STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure requests to access personal funds for less than $100 ($50 for Medicaid residents) were honored within the same day for one Resident (#15), out of a total sample of 18 residents and the facility failed to ensure Resident #15's funds, as well as the funds of 7 of 18 Residents in the sample were maintained in an interest-bearing account. Findings include:The facility policy titled Personal Needs Account, dated as revised 6/26/25, indicated the following:-Pine [NAME] maintains a separate interest-bearing account for the residents who want their moneys to be managed by the facility. -Accurate records will be kept of residents' moneys and, at a minimum, a quarterly accounting of financial transactions will be given to the resident. 1.Resident #15 was admitted to the facility in February 2023 and has diagnoses that include vertigo of central origin (dizziness and imbalance) and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/8/25, indicated that on the Brief Interview for Mental Status exam Resident #15 scored a 15 out of a possible 15, indicating intact cognition. During an interview on 9/02/2025 at 11:23 A.M., Resident #15 said that the Nursing Home Administrator (NHA) refuses to allow him/her access to the money in his/her personal account of $3300 and that it is not right because he/she is a Veteran and earned that money. Review of the current care plan indicated Resident #15 is his/her own responsible decision making party. The care plan failed to indicate any issues with regards to Resident #15's mismanagement of finances or need for a conservator (In MA, a conservatorship is a legal process where the court appoints a conservator to manage the financial, property, and business affairs of an individual who is unable to make informed decisions due to incapacity, disability, mental illness or other reasons). During an interview on 9/04/2025 at 11:16 A.M., the NHA said that Resident #15 asks for money all the time and then says that he/she has lost it, so she often will not let Resident #15 have money when it is requested. The NHA presented an example and said on August 15 I let him/her have $150, then he/she said he/she lost it and the Certified Nursing Assistant (CNA) found it in his/her sock. Since then he/she's been asking for money and I told him/her, no, not in good conscience, cause it disappears. The NHA said that On 8/26/25 I gave in, and gave him/her $40. The NHA expressed frustration that Resident #15 purchases takeout a lot and is unrealistic with what he/she wants to spend it on. When asked by the surveyor if Resident #15 should he have access to his/her own money the NHA responded yes, and verified the Resident is his/her own responsible party. The NHA provided the surveyor with a current statement of Resident #15's Personal Needs Account (PNA). Review of the PNA statement failed to indicate Resident #15 had accrued interest on the money in his/her PNA for the period reviewed of 2023-2025. During a follow-up interview on 9/04/2025 at 11:48 A.M., the NHA said that all residents at the facility that have a PNA have the funds pooled in one account managed by the facility and that she does not think it is interest bearing, but should be. The NHA reviewed Resident #15's statement and said I do not see that he/she is getting interest and said she would look into it. On 9/04/2025 at 1:33 P.M., the NHA updated the surveyor that she had called the bank to determine the amount of interest that should be accruing on the PNA account. The NHA said we added it in to Resident #15's account now, but its not like he/she doesn't have enough money. 2. On 9/04/2025 at 12:08 P.M., the surveyor provided the (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NHA with a list of 18 residents in the sample and requested copies of their Personal Needs Account (PNA) statements. The NHA said that she would be able to provide PNA statements for the residents on the list for whom the facility is the rep-payee. During a follow-up interview on 9/04/2025 at 1:33 P.M., the NHA provided the PNA statements for 7 of 18 residents in the sample. Review of the PNA statements failed to indicate the accounts had accrued interest for the period reviewed of 2023-2025. The NHA verified that the facility is the rep-payee for those residents and that the resident's PNAs should have been accruing interest but had not. The NHA said that the money had been added that day after verifying the interest rate with the bank.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to offer/administer influenza and pneumococcal vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations for four Residents (#6, #21, #25, and #42) out of a total of five residents reviewed. Specifically, for 1. Residents #6, #21, and #25 the facility failed to administer the annual influenza vaccine during the most recent influenza season (2024 to 2025).2. Resident #6 and #42 the facility failed to administer pneumococcal vaccinations. Findings include:Review of the facility policy titled, Vaccination of Residents, undated, indicated that all residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated.Policy Interpretation and Implementation1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. (See current vaccine information statements at http:www.cdc.gov/vaccines/hcp/vis/index.html for educational materials.)2. Provision of such education shall be documented in the resident's medical record.3. All new residents shall be assessed for current vaccination status upon admission. 4. The resident or the resident's legal representative may refuse vaccines for any reasons. 5. If vaccines are refused, the refusal shall be documented in the resident's medical record 6. If the resident receives a vaccine, at least the following information shall be documented in the resident's medical recordˆa. Site of administration;ˆb. Date of administration;ˆc. Lot number of the vaccine (located on the vial);ˆd. Expiration date (located on the vial); andˆe. Name of person administering the vaccine. 7. Certain vaccines (e.g., influenza and pneumococcal vaccines) may be administered per the physician-approved facility protocol (standing orders) after the resident has been assessed by the physician for medical contraindications for each vaccine. The resident's Attending Physician must provide a separate written order for any other vaccination, and such orders shall be recorded in the resident's medical record. 8.Inquiries concerning this policy should be referred to the Infection Preventionist or the Administrator. On 9/04/25 at 10:45 A.M., the surveyor requested documentation for influenza and pneumococcal vaccines after a review of Resident #6, #21, #25, and #42's electronic health record and paper medical record and surveyor was unable to locate immunizations for the most recent influenza vaccination or the pneumococcal vaccinations. 1.) Review of the facility policy titled, Influenza Vaccine, undated, indicated all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. Policy Interpretation and ImplementationBetween October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized.Employees hired or residents admitted between October 1st and March 31st shall be offered the vaccine within five (5) working days of the employee's job assignment or the resident's admission to the facility.Employees will be offered the influenza vaccine at no charge, at a location onsite.Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. (See current vaccine information statements at http://www.cdc.gov/vaccines/hcp/vis/index.html for educational materials.) Provision of such education shall be documented in the resident's/employee's medical record.For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record.A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record.If an employee refuses the vaccine for reasons other than medical contraindication, this shall be documented on the Employee Informed Consent for Influenza Vaccine.The Infection Preventionist will maintain surveillance data on influenza vaccine (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coverage and reported rates of influenza among residents and staff. Surveillance data will be made available to staff as part of educational efforts to improve vaccination rates among employees.Only inactivated influenza vaccine will be offered to residents, pregnant employees, and employees who work directly with severely immunocompromised residents.Residents and staff may obtain their influenza vaccines from their personal physicians. Documentation of previous vaccination should be provided to the facility.Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.a.) Resident #6 was admitted to the facility in May 2020 and was greater than [AGE] years old. Review of Resident #6's influenza vaccine consent, dated 9/25/20 and 11/5/22, indicated that the Resident or his/her responsible person consented to the annual influenza vaccine. Review of Resident #6's active physician's orders, dated 11/1/23, indicated: -May have annual influenza vaccine. Review of Resident #6's immunization tab in the electronic health record and in his/her paper medical record failed to include documentation to support he/she received the most recent influenza vaccine. b.) Resident #21 admitted to the facility in February 2022 and was greater than [AGE] years old. Review of Resident #21's active physician's order, dated 10/26/23, indicated: -May have annual influenza vaccine. Review of Resident #21's immunization tab in the electronic health record and in his/her paper medical record failed to include documentation to support he/she received the most recent influenza vaccine. c.) Resident #25 was admitted to the facility in June 2020 and was greater than [AGE] years old. Review of Resident #25's influenza vaccine consent, dated 9/19/23, indicated that the Resident or his/her responsible person consented to the annual influenza vaccine. Review of Resident #25's active physician's order, dated 10/29/23, indicated: -May have annual influenza vaccine. Review of Resident #25's immunization tab in the electronic health record and in his/her paper medical record failed to include documentation to support he/she received the most recent influenza vaccine. 2.) Review of the facility policy titled, Pneumococcal Vaccine, undated, indicated that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.Policy Interpretation and ImplementationPrior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission.Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. (See current vaccine information statements at http:www.cdc.gov/vaccines/hcp/vis/index.html for educationalmaterials.) Provision of such education shall be documented in the resident's medical record.Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol.Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination.For residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record.Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Review of the CDC website Pneumococcal Vaccine Timing for Adults greater than or equal to 65 years (cdc.gov), dated 9/12/24, indicated but was not limited to the following:- For adults 65 and over who have not had any prior pneumococcal vaccines, then the patient and provider may choose Pneumococcal conjugate vaccine (PCV) 20 or PCV15 followed by Pneumococcal polysaccharide vaccine (PPSV) 23 one year later.-For adults 65 and over who has had Pneumococcal Conjugate Vaccine 13 (PCV13) and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) and it has been 5 years or greater since the last (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pneumococcal Vaccination, then the patient and the vaccine provider may choose to administer the 20-Valent Pneumococcal Conjugate Vaccine (PCV20). a.) Resident #6 was admitted to the facility in May 2020 and was greater than [AGE] years old. Review of Resident #6's pneumococcal vaccine consent, dated 9/25/20, indicated that the Resident or his/her responsible person consented to the annual pneumococcal vaccine. Review of Resident #6's physician's orders, dated 11/1/23, indicated: -May have annual pneumococcal vaccine. Review of Resident #6's immunization tab in the electronic health record and in his/her paper medical record failed to include documentation to support he/she received the pneumococcal vaccine. b.) Resident #42 was admitted to the facility in December 2024 and was greater than [AGE] years old. Review of Resident #42's pneumococcal vaccine consent, dated 1/14/25, indicated that the Resident or his/her responsible person consented to the annual pneumococcal vaccine. Review of Resident #42's physician's order, dated 12/23/24, indicated:-May have pneumococcal vaccine. Review of Resident #42's immunization tab in the electronic health record and in his/her paper medical record failed to include documentation to support he/she received the pneumococcal vaccine. During an interview on 9/4/25 at 12:27 P.M., the Administrator and Director of Social Services said they were unable to find documentation that the three Residents (#6, #21, and #25) received the influenza vaccines as they had received them in the past with the consent in the medical record. They said they were unable to provide the surveyor with documentation of Resident #6 and #42's pneumococcal vaccines. During an interview on 9/4/25 at 1:00 P.M., the Director of Nursing said they did not have the influenza vaccines because they did not have an annual consent signed by the Resident's health care agent and he said that he was unsure why the pneumococcal vaccines were not administered.

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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. Based on observation, record review and interview, the facility failed to ensure the comprehensive care plan was revised by the interdisciplinary team for one Residents (#21) out of a total sample of 18 residents, after each assessment, including both the comprehensive and quarterly review assessments. Specifically, the facility failed to review and revise the care plan after a significant change of status assessment was completed to reflect the current status of the Resident after the Resident had a fall and sustained a wrist fracture. Findings include:Review of the facility policy, titled ?Comprehensive Careplan', dated as revised 9/22/24, indicated the following:-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.-The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.-The comprehensive, person-centered care plan will:l. Include measurable objectives and timeframes.m. Describe the services that are to be furnished to attain and maintain the residents' highest practicable physical, mental, and psychosocial well-being.r. Incorporate identified problem areas.s. Incorporate risk factors associated with the identified problems.x. Aid in preventing or reducing decline in the residents' functional status and/or functional roles.y. Enhance the optimal functioning of the resident by focusing on a rehabilitative program. Resident # 21 was admitted to the facility in February 2025 with diagnosis including dementia, diabetes, and rheumatoid arthritis. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/31/25, indicated that Resident #21 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15. The MDS indicated Resident #21 required assistance with all personal care and mobility and that he/she had a recent fall. The MDS did not indicate that Resident #21 had a fracture. Review of Resident #21's nursing progress note, dated 7/9/25, indicated Resident sustained a distal, radial fracture of his/her left wrist. Review of Resident #21's physician progress note, dated 7/9/25, indicated after unwitnessed fall found an undisplaced fracture of the distal radial metaphysis. Review of Resident #21's physician progress note, dated 7/30/25, indicated Continue 0% nonweightbearing on the affected extremity. For immobilization he/she was given a cast in place, which should be removed by orthopedics team. No motion limitations, full range of motion allowed without limitations, when alert encourage finger motion to prevent contractures. Additional activity and restrictions include RICE, rest, ice, compression, and elevation. Physical therapy. Follow-up appointments 7/31/25 with orthopedic surgery, repeat x-ray. Continue Tylenol for pain. Review of Resident #21's current plan of care failed to indicate care for the Resident's wrist fracture or any interventions to prevent future falls. During an interview on 9/5/25 at 10:03 A.M., the Minimum Data Set (MDS) nurse said that the Director of Nurses and nurses on the floors updates the care plan as needed. She said care plans should be updated and revised after each MDS assessment. During an interview on 9/5/25 at 9:04 A.M., the Unit Manager said the care plan for Resident #21 should have been updated by nursing when he/she returned from the hospital. During an interview on 9/5/25 at 9:15 A.M., the Director of Nurses (DON) said that updating the plan of care is up to the nurses on the floor and that the comprehensive care plan should include new diagnoses, any new treatment, precautions, measures to enhance the optimal functioning of the resident by focusing on a rehabilitative program and any other measures needed to create a person centered plan of care and for Resident #21 his/her care plans did not.

