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	03/02/2026

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 0688 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure three Residents (#24, #6, and #11) received appropriate treatment and services to prevent a decrease in range of motion. Specifically:1.For Resident #24, the facility failed to implement interventions to prevent a new contracture of the left fifth finger from developing and then worsening resulting in the amputation of this left fifth finger. The facility failed to:1a.) Ensure Occupational Therapy (OT) evaluated Resident #24 timely and provided therapy at the frequency ordered. In addition, the nursing staff failed to implement the contracture management devices as recommended by OT, and1b.) Ensure the Resident received recommended contracture treatment for botox injections (a medical procedure for contractures where the muscles are intentionally paralyzed) after being recommended by multiple physicians,2. For Resident #6, the facility failed to implement a splint for the Resident's left hand which resulted in a stage four pressure wound and failed to identify and treat a new contracture of the Resident's right hand; and3. For Resident #11, the facility failed to implement a physician's order for bilateral hand grips for contracture management. Findings include:Review of the facility policy titled 'Contractures', undated, indicated: -Residents of this facility will be given care to prevent formation and progression of contractures and deformities. -If a contracture is assessed on a resident, the physician will be notified. If indicated, orders will be received from the physician specific to the contracture and the resident. -The Nurse Manager or designated RN (registered nurse) will monitor compliance and notify the attending physician if progression of the contracture occurs. Review of the facility policy titled 'Splints, revised 1/3/26, indicated: -All splints require a physician's order. The order will include the type of splint and wearing schedule. -Application and Removal: Splints will be applied and removed according to the physician's order. -Documentation: Nursing staff will document splint use, skin condition, and resident tolerance. -Responsibility: Nursing and therapy staff are responsible for the safe application, monitoring, and documentation of splint use. 1.) Resident #24 was admitted to the facility in December 2024 with diagnoses including osteoarthritis, heart failure and hypertension. The list of Resident #24's diagnoses failed to include a (continued on next page)

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

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F 0688 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	neurological diagnosis that would cause an unpreventable contracture. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/29/25, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #24 had impairment of functional range of motion in one upper extremity. Review of Resident #24's discharge paperwork from previous facility, dated as faxed 12/3/24, at the time of his/her initial admission to this facility, indicated: -Annual Physical Examination Form: Musculoskeletal: No joint abnormality. -Physician Progress note: Musculoskeletal: feels stiff, no obvious joint swelling or tenderness. -Neurological: Moves all 4 extremities. Review of Resident #24's assessment titled Pre-admission Notification, dated 12/12/24, and completed by the facility failed to indicate Resident #24 was assessed to have any joint abnormalities, including contractures of the left hand or fingers. On 1/14/25, Resident #24 went out to the hospital with a question of a neurological event. Review of Resident #24's hospital paperwork, dated 1/15/25, indicated: -Alert, moving all four extremities. -Left upper extremity: nondeformed, motor and sensation grossly intact. -An occupational therapy evaluation that indicated Resident #24's left upper extremity had range of motion that was within function limits without impairment. -All hospital paperwork failed to indicate a contracture of the left hand or fingers was present at this time. Review of Resident #24's [Re]admission Assessment completed by the facility, dated 1/17/25, failed to indicate any contractures. During an interview on 2/13/26 at 8:24 A.M., the surveyor reviewed the Pre-admission notification, dated 12/12/24; the admission assessment dated [DATE]; and the Hospital [Re]admission assessment dated [DATE] with Unit Manager #1. Unit Manager #1 said there was no indication Resident #24 had any contractures at the time of these admissions/re-admissions. During an interview on 2/10/26 at 7:47 A.M., Resident #24's health care proxy (HCP) said she had concerns that the facility was not providing necessary therapy and interventions for Resident #24's left-hand contracture. Resident #24's HCP said the Resident developed a new contracture in July 2025 and it continued to worsen between July and December of 2025. Resident #24's HCP said it worsened because the facility did not provide necessary therapy and because Resident #24 never received botox (a medical procedure for contractures where the muscles are intentionally paralyzed), which the physician recommended back in September 2025. Resident #24's HCP said she kept telling the facility he/she needed botox, but his/her appointments kept being cancelled. Resident #24's HCP (continued on next page)

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F 0688 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	also said that the Resident had developed a pressure wound from the contracted fingers digging into his/her palm, and the wound appeared concerning but the facility wasn't doing anything about it. Resident #24's HCP said because of these concerns not being addressed by the facility she became frustrated and called the hospital herself to arrange for them to admit Resident #24 for his/her contracture and related concerns. Resident #24's HCP said the hospital had to amputate the Resident's left fifth finger because the contracture did not have appropriate interventions earlier and had worsened to a point where the only treatment intervention was amputation of the finger. During an observation and interview on 2/10/26 at 1:10 P.M., the surveyor observed Resident #24 with a palm guard (a device for contracture management) in his/her left hand with the scar tissue from a left fifth finger amputation visible. Resident #24 said he/she had to have his/her fifth finger amputated because he/she developed a new contracture last summer and it kept getting worse. Resident #24 said that prior to the amputation the staff often did not help him/her with contracture management devices that had been recommended by therapy, even though they were supposed to. Resident #24 further said he/she wished he/she could have had more therapy, but it wasn't available. Resident #24 said he/she wished more could have been done so that his/her finger did not have to be amputated. During an interview on 2/11/26 at 8:38 A.M., Certified Nurse Assistant (CNA) #6 said he had known Resident #24 since he/she was admitted in December 2024. CNA #6 said Resident #24 did not have any contractures when he/she was admitted , and that it appeared in the summer of 2025. CNA #6 said in the summer of 2025 Resident #24 was able to open his/her left hand to put things inside of it, like a hand carrot (a contracture management device), but it progressively got worse until he/she couldn't open the left hand at all in December 2025. CNA #6 said that was when his/her finger had to be amputated. During an interview on 2/11/26 at 8:56 A.M., Nurse #6 said Resident #24 had some stiffness in his/her left hand since admission in December 2024, but the left hand became contracted in July 2025. Nurse #6 said in July 2025 Resident #24 could open his/her left hand, but by December 2025 the contracture had worsened to the point Resident #24 could not open his/her hand at all and required hospitalization for amputation of the left fifth finger. Review of Resident #24's medical record indicated the Resident was discharged to the hospital on [DATE]. Review of the hospital discharge paperwork, dated 12/16/25, indicated: -Left hand pointer/index finger (digit 2) contracted straight outward with thumb touching. Able to visualize skin to palm next to these two digits only. Digit 3, 4, and 5 contracted and unable to visualize the nailbed of the 5th (pinky) finger. Pinky Finger appears swollen and pink. This clinician, along with wound colleague, was unable to extend digits to see the palm of the hand. Unable to visualize if there was a wound or not. Fingers tightly contracted. -The patient reports he/she has had difficulty moving his hand for months. He/she has also had associated hand pain, particularly in his/her pinky. -If the patient elects not to pursue amputation, alternative options such as Botox injections may be reconsidered, though per inpatient orthopedic discussion this may not be indicated at this time and would require outpatient reassessment. (continued on next page)

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F 0688 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-His/her left fifth finger was amputated on 12/19/25. a.) The facility failed to ensure Occupational Therapy (OT) evaluated Resident #24 timely and provided therapy at the frequency ordered. In addition, the nursing staff failed to implement the contracture management devices as recommended by OT. Review of Resident #24's Nurse Practitioner progress notes, dated 7/21/25, 7/23/25, 7/28/25, 8/6/25, 8/11/25, 8/25/25, 9/8/25, indicated: -Stiffness of finger joint of right hand and right wrist pain: Occupational therapy (OT) evaluation (eval) pending. During an interview on 2/11/26 at 2:08 P.M., Nurse Practitioner (NP) #1 said Resident #24 had stiffness and a contracture developed in his/her left hand, not right hand, and the documentation from NP #1's above noted progress notes, dated 7/21/25, 7/23/25, 7/28/25, 8/6/25, 8/11/25, 8/25/25, 9/8/25, were inaccurate. Review of Resident #24's medical record indicated an order for Occupational Therapy written on 8/6/25. The evaluation was completed on 9/8/25, 34 days after the order was written and 49 days after the Nurse Practitioner first documented the need for an OT evaluation in his note on 7/21/25. Review of Resident #24's medical record, dated 7/17/25 to 9/8/25, failed to indicate any rationale for why occupational therapy evaluation was delayed 49 days. Review of Resident #24's occupational therapy evaluation, dated 9/8/25, indicated the following: -Pt (patient) referred to OT services after concern over increased tightness in L (left) hand, assessment for brace and positioning. -Contracture: Tightness to left hand (2nd digit fixed in extension (straightened finger), 3-5th digits tighter in a flexed (bent finger) position. -Device = Other: rolled up wash cloth or carrot orthosis (an orthotic device in the shape of a carrot that can progressively widen a person's grasp) recommended. -Plan of Treatment: 10 time(s)/period; Cert. (Certification) Period: 9/8/25 – 10/7/25. Review of Resident #24's medical record indicated the Resident was re-evaluated by OT three more times and each time the OT ordered the Resident to be seen 10 times in a 30-day period. In the time period from the initial OT evaluation on 9/8/25 to when the Resident was discharged from services on 12/12/25, the Resident was ordered to receive 30 visits. Review of the OT notes indicated Resident #24 had been seen by OT 13 times, not even half the ordered frequency. Review of Resident #24's occupational therapy progress notes for the entirety of the treatment period of 9/8/25 to 12/12/25 indicated the following: -OT treatment was focused on manual manipulation (stretching/range of motion) of Resident #24's left hand and fingers. The treatment notes indicated Resident #24's range of motion to his/her fifth finger improved with treatment visits, however regressed between treatments. (continued on next page)

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F 0688 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-At the end of every visit, the OT recommended an orthotic device for the Resident to wear, and the Resident was in agreement. -The initial orthotic device recommended was a rolled towel. This was recommended on 9/8/25 and 10/2/25. The notes from these days indicated the OT recommended 24- hour wear of the rolled towel, however, failed to indicate if nursing was educated regarding the placement and use of the towel. -On 10/8/25, the OT recommended the use of a hand carrot. The note indicated Resident #24 was in agreement and the nursing staff were educated on the use and wearing schedule of the carrot (24 hours a day). -On 10/15/25, the OT again recommended the hand carrot and indicated the carrot had only been used one time since 10/8/25. The note again indicated Resident #24 was in agreement and the nursing staff were educated on the use and wearing schedule of the carrot (24 hours a day). -On 10/22/25, the OT indicated he observed Resident #24 without the hand carrot and the Resident had informed him he/she had not been wearing the orthotic. The note also indicated nursing was unaware if the Resident had worn the hand carrot and was again educated that the Resident should be wearing the carrot 24 hours a day. -On 10/29/25 the OT continued to recommend Resident #24 wear the hand carrot 24 hours a day and that nursing had reported the Resident had success wearing the carrot for a 24-hour period. -On 11/5/25, the OT continued to recommend Resident #24 wear the hand carrot 24 hours a day and that nursing had reported the Resident had only worn the carrot for 2 days since previous treatment session (2 days in a week). -On 11/12/25, the OT indicated that due to nursing lack of follow-through with the hand carrot and Resident #24's increased left hand pain, he discontinued the use of the hand carrot. The OT instead recommended a palm guard, however the Resident refused due to increased left-hand pain. -On 11/19/25, the OT indicated he once again recommended the use of a hand carrot with Resident #24 in agreement and nursing educated and in agreement to place orthotic in the Resident's hand. -On 12/3/25, the OT again discontinued the use of the carrot and recommended the use of a palm guard and Resident #24 was now in agreement with the orthotic change. The OT failed to indicate nursing was educated on the use of this orthotic. -Resident #24 was discharged from OT services with the last treatment date of 12/12/25 secondary being admitted to the hospital. Throughout this time period, there were never written orders for any of the orthotic devices recommended by the OT, there were no nursing notes that indicated nursing was utilizing the orthotic devices and there were no nursing notes that indicated Resident #24 was resistive to the use of orthotic devices. During an interview on 2/11/26 at 11:33 A.M., the Director of Rehab (DOR) said during July 2025 to December 2025 there was only one OT, (Occupational Therapist (OT) #1), available as needed for OT evaluations and treatments in the facility. The DOR said she was unaware OT #1 was delayed in (continued on next page)

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F 0688 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/11/26 at 2:08 P.M., Nurse Practitioner (NP) #1 said Resident #24 developed a contracture in his/her left hand in July 2025 and an OT evaluation referral was put in at that time. NP #1 said his expectation is that OT should complete an evaluation as soon as possible. NP #1 said the risk for delaying OT evaluation/treatment would be the contracture worsening. NP #1 said he was unaware there was a delay in Resident #24's OT evaluation and he should have been notified. Nurse Practitioner (NP) #1 further said his expectation is that OT provide the treatments they indicate are necessary. NP #1 said the risk of not providing the necessary frequency of OT treatments would be the Resident's contracture worsening. NP #1 said he was unaware that OT was not providing treatments at the frequency they noted were necessary (10 time(s)/period for each certification period) but should have been. NP #1 said Resident #24's left hand contracture worsened between July 2025 and December 2025 and it required amputation because of it. During an interview on 2/12/26 at 12:56 P.M., the Medical Director said his expectation is that OT should complete an evaluation as soon as possible after referral so OT treatment can begin if indicated. The Medical Director said he was unaware that the OT evaluation/treatment was delayed from 7/21/25 to 9/8/25 for Resident #24, but a provider should have been notified if it had not been completed. The Medical Director said his expectation is that OT provides the treatments they indicate are necessary and said he was unaware that OT was not providing treatments at the frequency they noted were necessary (10 time(s)/period for each certification period). The Medical Director said the risk of not evaluating a contracture timely and not providing the necessary frequency of OT treatments would be the Resident's contracture worsening. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said contractures require treatment to prevent decline. The DON said his expectation is that OT should complete an evaluation as soon as possible after the referral is made so OT treatment can begin if indicated. The DON said Resident #24 should have been evaluated by OT after first referred to OT on 7/21/15 and that not evaluating until 9/8/26 was a delay and that he was unaware of this delay in OT treatment. The DON further said that if the OT was unable or had not evaluated Resident #24 he should have been notified, as well as the physician, and they were not. The DON said his expectation is that OT provides the treatments they indicate are necessary. The DON further said that if the OT was unable or was not providing treatments at the frequency they noted were necessary (10 time(s)/period for each certification period) he should have been notified, as well as the physician. The DON said he was unaware OT was not providing treatment at the necessary frequency indicated on the initial evaluation and recertifications. The DON said he was responsible for monitoring if therapy referrals or treatments were being completed but had not been monitoring this for Resident #24 and he did not. The DON said that if the OT is trialing an orthotic device such as a hand carrot or palm guard, there should be a treatment form in the chart and the nurses should put in orders for the orthotic on the Medication Administration Record (MAR) so all nurses know to put the orthotic in place. The DON said Resident #24's left fifth finger contracture definitely became worse while at the facility and his/her left fifth finger was amputated because of this. 1b.) The facility failed to ensure Resident #24 received recommended contracture treatment for botox (a medical procedure for contractures where the muscles are intentionally paralyzed) after being recommended by multiple physicians. Review of Resident #24's Wound Physician's wound evaluation and management summary progress notes, dated 9/23/25, 9/30/25, 10/7/25, and 10/14/25, all indicated the following: -The patient is extremely contracted on his/her left hand. The patient would need either (continued on next page)

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F 0688 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	injections, and referred him/her to their neurology department to receive the botox on 11/10/25. The staff member said it is noted in his/her record that the facility cancelled that appointment on 11/10/25, and another appointment was rescheduled for 11/24/25. The staff member said the facility cancelled that appointment as well and never rescheduled, so Resident #24 never had any botox injections. During an interview on 2/11/26 at 11:01 A.M., Nurse #6 said Resident #24's had an appointment to get botox injections, but there was a problem with transportation and the appointment was cancelled. Nurse #6 said he was unaware if the appointment was ever rescheduled because it's not his responsibility. Nurse #6 said the nurses on the floor are not responsible for scheduling or rescheduling appointments. Nurse #6 said the Director of Nursing (DON) or Unit Manager were responsible for scheduling appointments. Review of Resident #24's medical record, dated 11/10/25 to 11/24/25, failed to indicate any mention of neurology appointments or any rationale regarding why the facility cancelled these appointments. During an interview on 2/11/26 at 11:22 A.M., the Director of Nursing (DON) said he and the Unit Manager are responsible for scheduling/rescheduling appointments. The DON said the previous Unit Manager left at the beginning of November and a new Unit Manager started on 12/1/26. The DON said he was unaware that Resident #24 had missed any botox appointments because he had never been notified it was something Resident #24 required. The DON said there is no record in the facility of Resident #24 having or missing this appointment. The DON said he was unaware that the Wound Physician had recommended botox injections on 9/23/25, 9/30/25, 10/7/25, 10/14/25, and 10/21/25. The DON said he was unaware of the facility cancelling the neurology appointment for Resident #24 on 11/10/25 and 11/24/25 and that it should have been rescheduled but was not. During an interview on 2/11/26 at 11:25 A.M., Unit Manager #1 said her first day was 12/1/25. Unit Manager #1 said she was unaware that Resident #24 was supposed to have any appointments for botox injections scheduled. During an interview on 2/11/26 at 2:08 P.M., Nurse Practitioner (NP) #1 said he had put a referral in to have Resident #24 to have botox injections beginning 9/26/25 as a treatment to manage his/her left-hand contracture. NP #1 said it was his expectation that the facility would obtain the first available appointment for Resident #24 to receive botox at an outpatient office. NP #1 said he would have expected to be notified if the facility was unable to make this appointment so he could reassess treatment plan but was never notified. NP #1 said the risk of Resident #24 not receiving the botox injections would be worsening of his/her contracture. NP #1 said Resident #24's left hand contracture worsened between July 2025 and December 2025 and it required amputation because of it. During an interview on 2/12/26 at 12:56 P.M., the Medical Director said he was unaware the botox appointment was cancelled and never rescheduled. The Medical Director said it should not have been cancelled by the facility, and that he would have expected them to notify himself or Nurse Practitioner #1 if for any reason Resident #24 couldn't make the appointment so they could reassess the treatment plan. 2). For Resident #6, the facility failed to implement a splint for the Resident's left hand which resulted in a stage four pressure wound and failed to identify and treat a new contracture of the Resident's (continued on next page)

