses including vascular Dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety and anemia. Review of the Minimum Data Set (MDS) Assessment, dated 2/17/25, indicated Resident #423 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of seven out of a total of 15 possible points. Review of Resident #423's Hospital Discharge summary, dated [DATE], indicated the following order: -Seroquel 12.5 milligram (mg), by mouth two times a day as needed (PRN), for agitation. Review of Resident #423's Physician's orders for May 2025 indicated: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Seroquel Oral tablet, give 12.5 mg by mouth every 12 hours as needed for agitation related to vascular Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety for 14 days, started 5/2/25. On 5/6/25 at 10:02 A.M., the surveyor observed Resident #423's Seroquel medication card with Nurse #6 with the following findings: -the Seroquel medication card was received from the pharmacy on 5/3/25 -the Seroquel medication card had (14 full tabs) 28 half tabs. -four pills were missing on the medication card. During an interview at the time, Nurse #6 said she was not sure when the medications were administered to the Resident, because there was no record on the MAR and there was no Progress Note. Review of Resident #423's May 2025 Medication Administration Records (MAR) failed to indicate that the Resident was administered PRN Seroquel medication on any days in May 2025. During an interview on 5/7/25 at 10:57 A.M., Nurse #2 said she would occasionally pick up shifts on the unit where Resident #423 resided. Nurse #2 said the Resident had increased behaviors in the evenings. Nurse #2 said she would usually give Resident #423 his/her PRN Seroquel and would usually put the medication in ice cream before the Resident's behaviors got to the point where it would be difficult to manage. Nurse #2 said she would not always document the administration of the medication, but she should. During a follow-up interview on 5/7/25 at 1:28 P.M., the DON said the Nurses should have signed off the administration of the Seroquel medications when they were administered but they had not always done so. 2. Resident #533 was admitted to the facility in April 2025 with diagnoses including Acute on Chronic Heart Failure, Ischemic Cardiomyopathy, and Hypertension (HTN). Review of the Resident #533's Skilled Nursing Note dated 4/28/25, indicated the Resident had a weight gain of 4 lbs. (pounds) and the Provider ordered Lasix 20 mg (milligrams) to be given in the P.M. [sic] for 3 days. Review of the Resident #533's Medication Administration Record for April 2025 indicated the following: -Lasix 20 mg in P.M. [sic] for 3 days was ordered to start on 4/28/25. -Lasix 20 mg was administered on 4/29/25 as ordered. -Lasix 20 mg was administered on 4/30/25 as ordered. Review of Resident #533's clinical record failed to include any evidence that the Resident was administered Lasix 20 mg as ordered on 4/28/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 8:46 A.M., the surveyor and Nurse #5 reviewed the April 2025 MAR and Nurse #5 said that the order for Lasix 20 mg in the P.M. was not signed off as given on 4/28/25 but should have been signed off if it was given. Nurse #5 said the Resident would be at risk for worsening Congestive Heart Failure if the medication was not given as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interviews, and record reviews, the facility failed to implement a system of surveillance for infection tracking, placing residents at risk for inadequate infection monitoring and spread of infections. Specifically, the facility failed to: -Maintain an up-to-date infection line listing for tracking incidents of infection in the facility when the facility's Infection Prevention and Control Plan indicated an up-to-date infection line listing would be maintained. -Include required information on the infection line listing for infection monitoring and tracking. Findings include: Review of the facility's policy titled Infection Control Guidelines for all Nursing Procedures, dated February 2014, indicated the following: -The purpose was to provide guidelines for general infection control while caring for residents. -The Infection Control Nurse, interchangeable referred to as Infection Preventionist (IP), and/or the Director of Nursing (DON) are responsible for the Infection Control Program in the facility. Review of the facility's Infection Prevention and Control Plan, undated, indicated: -The purpose was to establish a program to identify, treat and track infections . in an effort to prevent infectious disease processes for continuous quality improvement. -A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. -Its purpose is to identify infections and monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. -Surveillance is one of the most important elements of an infection control program. -Surveillance is defined as the collection, assembly and analysis of infections in the facility. -Surveillance provides knowledge of the specific and unique problems in each facility and is the foundation for the entire program. -Key components include: >To obtain optimum control of infections by identification of the numbers and characteristics of both community and facility acquired infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>To identify and measure baseline information about the frequency and type of facility acquired infections. >To provide a basis for evaluating effects of infection control measures and policies. -The IP serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility. -To facilitate the collection of relevant resident infection data, a line listing form will be used to collect data by incidence as it is verified. -The line listing will include but is not limited to: >Resident identification >Room number >Date of admission >Date of onset of symptoms >Specific signs and symptoms >Site of infection >Organism(s) >Treatment -The update [sic] McGeer criteria or other nationally-recognized surveillance criteria will be used to define infections. -Periodic review of line listing by IP or other nursing staff will be done to look for evidence of clustering, cross contamination, trends or other patterns of deviation from standards. -At the end of each month, data will be review [sic] and analyzed and documented. During an interview on 5/1/25 at 3:53 P.M. the Infection Preventionist (IP) said she was new to the IP role and that the Staff Development Coordinator (SDC) and Director of Nursing (DON) were assisting her with infection prevention in the facility. The IP said the facility used McGeer criteria for infections and that she used a monthly line listing to track residents on antibiotic medication for infections. The IP also said she would use the information on the line listing to see if there were any trends for infections in the facility. The IP said she would complete the line listing at the end of each month for residents identified to have had infections requiring antibiotic treatment during the month. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP provided the surveyor with a manilla folder labeled April. The surveyor observed that the folder included several completed McGeer infection criteria worksheets and failed to include any line listing. When the surveyor asked, the IP said the line listing had not yet been started for April 2025. During an interview on 5/6/25 at 9:55 A.M. with the IP and SDC, the IP said the antibiotic line listing for April 2025 had been completed. The IP and the SDC both said that the antibiotic line listing was the only infection tracker line listing used for the facility. The surveyor, the IP, and the SDC reviewed the completed April 2025 Line Listing for Antibiotic Use and observed as follows: -The columns on the Antibiotic Use line listing indicated: >Resident Name and Room Number (#). >Start Date. >Antibiotic. >Care Plan (Yes/No). >End Date. >Progress Documented. >Culture/Sensitivity. >Site. >Signature. -There were no columns to indicate: *date of admission *date of onset of symptoms *specific signs and symptoms, and organism(s) -The Line Listing for Antibiotic Use indicated 23 active resident infections treated with antibiotics during the month of April 2025. >Thirteen infections were listed as urinary infections. >Five infections were listed as viral infections. >Three infections were listed as skin/wound infections. >One infection was listed as sepsis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>No resident room numbers were recorded on the Line Listing. >The antibiotic column was not filled in for four residents. The IP and SDC both said the column titled Start Date referred to the antibiotic start date and that there were no columns on the line listing for symptom onset, and specific signs and symptoms of infection. When the surveyor asked how monitoring trends of infections in the facility was completed without completing the line listing until the end of the month, the SDC said, Right. During an interview on 5/6/25 at 2:00 P.M., the DON said the facility did have a line listing for tracking infections in addition to the Line Listing for Antibiotic Use. The DON said the Infection Tracker Line Listing was a shared document on the computer and that several staff could access the Tracker. At this time, the DON showed the facility's Infection Tracker Line Listing to the surveyor which included the following columns: -First Name. -Last Name. -Floor. -Long Term Care (LTC)/Short Term Rehab (STR). -Onset Date (or date of admission if admitted with). -Diagnosis. -Diagnostic Test. -Type of Infection. -Facility Acquired? -Catheter? (UTI Only). -Microorganisms. -MDRO (multi-drug resistant organism). -Precautions. -Met McGeers Criteria? -Infection Care Planned? -MD/NP Notified? -Responsible Party Notified? (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clinical Notes. -The Infection Tracker Line Listing failed to include resident room numbers, and specific signs and symptoms of infection. The DON said she would provide a copy of the facility's Infection Tracker Line Listing to the surveyor for residents with active infections during the month of April 2025. On 5/6/25 at 3:15 P.M., the facility provided the Infection Tracker Line Listing for residents with active infections during the month of April 2025 to the surveyor. The surveyor reviewed the facility's Infection Tracker Line Listing as follows: -Twelve residents were listed on the Infection Tracker Line Listing for a total of 12 infections (one resident was listed twice for a UTI with the same onset date). -Three of the 12 residents listed on the Infection Tracker Line Listing as having infections and being treated with an antibiotic medication were not indicated on the facility's Line Listing for Antibiotic Use. -Fourteen of the residents listed on the facility's Line Listing for Antibiotic Use as having infection and being treated with antibiotic medication were not indicated on the facility's Infection Tracker Line Listing. -Resident room numbers were not indicated on the facility's Infection Tracker Line Listing. -Specific signs and symptoms of infection were not listed on the facility's Infection Tracker Line Listing for any resident on the Line Listing. During a follow-up interview on 5/7/25 at 1:10 P.M., the DON said the facility's Infection Tracker Line Listing was to be used to track all infections in the facility. The DON said that the Unit Managers (UMs) at the facility had access to the Infection Tracker Line Listing and that the UMs were supposed to enter resident information into the Infection Tracker Line Listing upon the onset of infection symptoms. The DON said if a resident was not on the Infection Tracker Line List, it was because the UM did not enter the information. The DON said the Infection Tracker Line Listing did not contain information including resident room numbers and signs and symptoms of infection. The DON said including resident room numbers and infection signs and symptoms would be important because each unit at the facility had three wings, and it would be important to identify whether similar symptoms and infections were occurring on like-assignments and if clusters of infections were occurring. The DON said the Infection Tracker Line Listing would need to be updated to ensure accuracy, and that as the DON at the facility, she was responsible for the IPCP (Infection Prevention and Control Program).