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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 ensure that services provided met professional standards for two Residents (#35 and #8), out of 18 total sampled residents. 1. For Resident #35 the facility failed to ensure nursing implemented heel booties according to the physician's order.2. For Resident #8 the facility failed to ensure nursing implemented geri sleeves (arm protectors for residents who are at risk for bruising/injury) according to the physician's order.Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.1.Resident #35 was admitted to the facility in March 2018 with diagnoses including dementia and a history of a right ankle unstageable pressure ulcer. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/7/25, indicated that Resident #35 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 3 out of 15. This MDS indicated Resident #35 was dependent on staff for lower body dressing including taking off footwear. Review of Resident #35's active physician's order, dated 1/24/25, indicated:-Heel Protectors while in bed. Check placement and record other for prevent skin erosion on heels (sic). Scheduled on the Medication Administration Record (MAR) four times daily at 9:00 A.M., 12:00 P.M., 6:00 P.M., and 9:00 P.M.Review of Resident #35's active physician's order, dated 10/23/23, indicated:-PROTOCOL/HEEL PROTECTOR IN BOTH FEET WHILE IN BED, every shift. Scheduled on the Treatment Administration Record (TAR) every shift. On 9/2/25 at 7:48 A.M., 9/3/25 at 6:55 A.M., 9/4/25 at 6:40 A.M. and at 4:39 P.M., the surveyor observed Resident #35 in bed, his/her heels were directly touching his/her mattress, and he/she was not wearing his/her heel protectors. Review of Resident #35's Medication Administration Record and Treatment Administration Record, dated 9/2/25 through 9/4/25, indicated that nursing implemented the heel booties according to the physician's order. However, this documentation conflicts with the surveyor's observations.During an interview on 9/3/25 at 3:31 P.M., Nurse #2 said that he is familiar with Resident #35's care, and he said that Resident #35 does not wear heel boots. During an interview on 9/4/25 at 7:52 A.M., Certified Nursing Assistant (CNA) #1 said Resident #35 does not wear any heel booties on his/her feet and Resident #35 hasn't in a long time, CNA #1 said that Resident #35 doesn't need them (the heel booties).During an interview on 9/4/25 at 8:31 A.M., Nurse #1 said that Resident #35 is supposed wear heel booties, and the CNAs are supposed to make sure he/she is wearing them. Nurse #1 said that if Resident #35 refuses heel booties he would document the refusal on the mediation sheet and notify the provider and document this in a note in the medical record. During an interview on 9/4/25 at 4:18 P.M., the Director of Nursing said that nursing should implement Resident #35's physician's orders for heel booties and if Resident #35 is not using them nursing should discontinue the order. On 9/4/25 at 4:39 P.M., the surveyor and the DON observed Resident #35 heels directly touching the mattress. There were no booties in Resident #35's room. 2. Resident #8 was admitted to the facility in December 2022 with diagnoses including dementia, atrial fibrillation, depression, and anxiety. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/8/25, indicated that Resident #8 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 1 out of 15. This MDS indicated Resident #8 required substantial/maximal assistance with upper body dressing, Resident #8 was coded at risk for skin breakdown, received an anticoagulation medication, and he/she experienced behaviors including rejection of care daily.Review of Resident #8's active physician's order, dated 12/17/22, indicated:-Eliquis (blood thinning medication placing the resident at a high risk for bruising) 5 milligrams (mgs), give 1 tablet orally two times a day related to atrial (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fibrillation.-Aspirin 81 mg tablet, give 1 tablet orally one time a day for blood thinner.Review of Resident #8's active physician's order, dated 1/8/25, indicated:-Geri sleeves bilateral upper extremities (BUE) for frail, fragile, and paper-thin skin, every shift for skin issues.On 9/2/25 at 8:01 A.M., 8:47 A.M., 10:52 A.M., 12:31 P.M., and at 4:03 P.M., the surveyor observed Resident #8's arms without geri sleeves.On 9/3/25 at 6:53 A.M., 8:21 A.M., 1:23 P.M, 3:53 P.M., and at 4:56 P.M., the surveyor observed Resident #8's arms without geri sleeves.On 9/4/25 at 6:41 A.M., the surveyor observed Resident #8 in bed with no geri sleeves.Review of Resident #8's Medication Administration Record (MAR), dated 9/2/25 through 9/4/25, indicated that nursing implemented the geri sleeve according to the physician's order. However, this documentation conflicts with the surveyor's observations.Review of Resident #8's provider note, dated 1/8/25, indicated: Paroxysmal atrial fibrillation, chronic condition pharmacy visit summary reviewed agreed with recommendation I will order:-I will order monitor signs and symptoms of bruising and bleeding.-I will order geri sleeves bilateral upper extremities (BUE) for frail, fragile and paper-thin skin continue Eliquis, monitoring for bleeding.Review of Resident #8's plan of care related to potential for impaired skin related to poor safety awareness, dated 1/15/25, indicated, geri sleeves as ordered.During an interview on 9/4/25 at 8:35 A.M., Certified Nursing Assistant #2 said that he routinely cares for Resident #8 and Resident #8 does not wear geri sleeves.During an interview on 9/3/25 3:40 P.M., Nurse #2 said that he works the day and evening shift and he is familiar with Resident #8. Nurse #2 said that Resident #8 has not worn geri sleeves in a long time and he said that the Resident would take them off, and staff stopped applying the geri sleeves. During an interview on 9/4/25 at 8:34 A.M., Nurse #1 said that he works routinely on the night shift and he is familiar with Resident #8's care. Nurse #1 said that Resident #8 is supposed to wear geri sleeves and the CNAs will put them on. The surveyor and Nurse #1 observed Resident #8 without his/her geri sleeves. During an interview on 9/4/25 at 11:15 A.M., the Unit Manager said that Resident #8 hasn't worn geri sleeves in a while and the geri sleeves were used because he/she was at risk for bruising and bleeding due to medication use. During an interview on 9/4/25 at 4:15 P.M., the Director of Nursing said nursing should implement the physician's orders and apply Resident #8's geri sleeves and if Resident #8 was no longer wearing them, nursing should revise the order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents at risk for developing pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to prevent new ulcers from developing for one Resident (#18) out of a total of 18 Residents. Specifically, the facility failed to ensure the Resident's air mattress was set at the correct setting according to the physician's order. Findings include:Review of the facility policy titled Bed Safety- Air Mattress- Side Rails, dated February 2025, indicated the following:- It is the policy of the facility to provide air mattresses, with a physician's order, to residents who are bedridden, have limited mobility, are at high risk for pressure sores on the buttocks/hips or who are recovering from a wound. Nursing will follow these procedures:a. Obtain a physician's order for an air mattress.b. Apply mattress to the resident bed.c. Follow manufacturer's instructions for use and care of the mattress.d. The mattress should be pumped in accordance with the resident's weight.e. Document all skin assessments. Resident #18 was admitted to the facility in November 2020 with diagnosis including stage 4 pressure ulcer (a severe form of pressure injury that involves full-thickness tissue loss, exposing muscle, tendon, or bone) of sacral region, Alzheimer's dementia, and moderate protein-calorie malnutrition. Review of Resident #18's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated rarely/never understood and a staff assessment for Brief Interview for Mental Status (BIMS) indicated severe cognitive impairment. Further review of the MDS indicated that the Resident has one stage 4 pressure ulcer and is at risk of developing pressure ulcers and is dependent on staff for all activities of daily living. The surveyor made the following observations:- On 9/2/25 at 7:24 A.M. and 8:14 A.M. Resident #18 was lying on his/her bed. An air mattress was present and operating and was set at a line between 320-400. Next to the setting dial was a black mark between 80-160 indicating where weight setting should be.