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Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0688 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	right hand. Resident #6 was admitted to the facility in May 2020 with diagnoses including dementia and muscle weakness. Resident #6's diagnoses did not include a neurological disorder that would lead to contracture. Review of Resident #6's Minimum Data Set (MDS) assessment, dated 1/16/26, indicated the Resident scored a zero out of total 15 on the Brief Interview for Mental Status indicating severe cognitive impairment. Section GG of this MDS indicated Resident #6 has no impairment to his/her range of motion of his/her bilateral upper and impairment to one side of his/her lower extremities. On 2/5/26 at 8:56 A.M., the surveyor observed the Resident #6 lying in his/her bed. The Resident's right hand third to fifth fingers were bent forward towards the palm and the pointer finger and thumbs were sticking straight out. The left-hand fingers were all bent forward towards the palm in a fist. The Resident did not have a splint in either hand. On 2/9/26 at 7:17 A.M., the surveyor observed the Resident #6 lying in his/her bed. The Resident's right hand third to fifth fingers were bent forward towards the palm and the pointer finger and thumbs were sticking straight out. The left-hand fingers were all bent forward towards the palm in a fist. The Resident did not have a splint in either hand. On 2/9/26 at 7:30 A.M., the surveyor and Certified Nursing Assistant (CNA) #5 observed Resident #6 lying in his/her bed. Resident #5 was not wearing a splint in either hand at this time. CNA #5 said she is Resident #6's primary care giver and said

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to notify four Resident's (#24, #6, #21 and #9) physicians and legal guardian of a change in condition out of a total sample of 34 residents. Specifically:1.) For Resident #24, who developed a left-hand contracture in July 2025, the facility failed to notify the provider that the Resident's occupational therapy (OT) evaluation was delayed 49 days, that OT treatment was not being completed at necessary frequency, that his/her hand orthotic was not being tolerated because of increased pain and decreased range of motion, or that left-hand contracture was worsening, resulting in the amputation of the left fifth finger.2.) For Resident #6, the facility failed to notify the legal guardian of a worsening contracture of the left hand with development of a stage 4 pressure ulcer, development of a new contracture to the right hand and failed to notify the physician of the worsening of the left-hand contracture and development of a new contracture to the right hand.3.) For Residents #21 and #9, the facility failed to notify the physician of a change in respiratory status. Findings include: Review of the facility policy titled 'Change in a Resident's Condition or Status or Injury of Unknown Origin', dated 3/25/25, indicated: -The nurse will notify the resident's Attending Physician or physician on call when there has been a significant change in the resident's physical condition. -A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). 1.) Resident #24 was admitted to the facility in December 2024 with diagnoses including osteoarthritis, heart failure and hypertension. The list of Resident #24's diagnoses failed to include a neurological diagnosis that would cause an unpreventable contracture. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/29/25, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #24 had impairment of functional range of motion in one upper extremity. Review of Resident #24's Pre-admission notification, dated 12/12/24; the admission assessment dated [DATE]; and the Hospital [Re]admission assessment dated [DATE] all indicated Resident #24 did not have any contracture of the left hand upon admission/readmission. During an interview on 2/13/26 at 8:24 A.M., the surveyor reviewed the above assessments with Unit Manager #1. Unit Manager #1 said there was no indication Resident #24 had any contractures at the time of these admissions/re-admissions. During an interview on 2/10/26 at 7:47 A.M., Resident #24's health care proxy (HCP) said the Resident developed a new contracture in July 2025 and it continued to worsen between July and December of 2025. Resident #24's HCP said the Resident's left fifth finger was amputated because the contracture did not have appropriate interventions earlier and had worsened to a point where the only treatment intervention was amputation of the finger. During an observation and interview on 2/10/26 at 1:10 P.M., the surveyor observed Resident #24 (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	with a palm guard (a device for contracture management) in his/her left hand with the scar tissue from a left fifth finger amputation visible. Resident #24 said he/she had to have his/her fifth finger amputated because he/she developed a new contracture last summer and it kept getting worse. Review of Resident #24's Nurse Practitioner progress notes, dated 7/21/25, 7/23/25, 7/28/25, 8/6/25, 8/11/25, 8/25/25, 9/8/25, indicated the Resident had stiffness/pain in his/her fingers/wrist and that an Occupational therapy (OT) evaluation (eval) pending. Review of Resident #24's medical record indicated the occupational therapy (OT) evaluation was completed on 9/8/25, 49 days after the Nurse Practitioner first documented the need for an OT evaluation in his note on 7/21/25. This OT evaluation indicated: -Pt (patient) referred to OT services after concern over increased tightness in L (left) hand, assessment for brace and positioning. -Plan of Treatment: 10 time(s)/period; Cert. (Certification) Period: 9/8/25 – 10/7/25. Review of Resident #24's medical record failed to indicate the physician was notified of the delay in the completion of the OT evaluation. Review of Resident #24's medical record indicated the Resident was re-evaluated by OT three more times and each time the OT ordered the Resident to be seen 10 times in a 30-day period. In the time period from the initial OT evaluation on 9/8/25 to when the Resident was discharged from services on 12/12/25, the Resident was ordered to receive 30 visits. Review of the OT notes indicated Resident #24 had been seen by OT 13 times, not even half the ordered frequency. Review of Resident #24's medical record failed to indicate the physician was aware the OT was not meeting the frequency of treatments ordered. Review of Resident #24's occupational therapy (OT) progress notes for the entirety of the treatment period of 9/8/25 to 12/12/25 indicated the following left-hand contracture concerns: -OT treatment indicated Resident #24's range of motion to his/her fifth finger improved with treatment visits, however regressed between treatments. -On 10/15/25, the OT recommended hand carrot had only been used one time since 10/8/25. This note indicated that the Resident was in agreement to use the hand carrot and that nursing staff were educated on the use and wearing schedule of the carrot (24 hours a day). -On 10/22/25, the OT indicated he observed Resident #24 without the hand carrot and the Resident had informed him he/she had not been wearing the orthotic. The note also indicated nursing was unaware if the Resident had worn the hand carrot and was again educated that the Resident should be wearing the carrot 24 hours a day. -On 11/5/25, the OT continued to recommend Resident #24 wear the hand carrot 24 hours a day and that nursing had reported the Resident had only worn the carrot for 2 days since previous treatment session (2 days in a week). -On 11/12/25, the OT indicated that due to nursing lack of follow-through with the hand carrot and (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Resident #24's increased left hand pain, he discontinued the use of the hand carrot. The OT instead recommended a palm guard, however the Resident refused due to increased left-hand pain. -Resident #24 was discharged from OT services with the last treatment date of 12/12/25 secondary being admitted to the hospital. Review of Resident #24's medical record throughout the treatment period of 9/8/25 to 12/12/25 failed to indicate the physician was notified of recommendations for hand orthotics or that any physician orders had been obtained for their use. Further review of the medical record failed to indicate the physician was notified of any concerns of pain, inability to wear hand orthotic, or lack of improvement/decline in contracture. Review of Resident #24's medical record indicated the Resident was discharged to the hospital on [DATE]. Review of the hospital discharge paperwork, dated 12/16/25, indicated: -Left hand pointer/index finger (digit 2) contracted straight outward with thumb touching. Able to visualize skin to palm next to these two digits only. Digit 3, 4, and 5 contracted and unable to visualize the nailbed of the 5th (pinky) finger. Pinky Finger appears swollen and pink. This clinician, along with wound colleague, was unable to extend digits to see the palm of the hand. Unable to visualize if there was a wound or not. Fingers tightly contracted. -The patient reports he/she has had difficulty moving his hand for months. He/she has also had associated hand pain, particularly in his/her pinky. -If the patient elects not to pursue amputation, alternative options such as Botox injections may be reconsidered, though per inpatient orthopedic discussion this may not be indicated at this time and would require outpatient reassessment. -His/her left fifth finger was amputated on 12/19/25. During an interview on 2/11/26 at 1:29 P.M., Occupational Therapist (OT) #1 said he was the OT responsible for treating Resident #24 from 9/8/25 until his/her finger was amputated in December 2025. OT #1 said his specialty was contractures. OT #1 said he documented improvements after his direct treatments but, since his recommendations weren't followed by nursing, when he'd come back the next week Resident #24's contracture was back in the original spot and had to start from scratch. OT #1 said nursing often was unable to replace the hand carrot when it fell out, so the contracture didn't get better. OT #1 said it was nursing's responsibility to communicate Resident #24's worsening contracture or intolerance of hand orthotics, so he did not notify any physician regarding his concerns, late eval or missed treatments. During an interview on 2/11/26 at 8:38 A.M., Certified Nurse Assistant (CNA) #6 said Resident #24's left hand contracture worsened between July 2025 and when the left fifth finger was amputated in December 2025. CNA #6 said Resident #24 often didn't use his/her hand orthotic because he/she wasn't tolerating it because of increased pain and worsening range of motion. CNA #6 said he told many nurses that the contracture was getting worse and that Resident #24 was not tolerating the hand orthotics. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/12/26 at 7:44 A.M., Nurse #6 said he never notified any physician of Resident #24's worsening contracture, increased left hand contracture pain, or that Resident #24 was no longer tolerating his/her hand orthotics. Nurse #6 said he didn't think anyone had notified the physician, because since the Resident wasn't wearing the orthotic of course it was going to get worse. During an interview on 2/11/26 at 2:08 P.M., Nurse Practitioner (NP) #1 said Resident #24 developed a contracture in his/her left hand in July 2025 and he expected OT to evaluate promptly as he recommended it in July. NP #1 said he expected that the facility follow-up with OT evaluation, treatment, and recommendations. NP#1 said he would have been expected to be notified if there were any delays in therapy treatment, inability to provide therapy treatment, and/or changes in contractures so the Resident's plan of care could be re-evaluated. NP #1 said he was never notified of Resident #24's worsening contracture, increased left hand contracture pain, or that Resident #24 was not tolerating his/her hand orthotics but should have been. NP #1 said he was only aware it had worsened after Resident #24's left fifth finger was amputated. During an interview on 2/12/26 at 12:56 P.M., the Medical Director said a physician should have been notified if Resident #24's therapy treatment was delayed or not being completed, if hand orthotics were not being tolerated, and/or if there were any signs of the left-hand contracture worsening. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said Resident #24's left fifth finger contracture definitely became worse while at the facility and his/her left fifth finger was amputated because of this. The DON said a physician should have been notified if Resident #24's therapy treatment was delayed or not being completed, if hand orthotics were not being tolerated, and/or if there were any signs of the left-hand contracture worsening. 2.) For Resident #6, the facility failed to notify the legal guardian of a worsening contracture of the left hand with development of a stage 4 pressure ulcer, development of a new contracture to the right hand and failed to notify the physician of the worsening of the left-hand contracture and development of a new contracture to the right hand. Resident #6 was admitted to the facility in May 2020 with diagnoses including dementia. Review of Resident #6's Minimum Data Set (MDS) assessment, dated 1/16/26, indicated Resident #6 scored 0 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. Further review of the MDS indicated the Resident was dependent on staff for all activities of daily living (ADLs). Review of the medical record indicated Resident #6 had a legal guardian. On 2/9/26 at 7:30 A.M., the surveyor and Certified Nursing Assistant (CNA) #5 observed Resident #6 lying in his/her bed. Resident #5 was not wearing a splint in either hand at this time. CNA #5 said she is Resident #6's primary care giver and said Resident #6 has a splint ordered to be worn in his/her left hand but she has not seen the Resident's hand splint in a very long time. CNA #5 said the Resident used to wear the left-hand splint at night and it would be removed in the morning. The Resident's left hand was observed to be contracted inwardly, and the thumbs were overlapping the third finger. The right hand was also observed with the third to fifth fingers bent forward towards the palm of the hand. CNA #5 attempted to pry open the fingers on both hands and the Resident was observed saying ouch indicating pain. CNA #5 said the Resident's left hand has become progressively more contracted since (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	they stopped applying his/her splint and his/her right hand has a new contracture. CNA #5 said she has a difficult time cleaning the Resident's hands due to the worsened contractures on both hands. On 2/9/26 at 9:56 A.M., Nurse #2 told the Surveyor that CNA #5 reported an open area to the Resident's left hand third finger. The surveyor and Nurse #2 went to Resident #6 and when Nurse #2 pried open the Resident's left fingers, the surveyor observed an open area to the third finger. The middle of the wound bed was covered in a whitish substance, and the surroundings were reddened and inflamed. The Resident was attempting to pull back his/her had saying ouch indicating pain. Nurse #2 said that it was a new stage 2 pressure ulcer and had notified the Nurse Practitioner and obtained orders including referral to the wound care physician. Nurse #2 said the wound had developed due to the worsening of the contracture as it was getting difficult to open the Resident's fingers. Review of Resident #24's [Re]admission Assessment completed by the facility, dated 4/23/25, failed to indicate any contractures. Resident #6 medical record indicated he/she was treated by Occupational Therapy (OT) from 5/14/25 to 6/25/25 for contracture management of the left hand. Review of the Wound Care Specialist note, dated 2/10/26, indicated Resident #6 had a new stage 4 wound with the etiology of pressure. Review of the medical record failed to indicate the legal guardian was notified of a change in condition, when the Resident's left arm contracture worsened causing a development of a stage 4 pressure ulcer to the left hand third digit and the new contracture to the right hand. Review of medical record failed to indicate the facility notified the physician of the worsening of the left-hand contracture and the development of a new right-hand contracture. During an interview on 2/11/26 at 7:39 A.M., Resident Representative #1 said he was not notified of the worsening left-hand contracture, the development of a new contracture of the right hand and a new stage 4 pressure ulcer to the third finger. During an interview on 2/11/26 at 1:32 P.M., Occupational Therapist (OT) #1 said Resident #6 had been seen by OT back in June and left-hand splint was initiated for contracture management and he said it was nursing responsibility to carry through the splint application after the Resident had been discharged from OT. He further said if the splint was not being applied consistently the contractures would worsen. OT #1 said that at the time he was treating Resident #6 from May to June 2025, the Resident did not have a contracture of his/her right hand. During an interview on 2/11/26 at 3:00 P.M., Nurse #2 said when there is a change in condition, the physician and resident representative would be notified and documented in the progress notes. She said Resident #6 had a legal guardian. Nurse #2 said she believed the unit manager notified the legal guardian. During an interview on 2/11/26 at 3:06 P.M., Unit Manager #2 said she left the guardian a message about a skin tear but did not mention the worsened contracture or the stage 4 pressure ulcer to the left third finger. She said the nurse who found the pressure area should have notified the guardian. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/11/26 at 2:02 P.M., Nurse Practitioner #1 said staff never informed him of the worsening of the left-hand contracture or the development of a new contracture to the right hand. He said if he was aware he would have put in an occupational therapy referral. He further said staff should notify physicians with any changes in resident's status. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing said the nurse who finds a change in condition on a resident should be the one to notify the resident representative and the physician. 3). Resident #21 was admitted to the facility in February 2022 with diagnoses including chronic obstructive pulmonary disease (COPD), dementia and heart failure. Review of Resident #21's most recent Minimum Data Set (MDS) dated [DATE] indicated Resident had a score of 0 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she is severely cognitively impaired. The MDS also indicated Resident #21 is dependent on staff for activities of daily living. Review of Resident #21's physician orders, indicated the following order: -Oxygen 2 liters continuous via nasal cannula to keep o2 sat at or above 90%. Call MD/NP (medical doctor/nurse practitioner) if O2 (oxygen) sat (saturation) is below 90%. every shift for Hypoxemia Oxygen 2 liters continuous via nasal cannula to maintain sat at or above 90%. Call MD if sat is below 90%. On 2/6/26 at 7:34 A.M., Resident #21 was observed being brought to dining room by staff without his/her oxygen on. The portable oxygen tank was attached to the back of his/her wheelchair, however the tubing was wrapped around the tank and not placed on the Resident's nose. At 8:44 A.M., the Resident was observed with the oxygen nasal cannula on his/her nose, however the portable tank was observed to be empty. From 8:44 A.M. until 12:13 P.M., Resident #21 continued to sit with the nasal cannula on but with an empty tank. Throughout this observation time, Resident #21 was never observed attempting to take of the nasal cannula and was compliant with his/her oxygen wearing. On 2/6/26 at 12:13 P.M., the surveyor asked Nurse #9 to check Resident #21's portable oxygen tank. Nurse #9 checked the portable tank and told the surveyor it was empty. Nurse #9 said he did not know the level of oxygen Resident #21 was ordered to be receiving and had not assessed the Resident's oxygen yet today. Nurse #9 said the Certified Nursing Assistants (CNAs) are supposed to monitor the tanks throughout the day and refill them as needed. At 12:18 P.M., Nurse #9 said he should check Resident #21's oxygen level, however he did not have a working oximeter on the unit. Nurse #9 then left the Resident and the unit to obtain an oximeter on a different nursing unit. At 12:20 P.M., Nurse #9 returned to the unit, placed the oximeter on Resident #21's index finger and his/her oxygen level reading was 85%. At 12:25 P.M., the Director of Nursing entered the unit and was informed of the above observations by the surveyor. During an interview at this time, the Director of Nursing said the CNAs should be filling the portable oxygen tanks and the nurse should be checking Resident #21's oxygen level throughout the shift and ensuring the oxygen is being provided at the level ordered by the physician. At 12:32 P.M., the Director of Nursing took Resident #21's oxygen level with the oximeter again, and his/her reading at this time was 74%. At 12:33 P.M., the Director of Nursing said the level may be low because (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	the oximeter may need a new battery and he left the unit to obtain a new battery for the oximeter. At 12:38 P.M., the Director of Nursing returned to the unit with the oximeter and again took Resident #21's oxygen level and the reading was now 80%. At this time, the Director of Nursing said oxygen levels should be above 90% unless otherwise stated by the physician. During an interview on 2/6/26 at 12:37 P.M., Nurse #9 said if a resident's oxygen level is low, specifically if it is below 90%, he would need to notify the provider. During an interview on 2/6/26 at 12:39 P.M., the Director of Nursing said oxygen should always be provided to residents as ordered by the physicians. The Director of Nursing said if a resident's oxygen level drops below 90%, as Resident #21's dropped to as low as 80%, the physician or nurse practitioner should be notified to see if oxygen rate should be increased or other interventions added. During an interview on 2/9/26 at 9:59 A.M., the Nurse Practitioner said he was never notified of Resident #21's change in respiratory status and lowered oxygen saturation levels on 2/6/26. The Nurse Practitioner said he would need to be notified in case further assessment or interventions are required. 4). Resident #9 was admitted to the facility in June 2020 with diagnoses including chronic obstructive pulmonary disease (COPD), pulmonary nodule and heart failure. Review of Resident #9's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident score 0 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #9 is dependent on staff for all activities of daily living and mobility tasks. Review of Resident #9's care plan indicated the following interventions: - Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD (medical doctor) PRN (as needed): Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, -OXYGEN SETTINGS: I have O2 (oxygen) via nasal cannula 2L continuously. On 2/6/26 at 12:10 P.M. Resident #9 was observed sleeping in dining room. He/she had a portable oxygen tank attached to his/her recliner and a nasal cannula in his/her nose. The portable oxygen tank was observed to be empty. On 2/6/26 at 12:13 P.M., the surveyor asked Nurse #9 to check Resident #9's portable oxygen tank. Nurse #9 checked the portable tank and told the surveyor it was empty. Nurse #9 said he did not know the level of oxygen Resident #9 was ordered to be receiving and had not assessed the Resident's oxygen yet today. Nurse #9 said the Certified Nursing Assistants (CNAs) are supposed to monitor the tanks throughout the day and refill them as needed. At 12:18 P.M., Nurse #9 said he should check Resident #9's oxygen level, however he did not have a working oximeter on the unit. Nurse #9 then left the Resident and the unit to obtain an oximeter on a different nursing unit. At 12:21 P.M., Nurse #9 returned to the unit, placed the oximeter on Resident #21's index finger and at 12:26 P.M., five minutes later, Nurse #9 was able to get an oxygen reading of 74%. (continued on next page)

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Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0580 Level of Harm - Actual harm Residents Affected - Some	At 12:25 P.M., the Director of Nursing had entered the unit and was informed of the above observations by the surveyor. The Director of Nursing said the CNAs should be filling the portable oxygen tanks and the nurse should be checking Resident #9's oxygen level throughout the shift and ensuring the oxygen is being provided at the level ordered by the physician. At 12:33 P.M., the Director of Nursing said the level may be low because the oximeter may need a new battery and he left the unit to obtain a new battery for the oximeter. At 12:38 P.M., the Director of Nursing returned to the unit with the oximeter and again took Resident #9's oxygen level at 12:40 P.M., and the reading was now 80%. At this time, the Director of Nursing said oxygen levels should be above 90% unless otherwise stated by the physician. During an interview on 2/6/26 at 12:37 P.M., Nurse #9 said if a resident's oxygen level is low, specifically if its below 90%, he would need to notify the provider. During an interview on 2/6/26 at 12:39 P.M., the Director of Nursing said oxygen should always be provided to residents as ordered by the physicians. The Director of Nursing said if a resident's oxygen level drops below 90%, as Resident #9's dropped to as low as 74%, the physician or nurse practitioner should be notified to see if oxygen rate should be increased or other interventions added. During an interview on 2/9/26 at 9:59 A.M., the Nurse Practitioner said he was never notified of Resident #9's change in respiratory status and lowered oxygen saturation levels on 2/6/26. The Nurse Practitioner said he would need to be notified in case further assessment or interventions are required.

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review and interview the facility failed to ensure two Residents (#36 and #24) were free from abuse out of a total sample of 34 residents. Specifically,1.) For Resident #36, despite repeated emails sent by the Resident to the facility Administrator, Director of Nursing and Social Worker, the facility failed to prevent sexual abuse and protect the Resident from psychological harm due to the fear he/she lived with from this abuse and lack of protection provided by the facility. 2.) For Resident #24, the facility failed to ensure the Resident was free from abuse, when the facility failed to ensure after Resident #24 reported that another Resident (#47) kept entering his/her room to climb into his/her bed, exposing his/her private areas, and touching him/her and his/her belongings, which made him/her feel afraid and unsafe. Findings include:Review of the policy titled Suspected Adult, Disabled Resident or Elderly Abuse/Neglect/Exploitation, dated as revised 6/26/25, indicated the following: Sexual Abuse: Failure to make a reasonable effort to prevent sexual contact, sexual intercourse, sexual conduct, sexual assault or sodomy inflicted on, shown to or intentionally practiced in the presence of a resident. -Compelling or encouraging the resident to engage in sexual contact Neglectful Supervision: -Placing in, or failing to remove, the resident from a situation that a reasonable individual would realize required judgment or actions beyond that physical condition or mental abilities and that results in bodily injury or substantial risk of immediate harm to the resident. Procedure: -Management of Suspected Abuse/Neglect: Cases of suspected sexual assault, physical abuse or neglect will be given priority and will be investigated thoroughly. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. -To protect the resident from real or suspected mental, physical, sexual and verbal abuse, neglect and/or exploitation, staff will safeguard the resident from the offending individual(s). This safeguarding may be over tor covert, dependent upon the resident's mental and physical sense of well-being. If any type of abuse or exploitation is proven legitimate (witnessed and obvious), the offending individual will be restricted from access to the resident. Resident to Resident Altercations: -It is the policy of (the facility) to create and maintain a safe environment for all residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-An altercation free culture will be promoted through appropriate staff and resident screenings, staff and resident training, education, supervision and support. -The reporting of resident to resident altercations will adhere to the Department of Public Health guidelines. 1. Resident #36 was admitted to the facility in April 2025 and has diagnoses that include anxiety disorder, paraplegia and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/2/26, indicated that on the Brief Interview for Mental Status exam Resident #36 scored a 15 out of 15, which indicated he/she had intact cognition. The MDS further indicated that Resident #36 had no behaviors and is dependent on staff for self-care and transfers. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., Resident #36 said that there is a resident in the building that is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. Resident #36 said that one time he/she had to call the police because of it and that it is an ongoing issue that he/she has reported to the Director of Nursing on multiple occasions. During a follow-up interview on 2/10/26 at 8:22 A.M., Resident #36 said the following:-He/she has an ongoing issue with another resident who he/she describes as a disgusting pervert. Resident #36 said that on October 15, 2025 he/she was seated in the hall with several other residents when the resident approached him/her and said, you know you want me to **** you, you want this **** in your mouth and other vulgar things. -That at that time he/she emailed the Director of Nursing (DON) and Nursing Home Administrator (NHA) to tell them what was happening and said that if it was not stopped he/she would call the cops. Resident #36 said that shortly after sending the email he/she called the cops. Resident #36 said that later that same day the DON and the Operational Director (OD) came to the unit to speak with him/her. Resident #36 relayed to them what the resident had said, and Resident #36 said that the OD did not believe him/her and responded, I can't believe he/she could put that many words together in a sentence. Resident #36 said that the resident making these threats was taken by the responding police offers to the hospital but returned the next day, and the behaviors have continued since then. -Resident #36 said that he/she lives in fear the other resident will take it further and hurt me and touch me and I can't protect myself or get up and run. Resident #36 provided the surveyor with emails from October 2025 between him/herself and the NHA and DON:1. Email #1, dated 10/15/25, from Resident #36 to the NHA and DON: Something has got to be done with (the other resident). Today he/she drops his/her pants in the Hallway and then walks up to me later and said to me YOU Know you want my *** in your **** and right now he/she just took out his/her (genitals) in front of me and said you know you want this. If he/she does this in front of me or anyone else again, I'm calling the cops on him/her. Its lewn (sic) and obnoxious behavior. Please d something!!! (sic).2. Email #2, dated 10/15/25, from Resident #36 to the NHA and DON: Sorry but I called the cops, he/she wouldn't stop coming and bothering us men/ladies.3. Email #3, dated 10/16/25, from the DON to Resident #36: I understand. Resident #36 provided the surveyor with emails from January 2026 between him/herself and the NHA, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	DON and facility Social Worker (SW):1. Email #1, dated 1/18/26, from Resident #36 to the NHA, DON and SW: (the resident) and (another resident): THESE TWO NEED TO BE REMOVED FROM THIS AREA. They are out of control. You have (the resident) constantly speaking nasty to you. I had to call the cops on him one night because he/she was so bad. Neither one of them should be allowed down in our area. You have the Nurse and Certified Nursing Assistants (CNAs) take them away a couple of times but then they just let them go and ignore them because they are tired of dealing with them. Then you have days when the two of them are hanging in the hallway dancing around naked. 2. Email #2, dated 1/20/26, from the facility SW to Resident #36, the DON and NHA: We try to redirect the wanderers that are in and out of rooms and dressed inappropriately on a daily basis. It takes redirection and reattempting to address the concerns throughout the day. They have rights too, however, we will try to do better with supervising them, especially when they are roaming the hallways. It is hard to make everyone happy, but we are trying to address many of these concerns so that everyone feels safe and comfortable in their home. Resident #36 said that although the SW responded by email on 1/20/26, the SW never came to speak with him/her regarding the concerns he/she had reported in the 10/15/25 or 1/18/26 emails. Review of Resident #36's care plans failed to indicate any care plans regarding the abuse Resident #36 has reported to the facility. There is an unrelated psychosocial care plan in place that was last reviewed and revised in April 2025, which indicated: Focus: psycho-social well-being: (Resident #36) is at risk for an alteration in psychological well-being due to self-isolation, adjustment to a nursing home environment, progression of disease process, depression. cognitive decline/ deficit, mobility decline/ deficit, relocation (revised 4/25/25). Interventions: -Encourage loved ones to keep in contact. (4/25/25) -Encourage self-control and problem-solving skills including; imitating new behavior, awareness of behavior, directing/ redirecting energies into stress-reducing activities and behaviors. (4/25/25) -Explain procedures before beginning them (4/25/25) -Observe and report any changes in mental status (4/25/25) Review of the care plans fails to indicate any resolved or current care plans regarding the incident on 10/15/25. Review of Resident #36's clinical progress notes from October 2025 through February 2026 failed to indicate the sexual abuse sustained by Resident #36 on 10/15/25, was addressed by the facility SW, the Nurse Practitioner (NP), the nursing staff or Behavioral Services. During an interview on 2/10/26 at 11:17 A.M., the Psychiatrist said that he was never told about the abuse sustained by Resident #36, and that he would consider this sexual abuse. The Psychiatrist said that he would want to have this type of abuse reported to him because it can cause fear and be frightening for Resident #36 to have these things occur. The Psychiatrist said that he is the only psychiatric service in the building and that his role is to manage medication. He said that he has never been asked to see Resident #36 regarding the incident on 10/15/25 or after subsequent reports made (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	by him/her to the facility. The Psychiatrist said that it has been over a year since the building had talk therapy available and that Resident #36 would be the type of resident who would benefit from talk therapy to address his/her feelings regarding the abuse. During an interview on 2/10/26 at approximately 12:00 P.M., Certified Nursing Assistant (CNA) #1 said that she is Resident #36's regular CNA. CNA #1 said that Resident #36 requires two-person assistance with his/her care and transfers with a mechanical lift in and out of bed. CNA#1 said that Resident #36's mood is generally stable except whenever CNA #1 is providing care to him/her, Resident #36 will hear the (accused resident) in the hallway and ask CNA #1 to stop care and make sure he/she goes away because Resident #36 is scared and uncomfortable. CNA #1 did not report this to anyone because it is a regular occurrence that she manages during care. During an interview on 2/10/26 at 1:59 P.M., the SW said that Resident #36 has been upset with the accused resident for a long time because the resident has predatory behavior, is sexually inappropriate and wanders in and out of Resident #36's room regularly. The SW said that she was never informed about the incident on 10/15/25 or that Resident #36 called the police because of the abuse and that if she had been possibly the facility could have prevented its reoccurrence. The SW said that communication is lacking in the building and therefore she does not always find out about things like this but should. During an interview on 2/10/26 at 2:21 P.M., the DON said that in hindsight the 10/15/25 sexual abuse Resident #36 had experienced and reported to the facility should have been addressed and a plan made to adequately prevent recurrence but had not. He said that it is his expectation that when a behavior continues, and staff are aware that the behavior is upsetting the resident, that he be informed The DON said that he was not aware that Resident #36 was fearful of the other resident or that the resident's voice in the hall triggers Resident #36 to have his/her CNA stop care and send the resident away. During an interview on 2/11/26 at 12:02 P.M., the NHA said that at the time of the sexual abuse on 10/15/25 and in the months following, safeguards should've been put in place to protect Resident #36 and other residents, and he could not say why that did not happen. During an interview on 2/12/26 at 12:55 P.M., the Medical Director said all allegations of abuse need to be taken seriously and addressed. The Medical Director said he was unaware of the allegations of sexual abuse made by Resident #36. 2.) Resident #24 was admitted to the facility in December 2024 with diagnoses including osteoarthritis, heart failure and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/29/25, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #24 was dependent on staff for dressing, transfers, and mobility. On 2/6/26 at 2:12 P.M., the surveyor observed Resident #24 in his/her bed with the door to the hallway closed. Certified Nurse Assistant (CNA) #6 was also in the room behind a closed curtain with the Resident's roommate, not within view of Resident #24. Another Resident (#47), who did not reside in this room, walked out of the shared bathroom. Resident #47 walked through the room to Resident #24's bed, where he/she attempted to get into the bed with Resident #24. Resident #47 then stood (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	back up and pulled down his/her pants exposing his/her buttocks while attempting to pull back the sheets that were covering Resident #24. Resident #24 appeared frightened with wide eyes and grimace. CNA #6, who was still behind the closed curtain with the roommate, did not intervene or interact in any way. The Activities Director then entered Resident #24's room to see another roommate and the surveyor alerted her to the situation. The Activities Director responded Oh yeah, he/she does that. Let me get him/her out of here. The Activities Director was unable to redirect Resident #47, so she left to get Nurse #6, who came and was able to redirect Resident #47 out of the room. On 2/6/26 at 2:19 P.M., CNA #6, who was behind the closed curtain with the roommate, told the surveyor not to worry about Resident #47 because nothing ever happens and he/she wanders into Resident #24's room all the time. During an interview on 2/6/26 at 2:25 P.M., Resident #24 said Resident #47 comes into his/her room every day without permission. Resident #24 said Resident #47 often climbs into bed with him/her, pulls down his/her own pants to exposes private areas, and touches him/her and his/her belongings. Resident #24 said one time he/she got socked in the face by accident when he/she was trying to get into my bed. Resident #24 said he/she doesn't feel safe because he/she isn't able to move from the bed himself/herself and is afraid Resident #47 would overtake him/her. Resident #24 said staff continues to let Resident #47 wander into his/her room even though he/she's told many staff members he/she doesn't want Resident #47 there and that it makes him/her feel afraid. Resident #24 said he/she feels staff could do more to keep Resident #47 out of his/her room and the only thing they have done is tell him/her to press the call light if Resident #47 comes in, but they often don't answer timely and he/she just wants Resident #47 to stay out. Resident #24 said he/she often must shout at Resident #47 to leave, but he/she doesn't listen. Resident #24 said he/she has told staff he/she wishes he/she had something to throw at Resident #47 to protect himself/herself. Resident #24 said he/she does not feel safe. During an interview on 2/6/26 at 3:15 P.M., the Administrator and Director of Nursing (DON) said they were unaware Resident #24 did not feel safe and that based on the incident they would put interventions in place to ensure the other Resident did not enter Resident #24's room. Review of Resident #24's entire plan of care, reviewed by surveyor on 2/9/26, which was three days after the surveyor's observation of incident on 2/6/26, failed to indicate the Resident's concern of another Resident repeatedly entering his/her room or any interventions to deter intrusive wandering. During a follow-up interview on 2/9/26 at 11:04 A.M., which was three days after the surveyor's observation of incident on 2/6/26, Resident #24 said Resident #47 continued to come into his/her room over the weekend and still has free access to his/her room. Resident #24 said he/she had to shout at Resident #47 to get out of his/her room over the weekend. Resident #47 said he/she is fearful of Resident #47 because he/she takes my things, removes his/her clothes, and I feel like I'm going to get mugged or hurt all the time or he/she's going to get into my bed with me. Resident #24 said he/she does not sleep at times because he/she is fearful Resident #47 will come into his/her room. During an interview on 2/9/26 at 11:15 A.M., Certified Nurse Assistant (CNA) #6 said he wasn't aware of any new interventions to prevent Resident #47 from entering Resident #24's room over the weekend or during the current shift. CNA #5 said they provide general, intermittent oversight and redirection to Resident #47. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/9/26 at 11:19, Nurse #6 said they have been unable to stop Resident #47 from entering Resident #24's room, even after the incident on 2/6/26. Nurse #6 said he knew nobody on the floor likes when another Resident wanders into their room but they can't force Resident #47 to leave because it's Resident #47's right to be in whatever room he/she wants. During an interview on 2/9/26 at 11:28 A.M., CNA #5 said she wasn't aware of any new interventions to prevent Resident #47 from entering Resident #24's room over the weekend or during the current shift. CNA #5 said they provide general, intermittent oversight and redirection to Resident #47. During an interview on 2/10/26 at 7:47 A.M., Resident #24's health care proxy (HCP) said Resident #24 has not felt safe since March 2025, when Resident #47 began coming into his/her room. Resident #24's HCP said she's seen signs of psychological distress since March 2025, such as being on edge and not sleeping. Resident #24's HCP said she told staff that both she and Resident #24 did not want Resident #47 in his/her room in March or April of 2025 but stopped asking because it seemed staff was just unable to keep Resident #47 from going into everyone's room. During an interview on 2/10/26 at 11:17 A.M., the Psychiatrist said he was unaware Resident #24 had any concerns of psychosocial distress or psychological effects from being fearful from another Residents behaviors, but he/she should have been referred. During an interview on 2/10/26 at 1:59 P.M., the Social Worker (SW) said she was unaware Resident #24 was distressed by Resident #47 repeatedly entering his/her room since March 2025 but should have been. The SW said repeatedly wandering into their room could cause distress and anxiety. The SW said if behaviors cause distress, such as trying to get into bed or pulling down pants, these are considered resident to resident altercations and interventions should be put into place immediately specific to the Resident effected. The SW said she was first made aware 2/6/26 after the incident occurred, and when she followed up Resident #24 told her he/she was distressed. The SW said the facility did not put any interventions into place specific for Resident #24 but should have. During an interview on 2/10/26 at 2:21 P.M., the Director of Nursing (DON) said repeatedly wandering into their room could cause distress. The DON said if behaviors cause distress, such as trying to get into bed or pulling down pants, these are considered resident to resident altercations and interventions should be put into place immediately specific to the Resident effected. The DON said there were no interventions specifically implemented for Resident #24, but looking back there probably should have been. The DON further said staff should have notified himself and the physician/Psychiatrist of Resident #24's fearfulness and psychological distress but they had not. The DON said over the weekend through Monday (2/6/26 through 2/9/26), the staff was supposed to completed 15 minute face checks for Resident #47 and redirect him/her from entering any other resident rooms until 2/10/26. The DON was unaware that Resident #24 had ongoing concerns of Resident #47 entering his/her room or that CNAs were not aware of Resident #47's 15 minute face checks. During a follow-up interview on 2/11/26 at 8:26 A.M., CNA #5 said any resident to resident altercations, including wandering causing any resident distress, should be reported to the nurse and interventions should be put into place immediately. CNA #5 said Resident #24's family reported Resident #24 was distressed by Resident #47 wandering into his/her room a long time ago in March or April 2025 and had requested Resident 47 never enter his/her room. CNA #5 said she didn't think any interventions were put into place and that staff just redirects if we see it. CNA #5 further said that not providing necessary supervision to prevent resident to resident altercations would be considered (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	neglect and is a form of abuse. During a follow-up interview on 2/11/26 at 8:38 A.M., CNA #6 said Resident #24 had not wanted Resident #47 in his/her room since they were admitted in March 2025. CNA #6 said Resident #24 always tells staff to get Resident #47 out of his/her room and the Social Worker is always talking to him/her about it. CNA #6 said he believes the repeated wandering into his/her room had caused emotional distress to Resident #24. CNA #6 said he often sees Resident #24 shout at Resident #47 to get out and gets very emotional and upset that Resident #47 keeps coming in because he/she doesn't like him at all. CNA #6 said Resident #24 told him he/she doesn't want Resident #47 in his/her room because he will beat him up. CNA #6 said he has told management and the social worker many times that the current general oversight with redirection isn't enough and that they can't keep Resident #47 from wandering into other Resident's rooms, including Resident #24, and has requested 1:1 but the facility does not have enough staff for it. CNA #5 further said that not providing necessary supervision to prevent resident to resident altercations would be considered neglect and is a form of abuse. During an interview on 2/11/26 at 12:01 P.M., the Administrator said he was unaware of Resident #24's concerns or emotional distress related to repeated wandering from Resident #47. The Administrator said he would expect staff to notify administration immediately if Resident #24 was distressed or that interventions were not working so they could attempt alternate interventions promptly. During a follow-up interview on 2/11/26 at 8:56 A.M., Nurse #6 said any resident to resident altercations, including wandering that causes another resident distress or resident's shouting at other residents, should be immediately reported to administration. Nurse #6 said administration was aware of the concern of not being able to keep Resident #47 out of all other resident rooms, including Resident #24's room, and that even 15 minutes was too long in between checks but they did not want to put any other interventions into place because they did not have the staff for 1:1. Nurse #6 said he can only do interventions he is directed to do. Nurse #6 said they never attempted any interventions specific to Resident #24 but should have. Nurse #6 further said that not providing necessary supervision to prevent resident to resident altercations would be considered neglect, which is a form of abuse. During an interview on 2/11/26 at 2:08 P.M., Nurse Practitioner (NP) #1 said he would have expected to be notified immediately if any resident was experiencing emotional distress so they could figure out what they could do to help them. NP #1 said he should have been told about Resident #24's distress when it first was reported back in March or April 2025 and interventions should have been put into place to prevent it but was not. During an interview on 2/12/26 at 12:55 P.M., the Medical Director said he would expect interventions to be put into place for Resident #24 if there was a reoccurring issue with another Resident's behaviors causing emotional distress.