- On 9/3/25 at 7:22 A.M., and 4:46 P.M., Resident #18 was sleeping in his/her bed. An air mattress was present and operating and was set at a line between 320-400. Next to the setting dial was a black mark between 80-160 indicating where weight setting should be.- On 9/4/25 at 6:50 A.M., Resident #18 was sleeping in his/her bed. An air mattress was present and operating and was set at a line between 320-400. Next to the setting dial was a black mark between 80-160 indicating where weight setting should be. Review of Resident #18's physician's order dated 10/24/23 indicated the following:- Air mattress check placement and function. Air mattress to be set weight at 120 line and static bottom to be off every shift. Review of Resident #18's treatment administration record (TAR) dated 9/4/25 indicated the following:-Stage 4 pressure wound coccyx full thickness- 0.5 x 0.4 x 0.3 centimeters (cm).1-wash with normal saline, pat dry.2-apply leptospermum honey (wound healing ointment) once daily.3- apply xeroform gauze.4- cover with superabsorbent silicone boarder faced.5- peri wound area apply skin prep daily. Review of Resident #18's impaired skin integrity related to immobility and current pressure ulcers stage 4 coccyx care plan dated, 10/7/24, indicated the following intervention:-I will have an air mattress to my bed. Air mattress is a direct supply model, air element mattress. It will be set to the weight line of 118 pounds, and the static light will be off. Review of Resident #18's hospice services care plan dated, 6/2/22, indicated:-d/c weight on hospice care. During an interview on 9/4/25 at 12:14 P.M., Certified Nurses Aide (CNA) # XX said only the company adjusts the settings on the air mattress. During an interview on 9/4/25 at 1:40 P.M., Nurse #XX and surveyor observed the air mattress set between 320-400. She said air mattress settings should be at line (120) and should not be moved by anyone. Nurse #XX said if the air mattress settings are too high it could affect Resident #18's skin and increase pressure ulcer risk. During an interview on 9/5/25 at 9:11 A.M., the Unit Manager said that air mattress should be set according to the physician's order and the risk of the mattress being set too high was that it would cause weight to not be distributed properly and increase pressure to the Resident's skin. During an interview on 9/5/25 at 9:28 A.M., the Director of (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON) said air mattress settings should be set by a resident's weight and by the physician's order.

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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, record review, and interview, the facility failed to ensure professional standards of practice for the care of a urinary catheter (a tube inserted into the bladder to drain urine) for one Resident (#23) out of a total sample of 18 residents. Specifically, the facility failed to ensure nursing changed Resident #23's urinary catheter and urinary catheter drainage bag in accordance with physician's orders.Findings include:Review of the facility policy titled, Foley Catheter, dated as revised 7/15/24, indicated that the catheter size and frequency of changes will be determined by the physician's order. Resident #23 was admitted to the facility in January 2025 with diagnoses including urinary tract infection, urine retention, acute kidney failure, and heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/19/25, indicated that Resident #23 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 14 out of 15. This MDS indicated Resident #23 was dependent on staff for his/her toileting needs and he/she required an indwelling urinary catheter. On 9/2/25 at 7:54 A.M., the surveyor observed Resident #23 in his/her in bed receiving care by two Certified Nursing Assistants (CNAs) his/her urinary catheter drainage bag was dated 8/14/25. On 9/2/25 at 4:05 P.M., the surveyor observed Resident #23 in his/her bed, his/her urinary catheter drainage bag was dated 8/14/25. Resident #23 had a16 French (Fr) 30 milliliter (ml) balloon indwelling urinary catheter inserted into his/her bladder. Review of Resident #23's plan of care related to activities of daily living, dated 4/2/25, indicated:-Foley 16 Fr with 5 ml balloon. Needs to be changed every month on the 12th day. Review of Resident #23's physician's order, dated 12/18/24, indicated:-Change Foley Catheter 16 Fr 5 ml every month on the 12th day, monthly starting on the 12th and ending on the 12th every month for neuropathic bladder. Review of Resident #23's Treatment Administration Record (TAR), dated August 2025, indicated on 8/12/25, nursing documented they changed Resident #23's catheter as ordered by the physician. Review of Resident #23's physician's order, dated 12/12/24, indicated:-Urinary Catheter: Drainage Bag - Change, every day shift every Thursday. Review of Resident #23's Medication Administration Record (MAR), dated August 2025, indicated nursing documented they changed the urinary drainage bag on 8/14/25, 8/21/25, and on 8/28/25. During an interview on 9/4/25 at 7:39 A.M., Nurse #1 said that Resident #23's catheter and catheter bag are changed based on the physician's order. Nurse #1 said that the size of the catheter is based on the physician's order and if the correct size catheter is not available for the catheter change the provider should be notified, this notification would be documented in the medical record, and there would be a onetime order to insert a catheter for the catheter size on hand. Nurse #1 said he changed Resident #23's catheter bag based on the physician's order last month (August 2025). During an interview on 9/4/25 at 4:44 P.M., Nurse #5 (a nurse who changed the catheter bag once according to the TAR) said Resident #23's urinary catheter drainage bags are changed weekly, and he said that he had changed Resident #23's catheter bag. Nurse #5 said that when a urinary catheter bag is changed the old bag is thrown out and nursing is supposed to write the date and initials on the urinary drainage bag when the bag is changed. During an interview on 9/4/25 at 11:17 A.M., the Unit Manager said that Resident #23 requires an indwelling urinary catheter and that staff should insert the correct size into his/her bladder. The Unit Manager said that inserting a catheter too small could cause leakage and inserting a catheter too large could cause damage. The Unit Manager said catheter drainage bag changes are completed to help reduce the risk of infection. During an interview on 9/4/25 at 4:19 P.M., the Director of Nursing (DON) said nursing should implement the physician's orders for the correct catheter size and that nursing should be implementing the orders for urinary catheter bag changes. On 9/4/25 at 4:37 P.M., the surveyor and the DON observed Resident #23 in bed, he/she had a 16 Fr 30 ml balloon inserted into his/her bladder.