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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 0740 Level of Harm - Actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interview the facility failed to ensure two Resident (#36 and #24) were provided with the necessary behavioral health service to attain the highest level of psych-social well-being out of a total sample of 34 residents. Specifically:for Resident #36, the facility failed to provide psychotherapy or necessary behavioral health services when the Resident expressed fear and anxiety related to the intrusive wandering and sexual threats of another resident and despite Resident #36 sending multiple emails to the facility's Administrator, Director of Nursing and Social Worker regarding the ongoing concern. Resident #24, the facility failed to provide behavioral health services when the Resident expressed fearfulness and emotional distress related to another Resident's repeated intrusive wandering, indecent exposure, unwanted touching and attempts to enter his/her bed. Findings include: Resident #36 was admitted to the facility in April 2025 and has diagnoses that include anxiety disorder, paraplegia and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/2/26, indicated that on the Brief Interview for Mental Status exam Resident #36 scored a 15 out of 15, which indicated he/she had intact cognition. The MDS further indicated that Resident #36 had no behaviors and is dependent on staff for self-care and transfers. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., Resident #36 said that there is a resident in the building that is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. Resident #36 said that one time he/she had to call the police because of it and that it is an ongoing issue that he/she has reported to the Director of Nursing on multiple occasions. During a follow-up interview on 2/10/2026 at 8:22 A.M., Resident #36 said the following:-He/she has an ongoing issue with another resident who he/she describes as a disgusting pervert. Resident #36 said that on October 15, 2025 he/she was seated in the hall with several other residents when the resident approached him/her and said, you know you want me to **** you, you want this **** in your mouth and other vulgar things. Resident #36 said that since that incident the behaviors of his/her peer have continued and he/she therefore lives in fear the other resident will take it further and hurt me and touch me and I can't protect myself or get up and run. Resident #36 said that he/she does not receive any type of talk therapy but would accept it if offered. Resident #36 provided the surveyor with emails from October 2025 and January 2026 between him/herself, the Nursing Home Administrator (NHA), Director of Nursing (DON) and facility Social Worker (SW). Resident #36 detailed the abuse he/she was experiencing from a peer and pleaded for the facility to help him/her. During an interview on 2/10/2026 at approximately 12:00 P.M., Certified Nursing Assistant (CNA) #1 said that she is Resident #36's regular CNA. CNA #1 said that Resident #36 requires two-person assistance with his/her care and transfers with a mechanical lift in and out of bed. CNA#1 said that Resident #36's mood is generally stable except whenever CNA #1 is providing care to him/her, Resident #36 will hear the (accused resident) in the hallway and ask CNA #1 to stop care and make sure he/she goes away because Resident #36 is scared and uncomfortable. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #36's care plans failed to indicate behavioral health services as an intervention to maintain Resident #36's psychosocial well-being following the sexual abuse on 10/15/25. Review of Resident #36's medical record failed to indicate he/she was ever evaluated or treated by behavioral health services after the 10/15/25 incident or subsequent incidents thereafter. During an interview on 2/10/2026 at 11:17 A.M., the Psychiatrist said that he was never told about the abuse sustained by Resident #36, and that he would consider this sexual abuse. The Psychiatrist said that he would want to have this type of abuse reported to him because it can cause fear and be frightening for Resident #36 to have these things occur. The Psychiatrist said that he is the only psychiatric service in the building and that his role is to manage medication. He said that he has never been asked to see Resident #36 regarding the incident on 10/15/25 or after subsequent reports made by him/her to the facility. The Psychiatrist said that it has been over a year since the building had talk therapy available and that Resident #36 would be the type of resident who would benefit from talk therapy to address his/her feelings regarding the abuse. During an interview on 2/10/2026 at 1:59 P.M., the SW said that Resident #36 has been upset with the accused resident for a long time because the resident has predatory behavior, is sexually inappropriate and wanders in and out of Resident #36's room regularly. The SW said that the psychological effect of someone repeatedly wandering in their room could cause distress and anxiety. The SW said that she does not personally provide talk therapy to residents in the facility and that the facility's psychotherapist left in December of 2024 and has not been replaced. She said that her LICSW consultant comes in once a month and that at that time he has started to see a few residents for psychotherapy needs, but that she had never referred Resident #36 to receive that service. The SW said she thinks that the facility needs more psychiatric support to adequately manage the behaviors and support the residents in the facility. The SW added, that in hindsight she should have checked in on Resident #36 and provided support, knowing that Resident #36 was distressed by a peer's behavior toward him/her. During an interview on 2/10/2026 at 2:21 P.M., the DON said that in hindsight the 10/15/25 sexual abuse Resident #36 had experienced and reported to the facility should have been addressed and a plan made to emotionally support him/her by providing behavioral health services. The DON said that the facility has been without a psychotherapist (talk therapy) since December 2024 and that as situations arise, such as Resident #36's, we try to deal with them and sit down and talk but that there was no formal therapy available. The DON was unable to say if Resident #36 was receiving psychotherapeutic support but said that if he/she was it should be documented in the medical record. During an interview on 2/11/2026 at 12:02 P.M., the NHA said that Resident #36's experience with the peer on 10/15/25 was sexual abuse and that his/her continued distress validates this abuse. The NHA said that if a resident does not feel safe they should receive psychotherapy support to talk through the process. The NHA said that he was not aware that Resident #36 was not receiving psychotherapy. During an interview on 2/12/26 at 12:55 P.M., the Medical Director said he was unaware of the allegations of sexual abuse made by Resident #36 and that it is his expectation that a resident receive support from psych services to address being distressed by the sexual and intrusive behavior of his/her peer. The Medical Director said that he has not seen talk therapy available at the facility since the therapist providing it left over a year ago, and that it is a service that would be beneficial here. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	2.) Resident #24 was admitted to the facility in December 2024 with diagnoses including osteoarthritis, heart failure and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/29/25, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #24 was dependent on staff for dressing, transfers, and mobility. On 2/6/26 at 2:12 P.M., the surveyor observed Resident #24 in his/her bed with the door to the hallway closed. Certified Nurse Assistant (CNA) #6 was also in the room behind a closed curtain with the Resident's roommate, not within view of Resident #24. Another Resident (#47), who did not reside in this room, walked out of the shared bathroom. Resident #47 walked through the room to Resident #24's bed, where he/she attempted to get into the bed with Resident #24. Resident #47 then stood back up and pulled down his/her pants exposing his/her buttocks while attempting to pull back the sheets that were covering Resident #24. Resident #24 appeared frightened with wide eyes and grimace. CNA #6, who was still behind the closed curtain with the roommate, did not intervene or interact in any way. The Activities Director then entered Resident #24's room to see another roommate and the surveyor alerted her to the situation. The Activities Director responded Oh yeah, he/she does that. Let me get him/her out of here. The Activities Director was unable to redirect Resident #47, so she left to get Nurse #6, who came and was able to redirect Resident #47 out of the room. On 2/6/26 at 2:19 P.M., CNA #6, who was behind the closed curtain with the roommate, told the surveyor not to worry about Resident #47 because nothing ever happens and he/she wanders into Resident #24's room all the time. During an interview on 2/6/26 at 2:25 P.M., Resident #24 said Resident #47 comes into his/her room every day without permission. Resident #24 said Resident #47 often climbs into bed with him/her, pulls down his/her own pants to exposes private areas, and touches him/her and his/her belongings. Resident #24 said one time he/she got socked in the face by accident when he/she was trying to get into my bed. Resident #24 said he/she doesn't feel safe because he/she isn't able to move from the bed himself/herself and is afraid Resident #47 would overtake him/her. Resident #24 said staff continues to let Resident #47 wander into his/her room even though he/she's told many staff members he/she doesn't want Resident #47 there and that it makes him/her feel afraid. Resident #24 said he/she feels staff could do more to keep Resident #47 out of his/her room and the only thing they have done is tell him/her to press the call light if Resident #47 comes in, but they often don't answer timely and he/she just wants Resident #47 to stay out. Resident #24 said he/she often must shout at Resident #47 to leave, but he/she doesn't listen. Resident #24 said he/she has told staff he/she wishes he/she had something to throw at Resident #47 to protect himself/herself. Resident #24 said he/she does not feel safe. During an interview on 2/10/26 at 7:47 A.M., Resident #24's health care proxy (HCP) said Resident #24 has not felt safe since March 2025, when Resident #47 began coming into his/her room. Resident #24's HCP said she's seen signs of psychological distress since March 2025, such as being on edge and not sleeping. Resident #24's HCP said she told staff that both she and Resident #24 did not want Resident #47 in his/her room in March or April of 2025 but stopped asking because it seemed staff was just unable to keep Resident #47 from going into everyone's room. During an interview on 2/6/26 at 3:15 P.M., the Administrator and Director of Nursing (DON) said they (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	were unaware Resident #24 did not feel safe and that based on the incident they would put interventions in place to ensure the other Resident did not enter Resident #24's room. Review of Resident #24's entire plan of care, reviewed by surveyor on 2/9/26, which was three days after the surveyor's observation of incident on 2/6/26, failed to indicate the Resident's concern of another Resident repeatedly entering his/her room or any interventions to deter intrusive wandering. Review of Resident #24's entire medical record, dated 3/1/25 to 2/9/26, failed to indicate the Resident was referred to or evaluated for the need for any behavioral health services during this time frame. During a follow-up interview on 2/9/26 at 11:04 A.M., which was three days after the surveyor's observation of incident on 2/6/26, Resident #24 said Resident #47 continued to come into his/her room over the weekend and still has free access to his/her room. Resident #24 said he/she had to shout at Resident #47 to get out of his/her room over the weekend. Resident #47 said he/she is fearful of Resident #47 because he/she takes my things, removes his/her clothes, and I feel like I'm going to get mugged or hurt all the time or he/she's going to get into my bed with me. Resident #24 said he/she does not sleep at times because he/she is fearful Resident #47 will come into his/her room. Resident #24 said a lady came to follow-up with him/her on 2/6/26 after the incident and he/she told her that he/was afraid and did not feel safe. During an interview on 2/11/26 at 8:26 A.M., CNA #5 said Resident #24's family reported Resident #24 was distressed by Resident #47 wandering into his/her room a long time ago in March or April 2025 and had requested Resident #47 never enter his/her room. CNA #5 said she didn't think any interventions were put into place and that staff just redirects if we see it. During an interview on 2/11/26 at 8:38 A.M., CNA #6 said Resident #24 had not wanted Resident #47 in his/her room since they were admitted in March 2025. CNA #6 said Resident #24 always tells staff to get Resident #47 out of his/her room and the Social Worker is always talking to him/her about it. CNA #6 said he believes the repeated wandering into his/her room had caused emotional distress to Resident #24. CNA #6 said he often sees Resident #24 shout at Resident #47 to get out and gets very emotional and upset that Resident #47 keeps coming in because he/she doesn't like him at all. CNA #6 said Resident #24 told him he/she doesn't want Resident #47 in his/her room because he will beat him up. CNA #6 said he has told management and the social worker many times that the current general oversight with redirection isn't enough and that they can't keep Resident #47 from wandering into other Resident's rooms, including Resident #24, and has requested 1:1 but the facility does not have enough staff for it. During an interview on 2/11/26 at 8:56 A.M., Nurse #6 said if staff were aware of any emotional distress the provider should have been notified. Nurse #6 said he was unaware if anyone had notified the provider regarding Resident #24's emotional distress. During an interview on 2/10/26 at 11:17 A.M., the Psychiatrist said he was unaware Resident #24 had any concerns of psychosocial distress or psychological effects from being fearful from another Residents behaviors, but he/she should have been referred. The Psychiatrist said Resident #24 should have promptly been referred to behavioral health services to address any emotional distress from Resident #47's behaviors as soon as staff identified the concern but was not. The Psychiatrist said that it has been over a year since the building had talk therapy available and that Resident #24 would be the type of resident who would benefit from talk therapy to address his/her feelings of (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	emotional distress. During an interview on 2/10/26 at 1:59 P.M., the Social Worker (SW) said she was unaware Resident #24 was distressed by Resident #47 repeatedly entering his/her room since March 2025 but should have been. The SW said repeatedly wandering into their room could cause distress and anxiety. The SW said if behaviors cause distress, such as trying to get into bed or pulling down pants, these are considered resident to resident altercations and interventions should be put into place immediately specific to the Resident effected. The SW said she was first made aware 2/6/26 after the incident occurred, and when she followed up Resident #24 told her he/she was distressed. The SW said the facility did not put any interventions into place specific for Resident #24 but should have, including making a referral to behavioral health services. The SW further said staff should have notified herself and the Psychiatrist promptly when they identified emotional distress or fearfulness from Resident #47's behaviors so he/she could have been referred to behavioral health services but did not. The SW said that she does not personally provide talk therapy to residents in the facility and that the facility's psychotherapist left in December of 2024 and had not been replaced. The SW said thinks that the facility needs more psychiatric support to adequately manage the behaviors and support the residents in the facility. During an interview on 2/10/26 at 2:21 P.M., the Director of Nursing (DON) said repeatedly wandering into their room could cause distress. The DON said if behaviors cause distress, such as trying to get into bed or pulling down pants, these are considered resident to resident altercations and interventions should be put into place immediately specific to the Resident effected. The DON said there were no interventions specifically implemented for Resident #24, but looking back there probably should have been. The DON further said staff should have promptly notified himself and the physician/Psychiatrist of Resident #24's fearfulness and psychological distress and been referred to behavioral health services but they had not. The DON said that the facility has been without a psychotherapist (talk therapy) since December 2024 and that as situations arise we try to deal with them and sit down and talk but that there was no formal therapy available. During an interview on 2/11/26 at 12:01 P.M., the Administrator said he was unaware of Resident #24's concerns or emotional distress related to repeated wandering from Resident #47. The Administrator said he would expect staff to notify administration immediately if Resident #24 was distressed or that interventions were not working so they could attempt alternate interventions promptly. The Administrator said if a resident does not feel safe they should receive psychotherapy support to talk through the process. During an interview on 2/11/26 at 2:08 P.M., Nurse Practitioner (NP) #1 said he would have expected to be notified immediately if any resident was experiencing emotional distress so they could figure out what they could do to help them, including referring to behavioral health services. NP #1 said he should have been told about Resident #24's distress when it first was reported back in March or April 2025 and interventions should have been put into place to prevent it but was not. During an interview on 2/12/26 at 12:55 P.M., the Medical Director said he would expect interventions, including referral to behavioral health services, to be put into place for Resident #24 if there was a reoccurring issue with another Resident's behaviors causing emotional distress. The Medical Director said that it is his expectation that a resident receive support from psych services to address being distressed by the sexual and intrusive behavior of his/her peer. The Medical Director said that he has not seen talk therapy available at the facility since the therapist providing it left over a year ago, and that it is a service that would be beneficial here.

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F 0825 Level of Harm - Actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide specialized rehabilitative services for two Residents (# 24 and #3) out of a total sample of 34 residents. Specifically,1. For Resident #24, the facility failed to obtain a timely Occupational Therapy (OT) evaluation and failed to provide OT treatments at the frequency ordered to treat a left-hand contracture. The Resident's contracture worsened and he/she required an amputation of the left fifth finger. 2. For Resident #3, the facility failed to obtain a Physical Therapy (PT) evaluation as ordered by the Nurse Practitioner. Findings include: Review of the facility's policy titled Scheduling Therapy and Treatment Services, undated, indicated but was not limited to the following: -Therapy Services shall be scheduled in accordance with the residents' treatment plan. -Therapy is scheduled in coordination with Nursing Service and is documented in the resident's medical records. 1. Resident #24 was admitted to the facility in December 2024 with diagnoses including osteoarthritis, heart failure and hypertension. The list of Resident #24's diagnoses failed to include a neurological diagnosis that would cause an unpreventable contracture. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/29/25, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #24 had impairment of functional range of motion in one upper extremity. Review of Resident #24's medical record indicated the Resident was admitted to the facility without any contractures and in July 2025, he/she developed a new contracture to the left hand. Review of Resident #24's Nurse Practitioner progress notes, dated 7/21/25, 7/23/25, 7/28/25, 8/6/25, 8/11/25, 8/25/25, 9/8/25, indicated: -Stiffness of finger joint of right hand and right wrist pain: Occupational therapy (OT) evaluation (eval) pending. During an interview on 2/11/26 at 2:08 P.M., Nurse Practitioner (NP) #1 said Resident #24 had stiffness and a contracture developed in his/her left hand, not right hand, and the documentation from NP #1's above noted progress notes, dated 7/21/25, 7/23/25, 7/28/25, 8/6/25, 8/11/25, 8/25/25, 9/8/25, was inaccurate. Review of Resident #24's medical record indicated an order for Occupational Therapy written on 8/6/25. The evaluation was completed on 9/8/25, 34 days after the order was written and 49 days after the Nurse Practitioner first documented the need for an OT evaluation in his note on 7/21/25. Review of Resident #24's medical record, dated 7/17/25 to 9/8/25, failed to indicate any rationale for why occupational therapy evaluation was delayed 49 days. (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #24's occupational therapy evaluation, dated 9/8/25, indicated the following: -Pt (patient) referred to OT services after concern over increased tightness in L (left) hand, assessment for brace and positioning. Contracture: Tightness to left hand (2nd digit fixed in extension (straightened finger), 3-5th digits tighter in a flexed (bent finger) position. -Plan of Treatment: 10 time(s)/period; Cert. (Certification) Period: 9/8/25 – 10/7/25. Review of Resident #24's medical record indicated the Resident was re-evaluated by OT three more times and each time the OT ordered the Resident to be seen 10 times in a 30-day period. In the time period from the initial OT evaluation on 9/8/25 to when the Resident was discharged from services on 12/12/25, the Resident was ordered to receive 30 visits. Review of the OT notes indicated Resident #24 had only been seen by OT 13 times, not even half the ordered frequency. Review of Resident #24's medical record indicated the Resident was discharged to the hospital on [DATE]. Review of the hospital discharge paperwork, dated 12/16/25, indicated: -Left hand pointer/index finger (digit 2) contracted straight outward with thumb touching. Able to visualize skin to palm next to these two digits only. Digit 3, 4, and 5 contracted and unable to visualize the nailbed of the 5th (pinky) finger. Pinky Finger appears swollen and pink. This clinician, along with wound colleague, was unable to extend digits to see the palm of the hand. Unable to visualize if there was a wound or not. Fingers tightly contracted. -The patient reports he/she has had difficulty moving his hand for months. He/she has also had associated hand pain, particularly in his/her pinky. -If the patient elects not to pursue amputation, alternative options such as Botox injections may be reconsidered, though per inpatient orthopedic discussion this may not be indicated at this time and would require outpatient reassessment. -His/her left fifth finger was amputated on 12/19/25. During an interview on 2/10/26 at 7:47 A.M., Resident #24's health care proxy (HCP) said she had concerns that the facility was not providing necessary therapy for Resident #24's left-hand contracture. Resident #24's HCP said the Resident developed a new contracture in July 2025 and it continued to worsen between July and December of 2025. Resident #24's HCP said it worsened partly because the facility did not provide necessary therapy. Resident #24's HCP said the Resident eventually was admitted to the hospital resulting in an amputation of the Resident's left fifth finger. The Resident's HCP said she felt the amputation occurred because the contracture did not have appropriate interventions earlier and had worsened to a point where the only treatment intervention was amputation of the finger. During an observation and interview on 2/10/26 at 1:10 P.M., the surveyor observed Resident #24 with a palm guard (a device for contracture management) in his/her left hand with the scar tissue from a left fifth finger amputation visible. Resident #24 said he/she had to have his/her fifth finger amputated because he/she developed a new contracture last summer and it kept getting worse. Resident #24 said he/she wished he/she could have had more therapy, but it wasn't available. (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Some	Resident #24 said he/she wished more could have been done so that his/her finger did not have to be amputated. During an interview on 2/11/26 at 11:33 A.M., the Director of Rehab (DOR) said during July 2025 to December 2025 there was only one OT, (Occupational Therapist (OT) #1), available as needed for OT evaluations and treatments in the facility. The DOR said she was unaware OT #1 was delayed in completing the initial OT evaluation for Resident #24 and there should not have been a delay. The DOR said that once the evaluation was completed, OT #1 was responsible for monitoring and completing treatments at the frequency indicated on the initial evaluation and recertifications. The DOR said she was unaware OT #1 had not completed treatments at the frequency indicated of 10 time(s)/period for each certification period. The DOR said the risk of delay of treatment and not treating at necessary frequency would be the Resident's contracture worsening. During an interview on 2/11/26 at 1:29 P.M., OT #1 said he was the OT responsible for evaluating and treating Resident #24. OT #1 said his specialty was contractures, and that when he met Resident #24, his/her left-hand contracture was one of the worst contractures he had ever seen. OT #1 said the evaluation was delayed because that was the soonest he could see the Resident as he was the only OT working in the building and he only comes to the building on an as needed (PRN) basis. OT #1 said when he completed the initial evaluation and recertifications he indicated Resident #24 required 10 time(s)/period for each certification period because the Resident needed it. OT #1 said since he was the only OT available and he was only available once a week, so the Resident did not receive the OT treatments he required. OT #1 said Resident #24 would have benefitted from more therapy sessions for the manual techniques and joint mobility exercises, but since he was the only OT available it didn't happen. OT #1 said he did not report the missed frequencies to the DOR or ask if another OT could complete the visits he was unable to do. During an interview on 2/11/26 at 2:08 P.M., Nurse Practitioner (NP) #1 said Resident #24 developed a contracture in his/her left hand in July 2025 and an OT evaluation referral was put in at that time. NP #1 said his expectation is that OT should complete an evaluation as soon as possible. NP #1 said the risk for delaying OT evaluation/treatment would be the contracture worsening. NP #1 said he was unaware there was a delay in Resident #24's OT evaluation and he should have been notified. Nurse Practitioner (NP) #1 further said his expectation is that OT provide the treatments they indicate are necessary and said the risk of not providing the necessary frequency of OT treatments would be the Resident's contracture worsening. NP #1 said he was unaware that OT was not providing treatments at the frequency they noted were necessary (10 time(s)/period for each certification period) but should have been. NP #1 said Resident #24's left hand contracture worsened between July 2025 and December 2025 and it required amputation because of it. During an interview on 2/12/26 at 12:56 P.M., the Medical Director said his expectation is that OT should complete an evaluation as soon as possible after referral so OT treatment can begin if indicated. The Medical Director said he was unaware that the OT evaluation/treatment was delayed from 7/21/25 to 9/8/25 for Resident #24, but a provider should have been notified if it had not been completed. The Medical Director said his expectation is that OT provides the treatments they indicate are necessary and said he was unaware that OT was not providing treatments at the frequency they noted were necessary (10 time(s)/period for each certification period). The Medical Director said the risk of not evaluating a contracture timely and not providing the necessary frequency of OT treatments would be the Resident's contracture worsening. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said therapy at the facility (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Some	was being provided by an outside, contracted rehabilitation company and the facility had been having difficulty for months with the therapy services being provided. The DON said therapy was often not in the building and the facility would have to repeatedly call the therapy company to ask for therapists to come treat the residents of the facility. The DON said his expectation is that OT should complete an evaluation as soon as possible after the referral is made so OT treatment can begin if indicated. The DON said Resident #24 should have been evaluated by OT after first referred to OT on 7/21/15 and that not evaluating until 9/8/26 was a delay and that he was unaware of this delay in OT treatment. The DON said contractures require treatment to prevent decline. The DON also said his expectation is that OT provides the treatments they indicate are necessary. The DON said he was unaware OT was not providing treatment at the necessary frequency indicated on the initial evaluation and recertifications. The DON said he was responsible for monitoring if therapy referrals or treatments were being completed but had not been monitoring this for Resident #24 and he did not. The DON said Resident #24's left fifth finger contracture definitely became worse while at the facility and his/her left fifth finger was amputated because of this. During an interview on 2/11/26 at 2:53 P.M., the Administrator said the facility had noticed that the staffing of the therapy company had been getting worse and that, specifically, the therapy staffing between September 2025 and December 2025 was spotty. The Administrator said nursing was responsible for checking the therapy evaluations and ensuring the frequency ordered was being completed. The Administrator said he expects all therapy evaluations to be completed in a timely manner and, subsequently, all therapy visits be completed at the frequency ordered. The Administrator said he was unaware that the OT eval was delayed for Resident #24 and that the Resident was not receiving the amount of treatments ordered. 2. Resident #3 was admitted to the facility in September 2022 with diagnoses including dementia, osteoarthritis, left shoulder pain, fatigue, and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/7/25, indicated that Resident #3 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 13 out of a possible 15. The MDS further indicated the Resident required moderate to maximum assistance for performing activities of daily living (ADLs). Review of Resident #3's physician orders indicated: -Schedule physical therapy evaluation, dated 12/9/25. Review of the clinical record failed to indicate that Resident #3 was evaluated by PT (Physical Therapy) consistent with the physician orders. During an interview on 2/5/26 at 12:08 P.M., Resident #3 said he/she has pain in both shoulders that limits his/her ability to lift his/her arms. During a further interview on 2/6/26 at 7:35 A.M., Resident #3 said he/she is depressed about the pain and fed up with it because of his/her inability to use his/her arms. Resident #3 said he/she has not seen a Physical Therapist recently and is not actively receiving PT. During an interview on 2/11/26 at 4:56 P.M., Resident #3's activated Health Care Proxy (HCP) #2 said he feels Resident #3 has declined as evidenced by the Resident staying in bed more. The HCP said he (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Some	was not aware Resident #3 was ordered for a PT evaluation or that the evaluation did not take place. During an interview on 2/9/26 at 10:13 A.M., Unit Manager #1 said when the provider orders a PT consult, she or one of the nurses confirms the order in the Electronic Health Record and she will either email the PT company to notify them of the consult or will verbally tell the PT lead if he/she is on-site. During an interview on 2/10/26 at 11:27 A.M., Nurse Practitioner (NP) #1 said pain management has been a big issue for Resident #3 despite increasing his/her pain medications. NP #1 said Resident #3 has pain in his/her shoulders and knees, and he/she is immobile due to uncontrolled pain. NP #1 said he feels Resident #3's pain cannot be managed alone by pain medication, leading him to make referrals to multiple specialties including PT. The NP said the PT evaluation is still pending, but he would have preferred for the Resident to be evaluated as soon as possible to prevent decline. During an interview on 2/10/26 at 3:03 P.M., the Director of Nursing (DON) said the absence of a PT evaluation when ordered by the Provider is considered a delay in care and can lead to decline. The DON provided the surveyor with a copy of his email from 12/10/25 requesting a PT consult for Resident #3 without additional follow-up. The DON said nursing is responsible for ensuring consults, including PT evaluations, are completed. During an interview on 2/11/26 at 11:33 A.M., the Director of Rehabilitation said she never received a therapy evaluation referral for Resident #3. During an interview on 2/11/26 at 2:53 P.M., the Administrator said the facility had noticed that the staffing of the therapy company had been getting worse and that, specifically, the therapy staffing between September 2025 and December 2025 was spotty. The Administrator said nursing was responsible for checking the therapy evaluations were being completed as ordered. The Administrator said he expects all therapy evaluations to be completed in a timely manner.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to report allegations of abuse within the required two hour time frame to the Health Care Facility Reporting System for 5 Residents (#36, #47, #25, #55, #45 and #10) out of a total sample of 34 residents. Specifically, 1. For Resident #36 the facility failed to report an allegation of sexual abuse.2. For Resident #47 the facility failed to report an allegation of sexual abuse. 3. For Resident #25 the facility failed to report a resident-to-resident altercation. 4. For Resident #55 the facility failed to report an allegation of sexual abuse.5. For Resident #10 the facility failed to report a resident-to-resident abuse.6. For Resident #45 the facility failed to report an allegation of physical abuse by staff. Findings include: Review of the policy titled Suspected Adut, Disabled Resident or Elderly Abuse/Neglect/Exploitation, dated as revised 6/26/25, indicated the following: -All allegations of abuse will be reported to the Department of Public Health within 2 hours after the allegation is made. Sexual Abuse: Failure to make a reasonable effort to prevent sexual contact, sexual intercourse, sexual conduct, sexual assault or sodomy inflicted on, shown to or intentionally practiced in the presence of a resident. -Compelling or encouraging the resident to engage in sexual contact Neglectful Supervision: -Placing in, or failing to remove, the resident from a situation that a reasonable individual would realize required judgment or actions beyond that physical condition or mental abilities and that results in bodily injury or substantial risk of immediate harm to the resident. Procedure: -Management of Suspected Abuse/Neglect: Cases of suspected sexual assault, physical abuse or neglect will be given priority and will be investigated thoroughly. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Resident to Resident Altercations: -It is the policy of Pine [NAME] to create and maintain a safe environment for a residents. -An altercation free culture will be promoted through appropriate staff and resident screenings, staff (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and resident training, education, supervision and support. -The reporting of resident-to-resident altercations will adhere to the Department of Public Health guidelines. 1. Resident #36 was admitted to the facility in April 2025 and has diagnoses that include anxiety disorder, paraplegia and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/2/26, indicated that on the Brief Interview for Mental Status exam Resident #36 scored a 15 out of 15, indicating intact cognition. The MDS further indicated that Resident #36 has no behaviors and is dependent on staff for care and transfers. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., Resident #36 said that there is a resident in the building that is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. Resident #36 said that one time he/she had to call the police because of it and that it is an ongoing issue that he/she has reported to the facility on multiple occasions. Review of the HCFRS report on 2/6/26, failed to indicate Resident #36's allegation of sexual abuse was reported. During a follow-up interview on 2/10/26 at 8:22 A.M., Resident #36 said the following:-He/she has an ongoing issue with another resident who he/she describes as a disgusting pervert. Resident #36 said that on October 15, 2025 he/she was seated in the hall with several other residents when the resident approached him/her and said you know you want me to **** you, you want this **** in your mouth and other vulgar things. -That at that time he/she emailed the Director of Nursing (DON) and Nursing Home Administrator (NHA) to tell them what was happening and said that if it was not stopped he/she would call the cops. Resident #36 said that shortly after sending the email he/she called the cops. Resident #36 said that later that same day the DON and the Operational Director (OD) came to the unit to speak with Resident #36. Resident #36 relayed to them what the resident had done and said the OD did not believe him/her and responded, I can't believe he/she could put that many words together in a sentence. Resident #36 said that the resident making these threats was taken by the responding police offers to the hospital but returned the next day, and the behaviors have continued since then. -Resident #36 said that he/she lives in fear the other resident will take it further and hurt me and touch me and I can't protect myself or get up and run. Resident #36 provided the surveyor with emails from October 2025 between him/herself and the NHA and DON:1. Email #1, dated 10/15/25, from Resident #36 to the NHA and DON: Something has got to be done with (specific resident named). Today he/she drops his/her pants in the hallway and then walks up to me later and said to me YOU Know you want my *** in your **** and right now he/she just took out his/her (genitals) in front of me and said you know you want this. If he/she does this in front of me or anyone else again, I'm calling the cops on him/her. Its lewn (sic) and obnoxious behavior. Please d something!!! (sic).2. Email #2, dated 10/15/25, from Resident #36 to the NHA and DON: Sorry but I called the cops, he/she wouldn't stop coming and bothering us men/ladies.3. Email #3, dated 10/16/25, from the DON to Resident #36: I understand. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/26 at 2:21 P.M., the DON said that in hindsight the 10/15/25 sexual abuse Resident #36 reported to the facility should have been reported to the Health Care Facility Reporting System (HCFRS) within 2 hours. The DON said that would include resident-to-resident altercations and that a resident-to-resident altercation can be either verbal or physical in nature. The 10/15/25 sexual abuse sustained by Resident #36 was discussed and the DON said that it should've been reported to HCFRS but it was not. During an interview on 2/11/26 at 12:02 P.M., the NHA said an event or allegation of abuse should be reported to the HCFRS within in two hours if there is harm or injury. The 10/15/25 altercation between Resident #36 and a peer was discussed and the NHA said that it should've been reported to HCFRS. 2. Resident #47 was admitted to the facility in March 2025 and has diagnoses that include Dementia with other behavioral disturbance, wandering in diseases classified elsewhere and traumatic brain injury. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/19/25, indicated that on the Brief Interview for Mental Status exam Resident #47 scored a 1 of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #47 had no behaviors aside from wandering 1-3 days a week. Review of Resident #47's clinical progress notes indicated the following notes: 10/16/25: Patient is seen today after he/she was sent to the emergency room on 10/16 for provocative hypersexual behavior with aggression which he/she exhibited towards peers. 10/15/25: Resident #47 was down and was exposing him/herself to (a peer) while he/she was close, uttering words such as you want this, do you want this inside of you. Psychiatrist #1 was present during this episode and was informed that the male/female resident's do not feel safe in their rooms with Resident #47 wandering and being sexually disgusting as the male/female residents stated. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., a resident said that Resident #47 is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. The resident said that one time he/she called the police because of Resident #47's behavior. During an interview on 2/10/26 at 8:22 A.M., another resident said the following:-He/she has an ongoing issue with Resident #47 who he/she describes as a disgusting pervert. The other resident reported that Resident #47 approached him/her and said you know you want me to **** you, you want this **** in your mouth and other vulgar things. -That at that time he/she emailed the Director of Nursing (DON) and Nursing Home Administrator (NHA) to tell them what was happening and said that if it was not stopped he/she would call the cops. During an interview on 2/10/26 at 2:21 P.M., the DON said that in hindsight the 10/15/25 sexual abuse Resident #47 had been accused of should have been reported to the Health Care Facility Reporting System (HCFRS) within 2 hours. The DON said that would include resident-to-resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	altercations and that a resident-to-resident altercation can be either verbal or physical in nature. The 10/15/25 altercation between Resident #47 and a peer was discussed and the DON said that it should've been reported to HCFRS. Review of the HCFRS on 2/11/26 at 8:08 A.M., failed to indicate the facility had reported the allegation of sexual abuse reviewed with DON on 2/10/26. During an interview on 2/11/26 at 12:02 P.M., the NHA said an event or allegation of abuse should be reported to the HCFRS within two hours if there is harm or injury. The 10/15/25 altercation between Resident #47 and a peer was discussed and the NHA said that it should've been reported to HCFRS. 3. Resident #25 was admitted to the facility in July 2022 and has diagnoses that include bipolar and Alzheimer's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/18/25, indicated Resident #25 was unable to participate in the Brief Interview for Mental Status exam and was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #25 has daily behavior of physical behavior directed toward others and wandering and has no verbal behaviors and no other behaviors such as pacing or disrobing. Review of Resident #25's clinical progress notes indicated the following: -A progress note dated 1/6/26: Alert and confused. Screaming heard this writher ran to former activities office to find Resident #25 soaked in water. walking around, unable to give an accurate account of what had happened. The other resident would not say ether. No s/s (signs or symptoms) of trauma noted, no bruises, refused vital signs. Resident #25 was cleaned and changed had a 100% of super, po (by mouth) fluids tolerated well. Otherwise, stable. -A social work note dated 1/12/26: SW attempted to meet with Resident #25 s/p (status/post) resident altercation. Resident #25 was not able to report what led to the altercation. Resident #25 was observed in his room with his roommates and the aggressor. No concerns were observed at this time. -A progress note dated 1/13/26: Resident #25 had a brief altercation with a female resident. During an interview on 2/11/26 at 7:58 A.M., the DON said that allegations of abuse should be reported to the Health Care Facility Reporting System (HCFRS) within 2 hours. The DON said that would include resident-to-resident altercations and that a resident-to-resident altercation can be either verbal or physical in nature. Review of the HCFRS on 2/11/26 at 8:08 A.M., failed to indicate the facility had reported the any resident-to-resident altercations regarding Resident #25. During an interview on 2/11/26 at 12:02 P.M., the NHA said a resident-to resident altercation should be reported to the HCFRS within two hours if there is harm or injury. 4. Resident #55 was admitted to the facility in May 2024 with diagnoses including anxiety, depression and mild cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #55's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 15 out of a total 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS further indicated the Resident required supervision from staff to perform activities of daily living. During an interview on 2/5/26 at 9:40 A.M., Resident #55 said another resident had jumped in his/her bed and grabbed his/her breast on multiple occasions. The Resident said he/she got sexually assaulted by this other resident and had reported to staff but nothing was done about it. The Resident further indicated that the other resident was no longer at the facility. On 2/5/26 at 9:49 A.M., the surveyor reported this allegation from Resident #55 to the Director of Nursing (DON). The DON said this was the first time he heard of this allegation and was going to investigate it. On 2/6/26 at 7:53 A.M., the surveyor inquired from the DON of any investigations completed from the reported allegations. The DON said the Social Worker had the paperwork as this was an old allegation that had been reported. During an interview on 2/6/26 at 1:52 P.M., the Social Worker (SW) said she did not have any paperwork from this reported allegation and said it was her first time hearing about it. The SW said any allegations of abuse should be reported to the department of public health within two hours of knowledge. Review of the health care reporting system on 2/10/26 indicated the facility did not report the allegations within the required two hours. On 2/10/26 at 2:21 P.M., the Director of Nursing said he should have reported to the state agency within the required two hours. He said that he reported the allegation the following day. Review of the heath care reporting system n 2/11/26 indicated the report was initiated on 2/6/26 at 11 A.M., approximately 14 hours after the allegation was [NAME] to the Director of Nursing attention. During an interview on 2/11/2026 at 12:02 P.M., the Administrator said allegations of abuse should be reported within two hours if there is harm or injury, or within 24 hours if there is no harm or injury. The Administrator said that when in doubt, the facility should report allegations within two hours. 5. Resident #10 was admitted to the facility in July 2020 with diagnoses including Alzheimer's disease with late onset and anxiety disorder. Review of Resident #10's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored an 8 out of a total 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. The MDS further indicated that the Resident exhibited behaviors directed towards others, for example verbal or vocal occurred daily. During an interview on 2/5/26 at 8:47 A.M., the surveyor met with the Resident in his/her room. The Resident said to the surveyor you can call my daughter she will tell you what's happening here. Review of a Social Worker (SW) progress note dated 12/9/25 indicated the following: (continued on next page)