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and interview, the facility failed to designate a person who met the minimum qualifications to serve as the Food Service Director (FSD). Specifically, the facility did not employ a full-time dietitian or have a qualified dietary employee who met the minimum qualifications to serve as the FSD. Findings include: During an interview on 9/3/25 at 11:29 A.M., the FSD said he had been employed by the facility since March 2025. The FSD said that he had attended college and did not complete a college degree. The FSD provided the surveyor with his food safety training and certificate for food service professionals and his allergen awareness certificate. During an interview on 9/4/25 at 11:54 A.M., the Registered Dietician said that she is not employed by the facility on a full-time basis. During a follow up interview on 9/5/25 at 7:54 A.M., the surveyor reviewed the regulatory requirements with the FSD to be a qualified FSD, he said he did not meet the requirements, and the FSD said the Dietitian comes to the facility two to three days a week. During an interview on 9/5/25 at 8:11 A.M., the surveyor, the Nursing Home Administrator and the Executive Director reviewed the regulation text and interpretive guidelines and the Executive Director said that the FSD does not meet the regulatory requirements to be the FSD. The Executive Director said that the FSD has had several years working in assisted living and the FSD was brought to the facility to elevate the dining experience.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review and interview, the facility failed to serve what was listed on the menu for the pureed meal during three meals observed during the survey period. Specifically, the facility failed to ensure residents who required a pureed entree received the meal as indicated on the menu.Findings include: Review of the facility policy titled, Nutritional Services - Menu Planning, dated as revised 10/22/23, indicated professional planning of standard and therapeutic diets for residents is approved by a qualified registered dietitian in accordance with current recommended dietary allowances of the food and nutrition board, national research council and in accordance with physician's orders. Review of the menu, dated 9/3/25, indicated for lunch:-Chicken Piccata or Spinach Stuffed Sole -Parmesan Orzo -Spinach On 9/3/25 at 11:52 A.M., the surveyor observed the Food Service Director (FSD) serving several pureed meals. The FSD said that the pureed diets were receiving beef in tomato, mashed potatoes, and spinach. The FSD said that it is the facility practice to serve the pureed diets foods that are up to five days old and not to puree the posted menu items for the pureed diets. Reiew of the menu, dated 9/3/25, indicated for dinner:-Cheese Burger with caramelized onions or Egg Salad -Steak Fries -Carrots On 9/3/25 at 4:59 P.M., the surveyor observed the cook serving the evening meal, and the pureed diets were served ground beef in tomato, spinach, and mashed potatoes. On 9/4/25 at 12:02 P.M., the surveyor met with the Dietitian and reviewed the kitchen observations from 9/3/25. The Dietitian said that the pureed diets should receive the same entree as the regular textured diets, and she said was not aware the FSD was not following the menus for the pureed diets. The Dietitian said that there were currently 6 residents who required a pureed diet. The Dietitian and the surveyor reviewed the week at a glance spring/summer menu, and she said that she was not aware that the FSD was making all the changes he was making, and she said that the menus are based on nutritional needs and needed to be followed. Review of the menu, dated 9/4/25, indicated for lunch:-Breaded Pork Chop and [NAME] Gravy or Broccoli and Cheddar Quiche -Au Gratin Potatoes -Summer Blend Vegetables On 9/4/25 at 11:49 A.M., the surveyor observed the cook serving the lunch meal and the pureed diets were served ground beef in tomato, mixed vegetables, and mashed potatoes. During a follow up interview on 9/5/25 at 7:34 A.M., the FSD said in his past experience the pureed diets would come in frozen, but that at this facility he would need to come up with his own starch, protein, and vegetable for the pureed diets each day. The FSD was not aware that he should be serving the pureed diets based on the menu breakdown. During an interview on 9/5/25 at 8:18 A.M., the Executive Director said the cooks and FSD need to follow the menu for pureed diets, and the puree diet should be receiving the same meal as posted.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review and interview, the facility failed to provide the appropriate dessert for one Resident (#42) out of a total sample of 18 residents. Specifically, Resident #42, who required nectar thickened liquids was provided gelatin for dessert. Findings include: Review of the facility policy titled, Therapeutic Diets, dated as reviewed 11/24/24, indicated therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. 5. If a mechanically altered diet is ordered, the provider will specify the texture modification. Review of the facility policy titled, Thickened Liquids, dated as revised 1/16/23, indicated that the center will provide residents thickened liquids with a physician's order, to reduce the risk of choking and aspiration. 1.The physician's order will include the level of liquids tolerated: -Nectar-like: Thickened so that liquid runs off the spoon but at a slower rate, such as apricot or peach nectar. Resident #42 was admitted to the facility in December 2024 with diagnoses including dementia and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/22/25, indicated that Resident #42 had a memory impairment and his/her cognitive skills for daily decision making was coded as severely impaired.Review of Resident #42's active physician's order, dated 7/20/25, indicated:-Controlled Carb diet, Pureed texture, Nectar consistency, for dysphagia mildly thick liquids by small sips.Review of Resident #42's plan of care related to therapeutic diet related to dysphagia and thickened liquids requirement, indicated:- Provide, serve diet as ordered On 9/02/25 at 12:28 P.M., the surveyor observed Nurse #2 feed Resident #42 green gelatin (a food the returns to a thin liquid consistency. During an interview on 9/03/25 3:37 P.M., Nurse #2 said the Resident #42 requires a pureed diet and nectar thickened liquids, Nurse #2 said that Resident #42 could have gelatin based on his/her diet orders. On 9/04/25 at 11:58 A.M., the surveyor met with Dietitian about the gelatin being served to Resident #42. The Dietitian said that gelatin should not be severed to residents who require nectar thickened liquids. The Dietitian said that there were six residents in the facility, on 9/3/25, who required nectar thickened liquids that received gelatin for dessert because the kitchen staff, including the Food Service Director (FSD), were not aware that residents who required nectar thickened liquids could not have gelatin. During an interview on 9/04/25 at 4:11 P.M., the Director of Nursing said that Resident #42 should not have received gelatin as a dessert with a nectar thickened liquids order.During an interview on 9/05/25 at 7:32 A.M., the FSD said he was made aware by the Dietitian that gelatin should not be served to residents requiring nectar thickened liquids and that those Residents on nectar thickened liquids should have received pudding.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observations, interviews and record review, the facility failed to provide adaptive equipment for one Resident (#62) out of a total sample of 18 residents. Specifically, the facility failed to ensure Resident #62 was provided with a two handled cup and built-up utensils for use during his/her meals to maximize intake.Findings include:Review of the facility policy titled, Small Adaptive Devices for ADL's, dated as revised 11/24/24, indicated:-Proper, safe and consistent use of small adaptive devices can maximize the resident's level of independence.