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	225049	A. Building B. Wing	03/02/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	'SW met with Resident to follow up on staff report that he/she spilled water on roommate. Upon arriving at the room, Resident presented angry. When SW asked what had happened he/she reported he needs to stop messing with me. He is over there peeing in his thingy (urinal) and trying to climb into my bed. I don't sleep with men. SW observed water on the bedside table, floor and on the roommate's clothing. Residents have a history of spilling water on previous roommates and making the same alleged report. SW reached out to the Healthcare Proxy (HCP) regarding this incident, notified DON (Director of Nursing) and reached out to Dr Skewer to follow up with an assessment. SW will remain available for support. Review of the health care reporting system on 2/5/26, failed to indicate the facility reported this resident-to-resident altercation to the state agency. During an interview on 2/6/26 at 2:01 P.M., the Social Worker said that the Resident had a history of spilling water on other roommates and it was because he/she wanted to have a private room. The Social Worker said she reported this incident to the Director of Nursing as it was a resident-to-resident altercation and should be reported. During an interview on 2/9/26 at 9:52 A.M., Resident Representative (HCP) said the facility had notified her that the Resident was being moved out of the room as he/she had spilled water on another resident. During an interview on 2/10/26 at 2:35 P.M., the Director of Nursing said by Resident throwing water at another resident would be considered a resident-to- resident altercation, and that it should have been investigated and reported. The Director of Nursing the incident was not investigated or reported to the state agency. During an interview on 2/11/26 at 12:45 P.M., the Administrator said a report should have been filed with the state agency. 6. Resident #45 was admitted to the facility in August 2020 with diagnoses including Alzheimer's Disease and schizophrenia. Review of Resident #45's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #45 required partial to moderate assistance from staff for functional daily tasks. During an interview on 2/5/26 at 8:08 A.M, Resident #45 said she was recently grabbed by a staff member and was treated roughly, resulting in black and blue bruises on his/her arm. Resident #45 said he/she everybody knows about it and that he/she had told a lot of people about this incident. Resident #45 said no staff members have come to talk about the incident with him/her. On 2/5/26 at approximately 8:20 A.M., the surveyor reported this allegation from Resident #45 to the Corporate Operations Director. On 2/6/26, the surveyor asked the Director of Nursing for any investigation that had begun for this allegation. The Director of Nursing provided the surveyor with an incident report that indicated the following incident description: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing description: Went to the resident this morning because (he/she) stated (today) that 'a couple of weeks ago, (he/she) was rough handled by a female aide and had bruises on (his/her) right arm. I (the Director of Nursing) spoke with (him/her) and at first, (he/she) was not understanding what I was asking. I explained a 3rd time and (he/she) responded yes and look at my arm. I call her Hitler. (He/She) was asked when this happened and (his/her) response was I don't know, a couple of weeks ago. There were no bruises or any other skin abnormality observable when examined. -Resident description: Was unable to explain at first. (I had to request the information three times), (he/she) then answered, yes and she was rough. Look at my arm it's all bruised because of it. Review of the health care reporting system on 2/10/26, failed to indicate the facility reported this allegation of abuse to the state agency within the two hour time frame of receiving the report of the allegation. During an interview on 2/10/26 at 2:21 P.M., the Director of Nursing said he did not report this allegation to the state agency but that he should have. The Director of Nursing said he made the decision to not report this allegation because he felt he could not substantiate the abuse; however, he now realizes that he needs to report allegations while the investigation is still ongoing to ensure he is within regulatory compliance. During an interview on 2/11/2026 at 12:02 P.M., the Administrator said allegations of abuse should be reported within two hours if there is harm or injury, or within 24 hours if there is no harm or injury. The Administrator said that when in doubt, the facility should report allegations within two hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to investigate allegations of abuse for 5 Residents (#36, #47, #25 and #45 and #10) out of a total sample of 34 residents. Specifically,1. For Resident #36, the facility failed to investigate an allegation of sexual abuse.2. For Resident #47, the facility failed to investigate an allegation of sexual abuse.3. For Resident #25, the facility failed to investigate an allegation of resident-to-resident altercation. 4. For Resident #45, the facility failed to investigate an allegation of physical abuse by staff. 5. For Resident #10, the facility failed to investigate an allegation of resident-to-resident altercation. Review of the policy titled Suspected Adult, Disabled Resident or Elderly Abuse/Neglect/Exploitation, dated as revised 6/26/25, indicated the following: Sexual Abuse: Failure to make a reasonable effort to prevent sexual contact, sexual intercourse, sexual conduct, sexual assault or sodomy inflicted on, shown to or intentionally practiced in the presence of a resident. -Compelling or encouraging the resident to engage in sexual contact Neglectful Supervision: -Placing in, or failing to remove, the resident from a situation that a reasonable individual would realize required judgment or actions beyond that physical condition or mental abilities and that results in bodily injury or substantial risk of immediate harm to the resident. Procedure: -Management of Suspected Abuse/Neglect: Cases of suspected sexual assault, physical abuse or neglect will be given priority and will be investigated thoroughly. 1). Resident #36 was admitted to the facility in April 2025 and has diagnoses that include anxiety disorder, paraplegia and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/2/26, indicated that on the Brief Interview for Mental Status exam Resident #36 scored a 15 out of 15, indicating intact cognition. The MDS further indicated that Resident #36 had no behaviors and is dependent on staff for care and transfers. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., Resident #36 said that there is a resident in the building that is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. Resident #36 said that one time he/she had to call the police because of it and that it is an ongoing issue that he/she has reported to the Director of Nursing on multiple occasions. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the HCFRS report on 2/6/26, failed to indicate Resident #36's allegation of sexual assault was reported as required. During a follow-up interview on 2/10/26 at 8:22 A.M., Resident #36 said the following:-That he/she has an ongoing issue with another resident who he/she describes as a disgusting pervert. Resident #36 said that on October 15, 2025 he/she was seated in the hall with several other residents when the resident approached him/her and said you know you want me to **** you, you want this **** in your mouth and other vulgar things. -That at that time he/she emailed the Director of Nursing (DON) and Nursing Home Administrator (NHA) to tell them what was happening and said that if it was not stopped he/she would call the cops. Resident #36 said that shortly after sending the email he/she called the cops. Resident #36 said that later that same day the DON and the Operational Director (OD) came to the unit to speak with Resident #36. Resident #36 relayed to them what the resident had done and said the OD did not believe him/her and responded, I can't believe he/she could put that many words together in a sentence. Resident #36 said that the resident making these threats was taken by the responding police offers to the hospital but returned the next day, and the behaviors have continued since then. -Resident #36 said that he/she lives in fear the other resident will take it further and hurt me and touch me and I can't protect myself or get up and run. Resident #36 provided the surveyor with emails from October 2025 between him/herself and the Nursing Home Administrator (NHA) and Director of Nursing (DON):1. Email #1, dated 10/15/25, from Resident #36 to the NHA and DON: Something has got to be done with (the other resident). Today he/she drops his/her pants in the Hallway and then walks up to me later and said to me YOU Know you want my *** in your **** and right now he/she just took out his/her (genitals) in front of me and said you know you want this. If he/she does this in front of me or anyone else again, I'm calling the cops on him/her. Its lewn (sic) and obnoxious behavior. Please d something!!! (sic).2. Email #2, dated 10/15/25, from Resident #36 to the NHA and DON: Sorry but I called the cops, he/she wouldn't stop coming and bothering us men/ladies.3. Email #3, dated 10/16/25, from the DON to Resident #36: I understand. During an interview on 2/11/26 at 7:58 A.M., the DON said that allegations of abuse should be investigated. The DON said that would include resident-to-resident altercations and that a resident-to-resident altercation can be either verbal or physical in nature. He said that the 10/15/25 altercation between Resident #36 and a peer was not investigated but should have been. The facility's OD was present for this interview. During an interview on 2/10/26 at 2:21 P.M., the DON said that in hindsight the 10/15/25 sexual abuse Resident #36 had experienced should have been investigated but had not. During an interview on 2/11/26 at 12:02 P.M., the NHA said an event or allegation of abuse should be investigated. The NHA said that a thorough investigation includes interviewing the residents involved, any staff that were present and possibly staff from previous shifts. The 10/15/25 altercation between Resident #36 and a peer was discussed and the NHA said that it should've been investigated but it was not. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2). Resident #47 was admitted to the facility in March 2025 and has diagnoses that include Dementia with other behavioral disturbance, wandering in diseases classified elsewhere and traumatic brain injury. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/19/25, indicated that on the Brief Interview for Mental Status exam Resident #47 scored a 1 of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #47 had no behaviors aside from wandering 1-3 days a week. Review of Resident #47's clinical progress notes indicated the following notes: 10/16/25: -Patient is seen today after he/she was sent to the emergency room on 10/16 for provocative hypersexual behavior with aggression which he/she exhibited towards peers. 10/15/25: -Resident #47 was down and was exposing him/herself to (a peer) while he/she was close, uttering words such as you want this, do you want this inside of you. -Psychiatrist #1 was present during this episode and was informed that the male/female resident's do not feel safe in their rooms with Resident #47 wandering and being sexually disgusting as the male/female residents stated. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., a resident said that Resident #47 is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. The resident said that one time he/she called the police because of Resident #47's behavior. During an interview on 2/10/26 at 8:22 A.M., another resident said the following:-That he/she has an ongoing issue with Resident #47 who he/she describes as a disgusting pervert. The other resident reported that Resident #47 approached him/her and said you know you want me to **** you, you want this **** in your mouth and other vulgar things. -That at that time he/she emailed the Director of Nursing (DON) and Nursing Home Administrator (NHA) to tell them what was happening and said that if it was not stopped he/she would call the cops. During an interview on 2/10/26 at 2:21 P.M., the DON said that in hindsight the 10/15/25 sexual abuse Resident #47 had been accused of should have been investigated but it had not. During an interview on 2/11/26 at 12:02 P.M., the NHA said an event or allegation of abuse should be investigated. The NHA said that a thorough investigation includes interviewing the residents involved, any staff that were present and possibly staff from previous shifts. The 10/15/25 altercation between Resident #47 and a peer was discussed and the NHA said that it should've been investigated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but it was not. 3). Resident #25 was admitted to the facility in July 2022 and has diagnoses that include bipolar and Alzheimer's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/18/25, indicated Resident #25 was unable to participate in the Brief Interview for Mental Status exam and was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #25 has daily behavior of physical behavior directed toward others and wandering and has no verbal behaviors and no other behaviors such as pacing or disrobing. Review of Resident #25's clinical progress notes indicted the following: -A progress note dated 1/6/26: Alert and confused. Screaming heard this writher ran to former activities office to find Resident #25 soaked in water. walking around, unable to give an accurate account of what had happened. The other resident would not say ether. No s/s (signs or symptoms) of trauma noted, no bruises, refused vital signs. Resident #25 was cleaned and changed had a 100% of super, po (by mouth) fluids tolerated well. Otherwise, stable. -A social work note dated 1/12/26: SW attempted to meet with Resident #25 s/p (status/post) resident altercation. Resident #25 was not able to report what led to the altercation. Resident #25 was observed in his room with his roommates and the aggressor. No concerns were observed at this time. -A progress note dated 1/13/26: Resident #25 had a brief altercation with a female resident. During an interview on 2/11/26 at 7:58 A.M., the DON said that allegations of abuse should be investigated. The DON said that would include resident-to-resident altercations and that a resident-to-resident altercation can be either verbal or physical in nature. The 1/6/26, 1/12/26 and 1/13/26 progress notes were reviewed with the DON. He said that he was unaware of those notes and that there had not been an investigation into what had occurred, but there should have been. During an interview on 2/11/26 at 12:02 P.M., the NHA said an event or allegation of abuse should be thoroughly investigated. The NHA said that a thorough investigation includes interviewing the residents involved, any staff that were present and possibly staff from previous shifts. The 1/6/26, 1/12/26 and 1/13/26 progress notes were reviewed with the DON. He said that he was unaware of those notes and that there had not been an investigation into what had occurred, but there should have been. 4). Resident #45 was admitted to the facility in August 2020 with diagnoses including Alzheimer's Disease and schizophrenia. Review of Resident #45's most recent Minimum Data Set (MDS0 dated 12/2/25, indicated the Resident sore a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had server cognitive impairment. The MDS also indicated Resident #45 requires partial to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	moderate assistance from staff for functional daily tasks. During an interview on 2/5/26 at 8:08 A.M, Resident #45 said she was recently grabbed by a staff member and was treated roughly, resulting in black and blue bruises on his/her arm. Resident #45 said he/she everybody knows about it and that he/she had told a lot of people about this incident. Resident #45 said no staff members have come to talk about the incident with him/her. On 2/5/25 at approximately 8:20 A.M., the surveyor reported this allegation from Resident #45 to the Corporate Operations Director. On 2/6/25, the surveyor asked the Director of Nursing for any investigation that had begun for this allegation. The Director of Nursing provided the surveyor with an incident report that indicated the following incident description: -Nursing description: Went to the resident this morning because (he/she) stated (today) that 'a couple of weeks ago, (he/she) was rough handled by a female aide and had bruises on (his/her) right arm. I (the Director of Nursing) spoke with (him/her) and at first, (he/she) was not understanding what I was asking. I explained a 3rd time and (he/she) responded yes and look at my arm. I call her Hitler. (He/She) was asked when this happened and (his/her) response was I don't know, a couple of weeks ago. There were no bruises or any other skin abnormality observable when examined. -Resident description: Was unable to explain at first. (I had to request the information three times), (he/she) then answered, yes and she was rough. Look at my arm it's all bruised because of it. The incident report failed to indicate any further investigation was completed, including other staff interviews, other resident interviews, a full skin check or any other resident assessments were completed. During an interview on 2/10/26 at 2:21 P.M., the Director of Nursing said after an allegation of abuse an investigation should take place immediately. The Director of Nursing said the investigation would include interviewing the resident, other staff members and potentially other residents. The Director of Nursing said resident assessments such as skin or pain assessments would also be part of a thorough investigation. The Director of Nursing said the incident report he provided to the surveyor was the only investigation he did into Resident #45's allegation of abuse. The Director of Nursing said because there were no current bruises on the Resident's arms or because the Resident was unable to recall full specifics of the incident, he did not feel it necessary to complete any further investigation. During an interview on 2/11/2026 at 12:02 P.M., the Administrator said an investigation is started immediately if there is an event or allegation of abuse. The Administrator said the investigation would include an interview with the resident making the allegation, staff present and possibly previous shift, and the resident's roommate if they are a witness. The Administration also said assessments would be done if there is an injury. 5). Resident #10 was admitted to the facility in July 2020 with diagnoses including Alzheimer's disease with late onset and anxiety disorder. Review of Resident #10's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored an 8 out of a total 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. The MDS further indicated that the Resident exhibited behaviors (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directed towards others, for example verbal or vocal occurred daily. During an interview on 2/5/26 at 8:47 A.M., the surveyor met with the Resident in his/her room. The Resident said to the surveyor you can call my daughter she will tell you what's happening here. Review of a Social Worker (SW) progress note dated 12/9/25 indicated the following: 'SW met with Resident to follow up on staff report that he/she spilled water on roommate. Upon arriving at the room, Resident presented angry. When SW asked what had happened he/she reported he needs to stop messing with me. He is over there peeing in his thingy (urinal) and trying to climb into my bed. I don't sleep with men. SW observed water on the bedside table, floor and on the roommate's clothing. Residents have a history of spilling water on previous roommates and making the same alleged report. SW reached out to the Healthcare Proxy (HCP) regarding this incident, notified DON (Director of Nursing) and reached out to Dr Skewer to follow up with an assessment. SW will remain available for support. Review of the health care reporting system on 2/5/26, failed to indicate the facility reported this resident-to-resident altercation to the state agency. During an interview on 2/6/26 at 2:01 P.M., the Social Worker said that the Resident had a history of spilling water on other roommates and it was because he/she wanted to have a private room. The Social Worker said she reported this incident to the Director of Nursing as it was a resident-to-resident altercation and should be reported. The Social Worker said she does her part and documents in the progress noted and the Director of Nursing is responsible for completing the full investigation. During an interview on 2/9/26 at 9:52 A.M., Resident Representative (HCP) said the facility had notified her that the Resident was being moved out of the room as he/she had spilled water on another resident. During an interview on 2/10/26 at 2:35 P.M., the Director of Nursing said by Resident throwing water at another resident would be considered a resident-to- resident altercation, and that it should have been investigated and reported. The Director of Nursing the incident was not investigated or reported to the state agency. During an interview on 2/11/26 at 12:45 P.M., the Administrator said a report should have been investigated and filed to the state agency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically:1.) The facility failed to ensure medications with shortened expiry dates were dated once opened in two out of three medication carts and to ensure insulin that required refrigeration was refrigerated in one out of two medication rooms observed.2.) The facility failed to properly secure medication carts when unattended on one of three units.3.) The facility failed to ensure the medication room was locked when unattended.4.) The facility failed to ensure unauthorized staff did not have access to medication room.5.) The facility failed to ensure lorazepam, a controlled drug, was separately locked in a permanently affixed compartment for storage of controlled drugs. Findings include:Review of the facility policy titled 'Storage of Medications', dated 8/12/25, indicated:-Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. -The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.-The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.-Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. -Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys. 1.) On 2/5/26 at 11:28 A.M., the surveyor and Nurse #7 observed the following in the [NAME] Wing medication room:-One unopened lantus solostar insulin pen, not refrigerated. This insulin pen felt room temperature. The manufacturers guidelines listed on the label indicated to refrigerate unopened product. During an interview on 2/5/26 at 11:30 A.M., Nurse #7 said the lantus solostar insulin pen was unopened and unrefrigerated. Nurse #7 said based on the manufacturers' guidelines on the label, it should have been stored in the refrigerator. On 2/5/26 at 12:24 P.M., the surveyor and Nurse #7 observed the following in the [NAME] Wing medication cart:-One opened, undated fluticasone propionate and salmeterol inhaler. The manufacturers guidelines listed on the label indicated to discard one month after opening.-One opened, undated airsupra inhaler. The manufacturers guidelines listed on the label indicated to discard 12 months after removal from foil pouch.-One opened, undated symbicort inhaler. The manufacturers' guidelines listed on the label indicated to discard three months after opening.-Two opened, undated bottles of latanoprost eye drops. The manufacturers' guidelines listed on the label indicated to discard after six weeks.-Three opened, undated artificial tears eye drops. There were no manufacturers guidelines listed on the label indicating when to discard. During an interview on 2/5/26 at 12:34 P.M., Nurse #7 said all the medications with shortened expiry dates should be dated when opened so they can be discarded appropriately following the facility policy and manufacturers guidelines. On 2/6/26 at 8:11 A.M., the surveyor and Nurse #6 observed the following in the Central Wing medication cart:-One opened and undated bottle of latanoprost eye drops. The manufacturers' guidelines listed on the label indicated to discard after six weeks.-Two opened, undated fluticasone propionate and salmeterol inhaler. The manufacturers guidelines listed on the label indicated to discard one month after opening.-One opened, undated symbicort inhaler. The manufacturers' guidelines listed on the label indicated to discard three months after opening.-One opened, undated bottle of prosource liquid protein. The manufacturers' guidelines listed on the label indicated to discard three months after opening.-Three opened, undated artificial tears eye drops. One of these bottles was not labeled with a resident name or stored in the box, but directly in the drawer. There were no manufacturers guidelines listed on the label indicating when to discard.-Greater than (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	30 loose, unlabeled pills.-Multiple medications stored touching a sticky, brown liquid on the bottom of one of the drawers. During an interview on 2/6/26 at 8:15 A.M, Nurse #6 said all the medications with shortened expiry dates should be dated when opened so they can be discarded appropriately following the facility policy and manufacturers' guidelines. Nurse #6 said there should not be loose, unlabeled pills or any brown sticky substances touching the medications. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said all the medications, including eye drops, inhalers, and liquid protein with shortened expiry dates should be dated when opened so they can be discarded appropriately following the facility policy and manufacturers' guidelines. The DON said eye drops should always be stored in the original box and not loose in the medication cart. The DON said eye drops should be dated once opened and discarded after 30 days unless the manufacturers guidelines indicate otherwise. The DON said lantus solostar should be stored in the refrigerator until it is opened. The DON said there should not be loose, unlabeled pills or any brown sticky substances touching the medications. 2.) On 2/6/26 at 7:28 A.M., the surveyor observed the [NAME] Wing medication cart unlocked and unattended in the hallway. The nurse was not within sight line of the medication cart. During an interview on 2/6/26 at 7:30 A.M., the Unit Manager said that it was Nurse #13's medication cart and that he should have locked it whenever it was unattended. During an interview on 2/6/26 at 8:41 A.M., Nurse #13 said his medication cart should be locked whenever it was unattended. On 2/25/26 at 9:13 A.M., the surveyor observed the [NAME] Wing medication cart unlocked and unattended in the hallway. The nurse was not within sight line of the medication cart. The surveyor was unable to locate Nurse #13, who was assigned to this medication cart. During an interview on 2/25/26 at 9:16 A.M., the Unit Manager said that it was Nurse #13's medication cart and that he should have locked it whenever it was unattended. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said medication carts should be locked when unattended and not within the nurse's view. 3.) On 2/5/26 at 7:06 A.M. and 8:05 A.M., the surveyor observed the [NAME] Wing medication room ajar greater than a foot. There was no nurse within view of the medication room. There were two residents wandering around the desk in front of the open medication room. During an interview on 2/5/26 at 8:07 A.M., Nurse #7 said the medication room should never be left unlocked when unattended. During an interview on 2/5/26 at 11:54 A.M., the Director of Nursing (DON) said the medication room should never be left unlocked when unattended. 4.) On 2/5/26 at 11:34 A.M., the surveyor observed Nurse #7 give keys to person who was not wearing a facility name badge and was not wearing any type of staff uniform. The person used the keys to open and enter the medication room, not within view of Nurse #7. During an interview on 2/5/26 at 11:25 A.M., Nurse #7 said the person was an off-duty nurse who needed to retrieve his/her forgotten personal belongings in the medication room. During an interview on 2/5/26 at 11:50 A.M., Nurse #1 said nurses should never share keys with other staff members or store any personal items in the medication room. Nurse #1 said the facility had staff lockers available to store any of their personal items. During an interview on 2/5/26 at 11:54 A.M., the Director of Nursing (DON) said nurses should never share their keys with anyone. The DON said Nurse #7 should not have let any off duty nurse borrow her keys. The DON further said nurses should never store personal items in the medication room. The DON said the facility had staff lockers available to store any of their personal items. 5.) On 2/5/26 at 11:50 A.M., the surveyor and Nurse #1 observed the following in the North/Central medication room:-Two bottles of lorazepam in the shared medication refrigerator. These bottles were stored with a variety of other non-controlled drugs and not separately locked in a permanently affixed compartment for storage of controlled drugs. During an interview on 2/5/26 at 11:50 A.M., Nurse #1 said both herself and the other medication cart nurse have access to this refrigerator. Nurse #1 said those two bottles of lorazepam should be locked separately in a permanently affixed compartment, but that the facility doesn't have one. Nurse #1 said it didn't matter because they weren't being used as both residents the lorazepam was prescribed for passed away last year. During an interview on 2/5/26 at 11:54 A.M., the Director of Nursing (DON) said lorazepam should always be locked separately in a permanently affixed compartment that the other medication cart nurse did not have access to.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store and prepare food in accordance with professional standards for food service safety. Specifically, the facility failed to:1) Ensure food was labeled and stored under sanitary conditions without significant signs of decomposition. 2) Practice proper food handling during meals in the [NAME] Unit dining room. Findings include: Review of the facility's policy titled Food Storage, dated April 2020, indicated, but was not limited to, the following: -All foods stored in walk-in refrigerators and freezers shall be stored above the floor on shelves, racks, dollies, or other surfaces that facilitate thorough cleaning. -Perishable items are stored as follows: Sliced and shredded cheeses will be used within seven days of opening and labeled with a use-by date noting seven days from opening as according to the Date Marking Policy/ Reference sheet. Milk and other dairy products such as yogurt and cottage cheese, unopened, are good until the use by date noted by the manufacturer. Produce will be stored covered. Fruit and vegetables stored in the original box and labeled/dated with a vendor delivery sticker are acceptable. Products in covered storage bins will require a date of delivery. This is relative to all un-refrigerated and refrigerated produce. Fruits and vegetables will be checked for wholesomeness and/or spoiledness upon delivery and prior to use. (sic.) Refrigerated, ready-to-eat, potentially hazardous food opened or prepared shall be clearly marked at the time of preparation to indicate the date of preparation. Ready-to-eat food items shall be discarded within 72 hours of the date opened. On 2/5/26 at 7:20 A.M., the surveyor made the following observations during the initial walkthrough of the kitchen: -A case of acorn squash in the walk-in refrigerator with significant signs of decomposition including color changes, textural changes and the presence of a white wispy growth. -A case of sweet potatoes in the walk-in refrigerator with significant signs of decomposition including textural changes and the presence of a blueish-white wispy growth. -An undated bag of shredded cabbage in the walk in refrigerator with significant signs of decomposition including brown discoloration and textural changes. -A container of oranges in the walk-in refrigerator with significant signs of decomposition including color changes, textural changes, and the presence of a blueish-white wispy growth. -There was a black wispy growth present on the shelving in the walk-in refrigerator; food was stored on top of and below the black wispy growth. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two undated bags of shredded mozzarella cheese in the walk-in refrigerator, there was irregular blue coloring throughout one of the bags of cheese consistent in appearance with mold. -A container of salsa in the walk-in refrigerator; the salsa was dated opened 8/26 and had a blueish-white wispy growth on the outside of the bottle as well as the presence of a slimy white substance on the inside of the bottle in the salsa. -A box of raw fish fillets stored on the shelf above opened ready-to-eat ham in the walk-in refrigerator. -A box of chicken stored directly on the freezer floor. -Two bottles of juice opened but undated in the reach-in refrigerator. -Sliced deli turkey opened but undated in the reach-in refrigerator. -Salami open and dated 1/10/26 in the reach-in refrigerator. -The fan located in the reach-in refrigerator was covered in a brownish stringy debris, there was food stored below the fan. -Undated brownies in the reach-in refrigerator. During an interview on 2/5/26 at 7:37 A.M. the Food Service Director (FSD) said he noticed the acorn squash yesterday and should have thrown it out yesterday. The FSD said kitchen staff were supposed to label and date all prepared and opened foods and discard them after seven days. The FSD said he did not know when the shredded cabbage was opened and that it should have been dated. The FSD said staff should have gone through the sweet potatoes and discarded the ones showing signs of decomposition. The FSD said that the black wispy growth present on the shelving could be mold and that food should not be stored on top or below it. The FSD said the raw fish should not have been stored above the opened ready-to-eat ham. The FSD said the salsa should have been thrown away and that the chicken in the freezer should not have been stored on the floor. The FSD said he would have expected the open juice in the reach-in refrigerator to be dated when it was opened and that the deli turkey and salami should have been discarded. The FSD said food should not be stored below the fan in the reach-in refrigerator because the debris could fall and contaminate the food. 2. Review of the facility policy titled, Food Handling – Preventing Foodborne Illness, dated 10/10/25, indicated the following: -Food at (the facility) will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. -All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. The following was observed in the [NAME] Unit during the breakfast meal on 2/6/26 at 7:31 A.M.: -The Corporate Operations Director (COD) was assisting with serving meals to residents. While (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assisting, she touched seven pieces of toast with her bare hands to spread jelly and peeled a banana and with her bare hands took the banana out of the peel and placed it on a plate. The following was observed in the [NAME] Unit during the lunch meal on 2/9/26 at 11:42 A.M.: -The COD was opening a milk container and put her finger inside the spout of the container to open it. The COD was not wearing gloves. -The COD picked up a dinner roll, a ready to eat food item, with her bare hands to butter it for two different residents. The COD failed to apply gloves or wash her? Hands between tasks. -Two different Certified Nursing Assistants (CNAs) picked up dinner rolls with their bare hands to butter them for six different residents. -A nurse picked up a dinner roll with her bare hands to butter it for two different residents. -One resident took a glass of juice from a tablemate's tray and drank it. The juice had already been partially drunk by the other resident. This same resident also took food from the resident's plate with her bare hands and ate it. The Survey told the nurse at the time and the nurse did not stop the resident from eating the food from another resident's plate. The following was observed in the [NAME] Unit during the breakfast meal on 2/10/26 at 7:38 A.M.: -A nurse peeled a banana and with her bare hands took the banana out of the peel and placed it on a plate. This same nurse then touched two slices of bread with her bare hands to spread jelly and opened a milk container by putting her finger inside the spout of the container to open it. The following was observed in the [NAME] Unit during the breakfast meal on 2/12/26 at 7:38 A.M.: -A CNA peeled a banana and with her bare hands took the banana out of the peel and placed it on a plate. This same nurse then touched two slices of bread with her bare hands to spread jelly. -The COD removed a muffin wrapped with her bare hands, touching the muffin and then touched several pieces of toast with her bare hands to spread jelly. -A CNA removed a muffin wrapped with her bare hands, touching the muffin. During an interview on 2/12/26 at 1:36 P.M., the Director of Nursing said food should not be touched by staff and if staff are assisting with the setting up of meals, they should be wearing gloves when touching food. The Director of Nursing said staff should be aware of this and should know not to touch food because this could potentially contaminate the food.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to provide a dignified existence for one Resident (#74) out of a total sample of 34 residents. Specifically, staff failed to pull the privacy curtain for Resident #74 when he/she was in bed receiving assistance with bathing, which exposed Resident #74 to his/her roommates.Findings include:Review of the facility policy titled Quality of Life-Dignity, undated, indicated the following:Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment and procedures. Resident #74 was admitted to the facility in January 2026 with diagnoses including dysphagia, unspecified dementia and seizures. Review of Resident #74's Brief Interview for Mental Status (BIMS) indicated the Resident scored an 8 out of 15 indicating moderate cognitive impairment.Review of medical records indicated the Resident was dependent on staff for all activities of daily living. Review of Resident #74's current care plan indicated the following:Focus: Resident has potential or actual alteration in selfcare (initiated 7/30/25)Intervention: Assist resident to the extent required with bathing, dressing and grooming. During an observation on 2/6/26 at 9:02 A.M., Resident #74 was in his/her bed, naked receiving morning care by Certified Nursing Assistant (CNA) #4. His/her privacy curtain was open and two other residents were in the room able to see Resident #74 being bathed. During an interview on 2/6/26 at 9:53 A.M., CNA #4 said he should provide privacy to the residents when providing care. He further said residents should not be able to see other residents receiving personal care. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing said staff should pull privacy curtains when providing personal care.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interviews, the facility failed to inform residents or their representatives of charges for services available in the facility not covered under Medicare/Medicaid or by the facility's per diem rate for two out of two applicable records reviewed. Findings include: The SNF ABN (CMS-10055) notice is administered to a Medicare recipient when the facility determines that the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all the Medicare benefit days for that episode. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. Review of the notices provided to two residents who came off their Medicare Part-A Benefit, who had benefit days remaining and stayed at the facility, were provided Advanced Beneficiary Notices that did not include an estimated cost of services should they choose to pay privately. During an interview on 2/12/26 at 10:28 A.M., the Social Worker said she was responsible for providing the SNF ABN notices to residents or their representatives. The Social Worker said she left the cost breakdown sections blank because she does not know what the individual costs are, but the resident or their representative should have been provided with a cost breakdown in the event they assume financial responsibility for skilled services. During an interview on 2/12/26 at 10:39 A.M., the Operations Director said she was unsure of the cost breakdown for skilled services, but it should be listed on the SNF ABN.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to maintain a home-like environment. Specifically, the facility failed to ensure that the [NAME] Wing was free from odors. Findings include:Review of the facility policy titled ?Home-like Environment Policy', dated 2/4/26, indicated:-Purpose: To provide a safe, comfortable, and dignified environment that reflects a home-like atmosphere and promotes resident choice, independence, and well-being. On 2/5/26 at 7:59 A.M., 10:55 A.M., and 2:24 P.M.; and on 2/6/26 at 6:57 A.M., 7:47 A.M., 8:37 A.M., and 9:03 A.M., the surveyors noted the west wing hallway had a strong odor of stale urine. During the resident group meeting conducted on 2/6/26 at 10:30 A.M., half of the participating residents (4 out of 8 residents) reported unpleasant odors within the facility. Residents reported the following:-A resident said there was a poor odor present like somebody used the bathroom.-Another resident said there was a constant smell of doo-doo.-Another resident said that housekeeping doesn't really stay on top of the odors in the facility. During an interview on 2/6/26 at 9:04 A.M., Nurse #13 said staff uses a deodorizing spray to cover odors frequently on the [NAME] Wing. During an interview on 2/6/26 at 9:45 A.M., Housekeeper #1 said she is the primary housekeeper for [NAME] Wing. Housekeeper #1 said she has to wash the floors 3 to 4 times a day because urine had soaked into the flooring in two resident rooms on the [NAME] Wing. Housekeeper #1 said since the urine is within the flooring, she is unable to remove the odor, and her cleaning only covers up the smell. Housekeeper #1 further said she uses deodorizing spray frequently to cover up the odor. During an interview on 2/6/26 at 9:59 A.M., Certified Nurse Assistant (CNA) #7 said there is often strong odors of urine on the [NAME] Wing, especially in the morning before housekeeping comes. CNA #7 showed the surveyor a deodorizing spray, which he pulled out of his pocket, and said I carry this room spray to use whenever I need it. During an interview on 2/6/26 at 10:25 A.M., the Administrator said the [NAME] Wing smells of urine because there is a resident who urinates on the floor. The Administrator said the urine may have soaked into the floor causing the odor. During an interview on 2/9/26 at 8:29 A.M., Nurse #8 said the [NAME] Wing often smells of urine. Nurse #8 said it is expected to smell like urine because it's a dementia unit. During a follow-up interview on 2/9/26 at 8:46 A.M., Housekeeper #1 said she had been telling administration for over a year that she couldn't get the smell out of the floor in the [NAME] Wing. During an interview on 2/13/26 at 8:12 A.M., the Director of Facilities (DOF) said if staff suspected urine had soaked into the floor, he would expect the flooring to be replaced promptly. The DOF said he had extra flooring in the building. The DOF said, after the surveyor brought the concern to the facility's attention, he went down to the room Housekeeper #1 said had urine soaked into the floor. The DOF said the smell of urine was strong and he thought it might be in the radiator, so he removed the radiator covering and could see that urine had soaked into the flooring. The DOF said staff should have notified him of the ongoing odor concern on the [NAME] Wing and it should have been fixed promptly but was not.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interview, the facility failed to ensure that its staff completed a quarterly Minimum Data Set (MDS) assessment in a timely manner for one Resident (#27), out of 34 sampled residents. Findings include:Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) version 3.0 Manual, dated October 2025, indicated:-A Quarterly MDS Assessment is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments. -The Quarterly MDS Assessment must be completed no later than 14 calendar days after the Assessment Reference Date. Resident #27 was admitted to the facility in April 2022. Review of Resident #27's most recent Minimum Data Set (MDS) assessment was a quarterly MDS assessment with an assessment reference date of 10/2/25, which was 127 days prior. No further MDS assessments for Resident #27 were completed or transmitted to CMS since that date. During an interview on 2/5/26 at 2:12 P.M., the MDS Coordinator said Resident #27 was supposed to have a quarterly MDS completed on 12/26/25 but it was missed. The MDS Coordinator said Resident #27 should have had a quarterly MDS within 92 days, and it was overdue. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said he would expect the MDS Coordinator to complete all MDS assessments following the RAI manual instructions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop a care plan for suicidal ideation for one Resident (#33) out of a total sample of 34 residents. Findings include: Review of the facility policy titled, Oxygen Administration, dated 2/23/26, indicated the following:-Place appropriate oxygen device on the resident. -Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. Resident #33 was admitted to the facility in December of 2025 with diagnoses including schizoaffective disorder and schizophrenia. Review of Resident #33's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview of Mental Status (BIMS) score of 14 out of a possible 15 which indicated he/she is cognitively intact. The MDS also indicated Resident #33 required substantial assistance with activities of daily living. Throughout survey, Resident #33 was not agreeable to an interview. Review of the Psychiatrist note from 12/29/25 indicated Resident #33 had experienced suicidal ideation previously in the day, however at the time of his visit with the Resident, the Resident no longer expressed any suicidal ideation. Review of the medical provider note on 1/25/25 indicated the following:- Patient called Police at facility requesting to leave facility, expressed suicidal ideation with a plan, put on 1-1 to monitor for safety. NO Suicidal ideation and ideation on assessment today.Review of Resident #33's interdisciplinary care plans failed to indicate a care plan for suicidal ideation was created after 12/29/25. During an interview on 2/10/26 at 10:36 A.M., the Director of Nursing said any resident who has expressed suicidal ideation should have a care plan developed to address this concern. The Director of Nursing said the care plan would assist the staff to identify interventions to assist a resident is managing feeling of suicidal ideation. The Director of Nursing said Resident #33 should have had a suicidal ideation care plan developed and was unaware it had not been developed. During an interview on 2/10/26 at 1:44 P.M., the Social Worker said any resident who expresses suicidal ideation in present or past should have a suicidal ideation care plan developed. The Social Worker said such a care plan would be important to develop in order to identify possible triggers for the suicidal ideation as well as appropriate interventions for the resident. The Social Worker said she does not remember Resident #33 expressing suicidal ideation on 12/29/25, however, a care plan should have been developed for this.