-Utensils with built up handles provide a larger grasp for residents with weak grasp or decreased range of motion in the hand.-Cups allow resident to drink with hand tipped slightly forward. This is a safer method than tipping the head backward which opens the airway and increases risk of aspiration.Resident #62 was admitted to the facility in April 2021 with diagnoses including paranoid schizophrenia, dysphagia, moderate protein-calorie malnutrition, and dementia with behavioral disturbances.Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/25, indicated Resident #62 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 3 out of 15. The MDS also indicated Resident #62 required set up and clean up assistance with eating and that there was no weight recorded.Review of a dietary communication slip for Resident #62, dated 9/2/25 through 9/5/25, indicated:- Adaptive Equipment: 2-handle cup, built-utensil handlesReview of Resident #62's active physician's orders, dated 6/20/25, indicated:-Use adaptive eating utensils, sippy cups for fluids.Review of Resident #62's plan of care related to nutrition, dated 5/23/25, indicated:-Provide built-up utensils and sippy cup.Review of Resident #62's dietician assessment, dated 8/25/25, indicated:-Has an order for sippy cups and adaptive utensils to facilitate self-feeding. He/she is underweight w/ visible fat and muscle loss, however no recent significant weight loss. Monthly weight is pending, now that he/she is off hospice.On 9/2/25 at 7:38 A.M., the surveyor observed Resident #62 eating breakfast. The meal slip on the tray indicated a two handled cup and built-up utensil should be on the breakfast tray. There were no two handled cup or built-up utensils available on the meal tray. Resident #62's hands were shaking and he/she appeared to be having difficulty managing the cups and utensils.On 9/2/25 at 12:04 P.M., the surveyor observed Resident #62 eating lunch. The meal slip on the tray indicated a two handled cup and built-up utensils should be on the lunch tray. There were no two handled cup or built-up utensils available on the meal tray. Resident #62's hands were shaking and he/she appeared to be having difficulty managing the cups and utensils.On 9/3/25 at 12:15 P.M., the surveyor observed Resident #62 eating lunch. The meal slip on the tray indicated two handled cup and built-up utensils should be on the lunch tray. There were not two handled cup on the meal tray. The drinks were served in regular cups with straws. Resident #62's hands were shaking and he/she appeared to be having difficulty managing the cups and utensils.On 9/4/25 at 7:51 A.M., the surveyor observed Resident #62 eating lunch. The meal slip on the tray indicated two handled cup and built-up utensils should be on the lunch tray. There was no two handled cup on the meal tray. The drinks were served in regular cups with straws. Resident #62's hands were shaking and he/she appeared to be having difficulty managing the cups and utensils.During an interview on 9/4/25 at 12:06 P.M., Certified Nursing Aide (CNA) #6 observed Resident's meal slip with surveyor and said that she had asked the kitchen for the built-up utensils but was told they did not have any to provide.During an interview on 9/4/25 at 1:45 P.M., the Food Service Director said the meal slip should match what is served on the Resident's meal tray.During an interview on at 9/5/25 at 9:04A.M., the Unit Manager #1 said nurses are responsible to check the meal slip to ensure everything and adaptive eating equipment, including two handled cups and built-up utensils, are on the tray before it is delivered. Unit Manager #3 said if the two handled cups and built-up utensils were indicated on the meal slip and were not available, the nurse should have called the kitchen to obtain the two handled cup and built-up utensils.During an interview on 9/5/25 at 9:28 A.M., the Director of (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON) said nurses are responsible for checking the meal slip to ensure everything and adaptive eating equipment, including two handled cups and built-up utensils, are on the tray before it is delivered. The DON said if the two handled cup and built-up utensils were indicated on the meal slip and were not available, the nurse should have called the kitchen to obtain the two handled cup and built-up utensils.

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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. Based on observation, record review, and interview, the facility failed to ensure nursing accurately documented in the electronic health record for three Residents (#35, #8, and #62), out of 18 total sampled residents. Specifically, the facility failed to ensure the nurses accurately documented skin checks. Findings include:1.Resident #35 was admitted to the facility in March 2018 with diagnoses including dementia and a history of a right ankle unstageable pressure ulcer. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/7/25, indicated that Resident #35 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 3 out of 15. Review of Resident #35's active physician's order, dated 10/30/23, indicated:-WEEKLY SKIN ASSESSMENT ON FRIDAY THE 7-3 SHIFT, every day shift every Friday.Review of Resident #35's plan of care related to at risk for skin breakdown, dated 4/25/22, indicated:-Staff will document my weekly skin assessment.Review of Resident #35's Skin Only Evaluation assessments, dated 6/13/25, 6/20/25, 6/27/25, 7/4/25, 7/12/25, 7/20/25, 8/1/25, 8/8/25, 8/12/25, 8/15/25, 8/22/25, and 8/29/25, indicated the following:Skin: Does Resident have current skin issues, coded as yes.SK5. Skin Issue #1, g) discolorationSk5b. Location- left footSK5d. Length- 5 centimetersSK5e. Width- 2.5 centimetersSK5n. Tissue- a. Painful, checked, e. Warm, checked. Review of Resident #35's consultant podiatry note, dated 7/22/25, indicated: Dermatological Exam: Left Foot / Right FootSkin Color: Pallor (pale)Temperature: NormalSkin Texture: ThinSkin Discoloration: No During an interview on 9/4/25 at 7:52 A.M., Certified Nursing Assistant (CNA) #1 said he routinely cares for Resident #35, and Resident #35 has no skin issues on his/her feet, and that there are no discolorations and no pain.During an interview on 9/3/25 at 3:31 P.M., Nurse #2 said that Resident #35 requires weekly skin checks. Nurse #2 said that regularly cares for Resident #35 and he/she has no skin issues. Nurse #2 said that Resident has not had any bruising to his/her feet in months. Nurse #2 said that skin checks are completed each week, and this involves looking at each resident's skin and documenting findings in the electronic health record (EHR).During an interview on 9/4/25 at 4:17 P.M., the Director of Nursing (DON) said that skin checks should be documented on accurately to reflect the resident's skin in the EHR (electronic health record). On 9/4/25 at 4:39 P.M., the surveyor and the DON observed Resident #35's feet in bed, he/she had no skin issues. 2. Resident #8 was admitted to the facility in December, 2022 with diagnoses including dementia, atrial fibrillation, depression and anxiety. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/8/25, indicated that Resident #8 had a severe cognitive impairment, as evidenced by a Brief Interview for Mental Status (BIMS) score of 1 out of 15.Review of Resident #8's progress note, dated 4/4/25, indicated:- Resident presented with an abscess on his/her left buttock oozing serosanguineous drainage, area red and tender, skin surrounding red and fragile. Tip of right-hand Ring finger swollen with reddened discoloration. Review of Resident #8's physician's order dated 5/1/25 and discontinued on 5/16/25, indicated: -WOUND OF THE LEFT BUTTOCK FULL THICKNESS: Wash with normal saline, pat dry, apply hydrogel gel with silver, xeroform gauze, cover with gauze island with boarder, skin prep to peri wound, every day shift for wound care.Review of the consultant wound doctors note, dated 5/15/25, indicated Resident #8's left buttock wound was healed. Review of Resident #8's physician's orders, dated 5/23/25 and discontinued on 6/6/25, indicated:-WOUND OF THE RIGHT, FOURTH FINGER FULL THICKNESS: 1 - Wash with normal saline, pat dry, 2 - apply mupirocin topical 2%, 3 - cover with dressing twice daily and as needed, two times a day for wound care.Review of Resident #8's Skin Only Evaluation assessment, dated 6/11/25, 7/2/25, 7/30/25, 8/6/25, 8/13/25, 8/20/25, 8/27/25, and 9/3/25, indicated:Skin Evaluation: Skin color is within normal limits (WNL). Resident has current skin issues.Skin Issue: Other skin issue.-Other skin issue: Blister Skin issue, location: right hand ring finger.Length: 0.3Width: 0.2Depth: 0.0Wound bed: Necrotic.Wound exudate: None.Peri wound condition: WNL.Dressing saturation: None.Wound odor: No.Tunneling: No.Undermining: No.Tissue: Painful. -Other (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin issue: abscess. Skin issue location: left buttockLength: 2.5Width: 2.0Depth: 0.0Wound bed: Slough (dead tissue typically white or grey). Wound exudate: Purulent (green or yellow drainage). Peri wound condition: WNL.Dressing saturation: Moderate (26-75%).Wound odor: No.Undermining: No.Tissue: Painful.On 9/2/25, 9/3/25, and on 9/4/25, the surveyor was unable to observe a blister on Resident #8's right hand ring finger.During an interview on 9/4/25 at 8:15 A. M., CNA #2 said he routinely cares for Resident #8, and he/she has no areas on his/her buttocks and no areas on his/her fingers.During an interview on 9/4/25 at 11:15 A.M., the Unit Manager said that Resident #8 no longer had areas on his/her buttocks and doesn't have an area on his/her right ring finger. The Unit Manager said that staff should accurately document skin checks in the EHR. During an interview on 9/4/25 at 4:12 P.M., the Director of Nursing said that nursing should document accurate skin checks and Resident #8's left buttocks was healed and May 2025 and Resident #8's finger was healed in June 2025 and said he was not sure why nursing still documented the areas. On 9/4/25 at 4:42 P.M., the surveyor and the DON observed Resident #8's skin, there were no skin issues identified. 3. Resident #62 was admitted to the facility in April 2021 with diagnoses including paranoid schizophrenia, moderate protein-calorie malnutrition, and dementia with behavioral disturbances.Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/25, indicated Resident #62 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 3 out of 15. This MDS also indicated Resident #62 had 2 unstageable pressure ulcers/injuries due to non-removable dressing/device and open lesions.Review of Resident #62's active physician's order, dated 4/10/25, indicated:-Bacitracin External Ointment 500 unit/gm (grams). Apply to left great toe topically one time a day related to disorder of the skin and subcutaneous tissue, unspecified. Apply to left great toe toe daily for skin integrity.Review of Resident #62's active physician's order, dated 3/11/25, indicated:-Bacitracin External Ointment 500 unit/gm. Apply to forehead wound topically two times a day for skin carcinoma. Leave open to air due to patient's non compliance with dry protective dressing (DPD).Review of Resident #62's physician's orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR), indicated:-Bacitracin External Ointment 500 unit/gm. Apply to left great toe topically one time a day on the day shift, dated 4/10/25.-Cleanse with normal saline (NS), apply wound gel, cover with xeroform gauze and gently wrap the toe with gauze daily on the day shift and as needed if dressing becomes saturated. Monitor for infection, dated 8/11/25.-Left ankle wound: Wash area with NS and pat. Apply xeroform and cover with a non-adhesive pad. Wrap with kerlix wrap and secure. Every day shift for wound care, dated 7/28/25.-Left thigh wound: Wash with NS and pat dry. Apply DSD to area every day on the day shift until resolved, dated 7/28/25.-Weekly skin assessment on Wednesday, 3-11 shift.-Xeroform Petrolat Patch 2 (Bismuth Tribromophenate-Petrolatum). Apply to Right lower leg topically every day shift for skin tear. Wahs with NS, apply xeroform- cover with DPD every days until healed, dated 6/6/25.-Bacitracin External Ointment 500 unit/gm. Apply to forehead wound topically two times a day for skin carcinoma. Leave open to air due to patient's non-compliance, dated 3/11/25.-Monitor reddened area below anterior aspect of right knee every shift. Alert physician if area opens or increases in size. Discontinue when resolved, dated 3/20/25.-Monitor wound to right anterior shin every shift. Update physician if area becomes larger or opens, or shows signs of infection, dated 3/11/25.Review of skin checks indicate the following:-carcinoma forehead and wound right shin, dated 8/2/25 at 9:33 A.M.-forehead wound bleeding, dated 8/6/25 at 10:19 P.M.-no skin issues, dated 8/13/25 at 9:15 P.M.-carcinoma forehead and wound right shin, dated 8/20/25 at 11:15 P.M.-carcinoma forehead and wound right shin, dated 8/27/25 at 10:05 P.M.-carcinoma forehead and wound right shin, dated 9/3/25 at 10:33 P.M.Review of Resident #62's nursing progress note, dated 9/4/25, indicated:-very resistive with care. Dressing done on his/her right lower leg, right foot toes. Bacitracin applied, left dorsal foot small area healing well. Closed. No drainage. Unable to touch, to assess the forehead. Very resistive. Areas monitored despite the patient non-compliant behavior.Review of Resident #62's physician's progress note, dated 9/3/25, indicated:-Aggression (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	towards staff when providing care. Attempts to punch and hit staff when wound care is offered.During an interview on 9/3/25 at 1:10 P.M., Nurse #7 said that Resident #62's wounds include:-Right shin wound.-Forehead wound.-Left thigh wound.-Left ankle wound.-Left great toe wound.Nurse #6 said wound notes are written daily under progress notes. Weekly skin checks are done and should match the treatments that are being done for the Resident. There is a wound doctor that rounds weekly, and uploads notes in the electronic medical record. Incident reports are not done for wounds.During an interview on 9/4/25 at 7:31 A.M., Nurse #6 said that Resident #62 is not followed by wound doctor as he/she refuses and is combative. She described the area on left ankle as a small open area and said the Resident does not have any wounds on left thigh or left great toe. She said she puts bacitracin on the forehead wound and between toes on right foot and does treatment that is ordered to Resident's right shin. She said she documents daily in skin wound notes. Wound treatments are scheduled for the day shift. Nurse #6 had already completed Resident's daily treatments and the Resident would not allow her to remove dressings or do a skin check so the surveyor could observe.During an interview on 9/4/25 at 9:46 A.M., Nurse #6 said that she does not document daily on Resident #62 as he/she is not followed by wound doctor, but she does write notes sometimes. She said weekly skin checks should match wounds that are currently being treated.During an interview on 9/5/25 at 9:04 A.M., the Unit Manager said that skin checks should match the actual condition of the Resident's skin.During an interview on 9/5/25 at 9:43 A.M., the Director of Nursing said that skin check should reflect the Resident's actual skin integrity.

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on Minimum Data Set (MDS) assessment review and staff interview, the facility failed to ensure staff completed the Quarterly MDS assessment within the required time frame for two Residents (#20 and #6), out of a total of 18 residents.Findings include:The MDS is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment.A Quarterly MDS assessment is considered timely if the Assessment Reference Date (ARD) of the Quarterly MDS is completed within 92 days of the most recent OBRA Assessment reference date (Admission, Annual, Quarterly, or a Significant Change in Status Assessment) and submitted no later than 14 days after the completion date.1. Resident #20 was admitted to the facility in January 2025.Review of the quarterly MDS assessment, dated 4/30/25, indicated it was completed 5/26/25 and, as of 9/5/25 there had not been another quarterly MDS complete, making it a total of 37 days late.2. Resident #6 was admitted to the facility in April 2025.Review of the quarterly MDS assessment, dated 7/30/25, indicated it was not completed until 9/3/25, a total of 21 days late.During a telephone interview on 9/5/25 at 10:06 A.M., the MDS Nurse said she was responsible for the completion of the MDS assessments and said that she was not aware that the MDS' for Resident #30 and Resident #6 were late and that these late assessments were a result of oversites on her part.During an interview on 9/5/25 at 9:28 A.M., the Director of Nursing said he would expect the MDS' to be completed timely and according to the Resident Assessment Instrument (RAI) manual.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to ensure that Minimum Data Set (MDS) assessments were transmitted within 14 days after a resident assessment was completed for three Residents (#38, #7, and #28), out of a total sample of 18 residents.Findings include: Review of Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, Version 3.0, indicated assessments must be completed no later than 14 calendar days after the assessment reference date (ARD) and transmitted and encoded within 14 days of assessment completion.1.Resident #38 was admitted to the facility in November 2023.Review of the most recent MDS assessment indicated that it was completed on 8/15/25 and had not been submitted as of 9/5/25, 21 days after the completion date.2.Resident #7 was admitted to the facility in July 2021.Review of the most recent MDS assessment indicated that it was completed on 8/15/25/25 and had not been submitted as of 9/5/25, 21 days after the completion date.3.Resident #28 was admitted to the facility in April 2025.Review of the most recent MDS assessment indicated that it was completed 8/14/25 and had not been submitted as of 9/5/25, 22 days after the completion date.During a telephone interview on 9/5/25 at 8:03 A.M., the MDS Nurse said that MDS assessments should be completed based on the instructions in the RAI manual. She said that quarterly MDS assessments should be submitted within 14 days of the completion date, but for Resident's #38, #7, and # 28 they were not. The MDS Nurse said that she is in the process of being trained on how to submit MDS's, but at this time she relies on the previous MDS Nurse to submit the MDS's and was not aware they were late.During an interview on 9/5/25 at 9:28 A.M., the Director of Nurses said that he would expect that MDS assessments are completed as per the RAI manual, and that MDS assessments are submitted within 14 days of the completion date.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure the Minimum Data Set (MDS) assessment was coded accurately for four Residents (#24, #42, #3 and #7) out of a total sample of 18 residents. Specifically:1) For Resident #24, the Resident was erroneously coded as receiving an antianxiety medication on the 7/01/25 MDS.2) For Resident #42, the Resident was erroneously coded as receiving antianxiety medication, and not receiving hypoglycemic and anticonvulsant medication on the MDS dated [DATE]) For Resident #3, the Resident was erroneously coded as receiving an antianxiety medication on the 7/23/25 MDS.4) For Resident #7, the Resident was erroneously coded as having a diagnosis of Schizophrenia on the 5/03/25 MDS.Findings include: 1. Resident #24 was admitted to the facility in July 2022 and has diagnoses that include Alzheimer's disease and bipolar disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/01/25, indicated that Resident #24 was coded to be receiving antianxiety medication. Review of the June 2025 and July 2025 Medication Administration Record (MAR) failed to indicate Resident #24 was prescribed an antianxiety classified medication. Review of the Physician's orders for Resident #24, for June 2025 and July 2025, failed to indicate Resident #24 was prescribed an antianxiety medication. The MD orders included the following order: -Donezepil 10 milligram (mg) tab, give 1 tablet orally at bedtime for bipolar/anxiety, start date 8/7/23. Donepezil is a cholinesterase inhibitor used to treat dementia During a phone interview with the MDS Coordinator on 9/05/2025 at 10:13 A.M., she said that she was not aware that medications should be coded on the MDS according to their classification and not the reason for use. During an interview with the Executive Director on 9/05/2025 at 10:28 A.M., he said that it is his expectation that the MDS be coded accurately. 2. Resident #42 was admitted to the facility in December 2024 with diagnoses including restlessness and agitation, dementia, and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/22/25, indicated that Resident #42 was coded as having received an antianxiety medication, was coded as not having had received a hypoglycemic or anticonvulsant medication. Review of Resident #42's physician's orders failed to include an antianxiety medication was administered during the assessment reference date. Review of Resident #42's physician's order, dated 5/15/25, indicated: -Glipizide extended release 24 Hour 5 milligrams (mg), give 5 mg by mouth one time a day for diabetes, (hypoglycemic medication). Administered by nursing during the assessment reference date. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #42's physician's order dated 12/26/24, indicated: -Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 mg, give 750 mg by mouth two times a day related to dementia (an anticonvulsant medication). Administered by nursing during the assessment reference date. During an interview on 9/5/25 at 10:10 A.M., the MDS Nurse reviewed Resident #42's physician's orders, Medication Administration Record, and the MDS dated [DATE] and said she did not code the antianxiety use, hypoglycemic medication use, and anticonvulsant medication use correctly. Further she said that she was not aware that medications should be coded on the MDS according to their classification and not the reason for use. 3. Resident #3 was admitted to the facility in September 2015 and has diagnoses that include dementia, anxiety, and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/23/25, indicated that Resident #3 was coded to receive antianxiety medication. Review of the July 2025 Medication Administration Record (MAR) failed to indicate Resident #3 was prescribed an antianxiety classified medication. Review of Resident #3's physician orders, dated July 2025, indicated he/she received: -Fluvoxamine 50mg, give one tablet orally two times a day for OCD, start date 7/27/23; Fluvoxamine is a selective serotonin reuptake inhibitor (SSRI) primarily used to treat obsessive compulsive disorder (OCD). -Trazadone HCl oral table 50mg, give one table one time a day for agitations related to unspecified mood disorder, start date 1/17/24; Trazadone is serotonin antagonist and reuptake inhibitor ([NAME]). During an interview with the MDS Nurse on 9/05/2025 at 10:13 A.M., she said that she was not aware that medications should be coded on the MDS according to their classification and not the reason for use. During an interview with the Executive Director on 9/05/2025 at 10:28 A.M., he said that it is his expectation that the MDS be coded accurately. 4. Resident #7 was admitted to the facility in November 2019 and has diagnoses that include Alzheimer's, dementia without psychotic disturbance, and anxiety. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/03/25, indicated that Resident #7 had an active diagnosis of Schizophrenia. Review of Resident #7's physician progress note, dated 12/19/22, indicated that the note was entered in the wrong medical record and included a diagnosis of paranoid schizophrenia for another resident. Review of Resident #7's active diagnosis list indicated the diagnosis of schizophrenia had been added (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	to his/her diagnosis list following the physician progress note dated 12/19/22. Review of Resident #7's nursing progress note, dated 9/4/25, indicated that incorrect diagnosis listed on hospital paperwork. During a telephone interview on 9/04/25 at 11:10 A.M., the Physician said that Resident #7 does not have a diagnosis of paranoid schizophrenia and that he had documented it in the wrong medical record. During an interview at 9/04/25 at 11:36 A.M., the Director of Nursing (DON) said he had received a telephone call that day from the Physician and was made aware of the error in diagnosis documentation. The DON said he would expect the MDS to reflect the accurate, active diagnosis. During an interview with the MDS Nurse on 9/05/2025 at 10:13 A.M., she said that she was not aware of the inaccurate medical diagnosis for Resident #7, but that the MDS should be coded with accurate, active diagnosis.