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Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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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 record review and interviews, for 2 Residents (#47 and #50) out of a total sample of 34 residents, the facility failed to ensure they reviewed and revised the Comprehensive Care Plan following the completion of his/her scheduled Quarterly Minimum Data (MDS) assessment. Specifically,For Resident #47 the facility failed to update the care plan to remove interventions of 15-minute checks when they were no longer being implemented.For Resident #50, the facility failed to revise the comprehensive care plan relating to communication problem, which did not include any interventions related to his/her language barrier.Findings include: Review of the facility policy titled 'Resident-Centered Comprehensive Careplan (AIMS)', revised 9/22/24, indicated: -The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family and legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -The care plan interventions are derived from the thorough analysis of the information gathered as part of the comprehensive assessment. -The care planning process will incorporate the resident's personal and cultural preferences in developing the goals of care. -The comprehensive, person-centered care plan will: describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and incorporate identified problem areas. 1. Resident #47 was admitted to the facility in March 2025 and has diagnoses that include Dementia with other behavioral disturbance, wandering in diseases classified elsewhere and traumatic brain injury. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/19/25, indicated that on the Brief Interview for Mental Status exam Resident #47 scored a 1 of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #47 had no behaviors aside from wandering 1-3 days a week. Review of Resident #47's active physician orders include the following orders: -Please check resident status every 15 minutes, start date 8/8/25. Review of Resident #47's active care plans includes the following care plans: 1. FOCUS: I have the potential for becoming physically aggressive with other residents when I may not understand what is happening. Resident has a physical aggressive altercation with another resident (last updated 7/9/25) Interventions include: -Resident shall be monitored every 15 minutes and documented by staff members to prevent him from (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entering other residents' rooms and to be able to recognize when his mood/behavior changes. (start date 7/18/25) Review of the Clinical progress notes includes a note dated 2/6/26 that indicated Resident #47 was behavioral and the intervention implemented was to put him/her on 15-minute checks, despite this already being an active MD order that was on Resident #47's care plan. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to indicate that the 15-minute checks were done at any time from July 2025 until they were implemented on 2/6/26. During an interview on 2/10/26 at 2:21 P.M., the Director of Nursing (DON) said that the 15-minute checks on Resident #47's care plans since 7/18/25 and ordered by the Physician on 8/8/25 were not actually being done. The DON said that it was an outdated intervention and should have been caught during each quarterly care plan meeting after that date and the care plan revised to reflect the current plan of care. As well, the MD order should have been discontinued. During an interview on 2/11/26 at 12:02 P.M., the Nursing Home Administrator said that if 15-minute checks were on the care plan since July 2025 and ordered by the MD since August 2025, he would have expected the 15-minute checks to be done, or the care plan revised to reflect that the checks were no longer in place. 2. Resident #50 was admitted to the facility in March 2025 with diagnoses including Alzheimer's dementia and failure to thrive. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/11/25, indicated Resident #50 spoke Swahili and needed or wanted an interpreter to communicate with a doctor or health care staff. This MDS indicated he/she was usually understood and usually understands in Section B. On 2/5/26 at 8:10 A.M., the surveyor observed Resident #50 in his/her room eating breakfast. Resident #50 was unable to answer the surveyor's questions such as how are you? and how is your breakfast but instead shrugged and spoke in another language. During a follow-up interview on 2/6/26 at 11:14 P.M., Resident #50 conversed with a surveyor, who spoke Swahili. Resident #50 was able to respond to questions about his/her care such as that he/she prefers tea over coffee and discussed his/her personal past with the surveyor. Review of Resident #50's plan of care related to communication problem, dated 1/21/26, indicated: -Focus: Resident #50 has a communication problem related to language barrier; his/her primary language is Swahili. -Intervention: Anticipate and meet needs. -Intervention: Ensure/provide a safe environment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #50's plan of care failed to indicate any interventions used to assist with communicating in Swahili, such as communication board or use of translator services. During an interview on 2/6/26 at 10:40 A.M., Certified Nurse Assistant (CNA) #9 said she cannot communicate with Resident #50 because he/she speaks Swahili. CNA #9 said there are no staff in the building on the current shift that speak Swahili, but that there are a few staff employed on other shifts that speak Swahili, so if Resident #50 needs something he/she can tell them on other shifts. CNA #9 said Resident #50 often urinates on the floor and before doing so will often be attempting to communicate in Swahili, but she doesn't know what he/she is saying because there was no way to understand him/her. CNA #9 was unaware of any interventions, such as a communication board or electronic translator services. During an interview on 2/6/26 at 10:49 A.M., the Administrator said he was unaware there was Resident #50's language barrier. The Administrator said Resident #50 has a communication board and he expected staff would utilize an electronic translator program. The Administrator said Resident #50 should have had interventions, such as the communication board and electronic translator, included in his/her care plan to ensure staff were aware of how to communicate with the Resident but they were not. During an interview on 2/9/26 at 8:24 A.M., Nurse #8 said she frequently cares for Resident #50. Nurse #8 said she does not speak Swahili, so she is unable to communicate with Resident #50. Nurse #8 said they anticipate his/her needs the best they can and rely on a few staff members who work evening shift to communicate in Swahili with Resident #50 when they are scheduled if needed. Nurse #8 said she was unaware of any interventions, such as communication board or use of electronic translator, used to communicate with Resident #50. Nurse #8 said if these were supposed to be used, she would expect them to be in Resident #50's care plan but they were not. During an interview on 2/9/26 at 10:06 A.M., the Social Worker (SW) and MDS Coordinator said the interdisciplinary team meets quarterly to review Resident #50's care plan. They both said since staff are unable to communicate with Resident #50 when Swahili speaking staff is unavailable they are expected to utilize a communication board and electronic translator services. They said these interventions should have been included in Resident's care plan. They said the care plan should have been revised to include these interventions following the last MDS assessment, which was dated 12/11/25, but was not. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said Resident #50 should have had interventions in his/her care plan, such as the use of a communication board and electronic translator services but did not. The DON said that these interventions should have been added to the care plan during review of the most recent MDS on 12/11/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide care in accordance with professional standards of practice for one Residents (#74) out of a total of 34 sampled residents. Specifically:1. For Resident #74, the facility failed to ensure a physician's order was implemented for padded side rails. Findings include: Review of [NAME], Manual of Nursing Practice 11ed, dated 2019 indicated the following:- The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers 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 errors.1.Resident #74 was admitted to the facility in January 2026 with diagnoses including seizure and epilepsy. Review of Resident #74's Brief Interview for Mental Status (BIMS) indicated the Resident scored a 13 out of 15 indicating intact cognition. Review of the medical record indicated Resident #74 was dependent on staff for activities of daily living. On 2/5/26 at 9:06 A.M., the surveyor observed Resident #74 lying in his/her bed with two quarter side rails up. The side rails were not padded. On 2/6/26 at 7:49 A.M., the surveyor observed tResident #74 lying in his/her bed with two quarter side rails up. The side rails were not padded. On 2/6/26 at 9:02 A.M., the surveyor observed Resident #74 lying in his/her bed with two quarter side rails up. The side rails were not padded. On 2/9/26 at 7:14 A.M., the surveyor observed Resident #74 lying in his/her bed with two quarter side rails up. The side rails were not padded. Review of the active physician's order indicated the following:Padded side rails while in bed secondary to seizures activities, dated 2/28/23. During an interview on 2/9/26 at 7:24 A.M., Nurse #2 said based on the physician orders the Resident should have padded side rails. During an interview on 2/10/26 at 10:19 A.M., Certified Nursing Assistant (CNA) #4 said he has not seen the Resident's bed with padded side rails. He further said if the Resident required padded side rails the nurses would be the one to place them. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing said physician orders should be followed as ordered and that Resident #74 was ordered to have padded side rails and those should have been in place.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for 3 Residents (#69, #67 and #45) out of a total sample of 34 residents. Specifically, the facility failed to:1) Provide incontinence care for Residents #69 and #67. 2) Provide assistance to Resident #45 for grooming tasks and removal of unwanted facial hair. Findings include:Review of the facility policy titled, Activities of Daily Living (ADLs), dated 11/6/24, indicated the following:-Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).-Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.-Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming and oral care), c. Elimination (toileting). Review of the facility policy titled, Incontinent Care, dated 3/5/25, indicated the following:-All residents are to be given incontinent care after each episode of incontinence. Residents are to be checked for incontinence every two hours and as needed.-Each resident's care plan is specific to the needs of the individual resident. 1a. Resident #69 was admitted to the facility in April 2019 with diagnoses including Alzheimer's Disease. Review of Resident #69's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 00 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident is dependent on staff for toileting tasks and is frequently incontinent of both bowel and bladder. Review of Resident #69's most recent bowel and bladder assessment dated [DATE], indicated Resident #69:-never voids appropriately without incontinence,-has daily incontinence of stool, and-is never mentally aware of need to toilet. Review of Resident #69's incontinence care plan, last revised on 8/1/25 indicated the following intervention: -check and change every 2 hours and as needed apply barrier cream to coccyx buttocks area after each incontinent episode. Routine toileting q (every) 2 hours and PRN (as needed). Review of Resident #69's ADL care plan, last revised 8/1/25, indicated the following intervention:-Bladder-incontinent, provide incontinent care after each episode. Bowel-incontinent, provide incontinent care after each episode. Toilet every 2 hours and as needed. On 2/5/26 at 8:18 A.M., Resident #69 was observed sitting in his/her wheelchair in the dining room. Resident #69 sat in the same position in the dining room until he/she was taken to the bathroom at 12:29 P.M., over four hours later. During this time period, no staff were observed checking the Resident for possible incontinence. On 2/6/26 at 7:30 A.M., Resident #69 was observed sitting in his/her wheelchair in the dining room. Resident #69 sat in the same position in the dining room until 12:00 P.M., over four hours later. During that time period, Resident #69 was not assisted to the bathroom and was not checked for incontinence. On 2/9/26 at 7:43 A.M., Resident #69 was observed sitting in his/her wheelchair in the dining room. Resident #69 sat in the same position in the dining room until he/she was taken to the bathroom at 12:38 P.M., almost five hours later. The surveyor observed Certified Nursing Assistant #11 provide toileting assistance to Resident #69 and the Resident's incontinence brief was observed to be saturated with urine. During an interview on 2/9/26 at 12:04 P.M., Certified Nursing Assistant (CNA) #11 said the majority of residents on the unit, including Resident #69, are incontinent. CNA #11 said the nursing staff typically assist residents with toileting after breakfast and after lunch or as needed. CNA #11 said she cares for Resident #69 regularly and usually toilets him/her before breakfast and after lunch. During an interview on 2/10/26 at 9:43 A.M., the Unit Manager said all residents should be checked every two hours and have incontinence care provided if needed. The Unit Manager said it is a nursing standard that any resident who is incontinent of either bowel or bladder is provided with incontinence care every two hours. The (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager said Resident #69 is incontinent of both bowel and bladder and nursing should be providing care to him/her every two hours. The Unit Manager said if incontinent care is not provided every two hours there is a risk of infection, rash or skin breakdown. During an interview on 2/10/2026 at 10:36 A.M., the Director of Nursing said all residents who are incontinent should be toileted every two hours. The Director of Nursing said Resident #69 is incontinent and should be checked and changed every two hours and the length of time the surveyor observed the Resident without being toileted was not acceptable. The Director of Nursing said the risk of not having timely incontinence care is skin breakdown. 1b. Resident #67 was admitted to the facility in January 2020 with diagnoses including Alzheimer's Disease, Review of Resident #67's most recent Minimum Data Set, dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status and the staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #67 is dependent on staff for all functional tasks and is always incontinent of both bowel and bladder. Review of Resident #67's most recent bowel and bladder assessment dated [DATE], indicated the Resident:-never voids without incontinence,-has daily incontinence of stool, and -is not usually aware of need to toilet. Review of Resident #67's incontinence care plan last revised 6/12/25, indicated the following intervention:-Incontinent program: check and change every 2 hours Assist me to toilet every 2 hours and as needed Review of Resident #67's ADL care plan last revised 6/12/25, indicated the following intervention: -Preventative skin care every shift and as needed. Bladder- incontinent, provide incontinent care after each episode Bowel- incontinent, provide incontinent care after each episode. On 2/5/26 at 7:59 A.M., Resident #67 was observed lying in a recliner in the dining room. Resident #67 was in the same position in the dining room until 12:30 P.M., over four hours later. During that time period, Resident #69 was not assisted to the bathroom and was not checked for incontinence. On 2/6/26 at 7:30 A.M., Resident #67 was observed lying in a recline in the dining room. Resident #67 was in the same position in the dining room until 12:00 P.M., over four hours later. During that time period, Resident #69 was not assisted to the bathroom and was not checked for incontinence. On 2/9/26 at 7:43 A.M., Resident #67 was observed lying in a recliner in the dining room. Resident #67 was in the same position in the dining room until he/she was taken to the bathroom at 12:46 P.M., five hours later. The surveyor observed Certified Nursing Assistant #11 provide toileting assistance to Resident #67 and the Resident's incontinence brief was observed to be saturated with urine. During an interview on 2/9/26 at 12:04 P.M., Certified Nursing Assistant (CNA) #11 said the majority of residents on the unit, including Resident #67, are incontinent. CNA #11 said the nursing staff typically assist residents with toileting after breakfast and after lunch or as needed. CNA #11 said she cares for Resident #67 regularly and usually toilets him/her before breakfast and after lunch. During an interview on 2/10/26 at 9:43 A.M., the Unit Manager said all residents should be checked every 2 hours and have incontinence care provided if needed. The Unit Manager said it is a nursing standard that any resident who is incontinent of either bowel or bladder is provided with incontinence care every two hours. The Unit Manager said Resident #67 is incontinent of both bowel and bladder and nursing should be providing care to him/her every two hours. The Unit Manager said if incontinent care is not provided every two hours there is a risk of infection, rash or skin breakdown. During an interview on 2/10/2026 at 10:36 A.M., the Director of Nursing said all residents who are incontinent should be toileted every two hours. The Directof of Nursing said Resident #67 is incontinent and should be checked and changed every two hours and the length of time the surveyor observed the Resident without being toileted was not acceptable. The Director of Nursing said the risk of not having timely incontinence care is skin breakdown. 2. Resident #45 was admitted to the facility in August 2020 with diagnoses including Alzheimer's Disease and schizophrenia. Review of Resident #45's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #45 had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #45 required moderate assistance from staff for grooming tasks. On 2/5/26 at 11:31 A.M., Resident #45 was observed lying in bed. The (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident had significant, long chin hair. During an interview at this time, Resident #45 said he/she would like to have his/her chin hair removed and prefers to have a smooth chin without hair. On 2/12/26 at 7:25 A.M., Resident #45 was observed lying in bed with significant long chin hair still present. During an interview at this time, Resident #45 said staff had not offered to remove his/her chin hair and he/she would very much like it removed. Review of Resident #45's activity of daily living care plan, last revised on 7/2/25, indicated the following interventions:-I am an assist of one with Bathing, dressing and grooming. -Staff will offer me positive reinforcement for accomplishments and efforts. grooming assist of 1 During an interview on 2/12/26 at 7:29 A.M. Certified Nursing Assistant (CNA) #8 said removing unwanted facial hair is a part of daily care. CNA #8 said Resident #45 will at times refuse showers and washing his/her hair, however, never refuses grooming assistance, including removing chin hair. CNA #8 said Resident #45 prefers to have all chin hair removed. During an interview on 2/12/26 a1:36 P.M., the Director of Nursing said all unwanted facial hair should be removed as part of daily grooming. The Director of Nursing said if a resident were to refuse care, the nursing staff would document the refusal. Review of Resident #45' medical record failed to indicate the Resident refused assistance with grooming tasks.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide an activities program for residents on the [NAME] Unit. Findings include: Review of the facility policy titled, Activities, dated 5/10/25, indicated the following:-It is the policy of (the facility) to provide an activities program that is appropriate to the needs and interests of each resident that will encourage self-care, resumption of normal activities, maintenance of optimal cell functioning and contact with the environment.-The planned activities program shall be suited to the needs, abilities and interests of each resident. Activities shall be provided in individual and group settings for ambulatory and non ambulatory residents.-The activities program shall include a variety of activities both inside and outside the facility. Planned activities shall include, but not be limited to, exercise classes, recreational or social activities, literary or educational activities, community activities, spiritual activities and continuing life experiences that allow the resident to maintain his or her present life cycle.-A member of the staff shall be assigned responsibility for developing, documenting and maintaining an activities program. Sufficient support staff must be available to meet the activity needs of all residents. Review of the activities calendar for 2/5/26 indicated the following activities were scheduled:-Refreshments at 10:15 A.M.-Animal [NAME] at 11:00 A.M. On 2/5/26, from when breakfast ended at approximately 9:30 A.M. to when lunch began at approximately 11:45 A.M., the surveyor observed the activity room. The activities listed on the activity calendar did not take place. There were three residents that were provided with individual activities on the table. The rest of the residents were lined up in front of the television while cat videos were playing and several of the residents were sleeping. The Certified Nursing Assistants (CNAs) who were supervising the room throughout this time period did not engage with the residents and there was not an activity staff member present during this time. Review of the activities calendar for 2/6/26 indicated the following activities were scheduled:-Refreshments at 10:15 A.M.-[NAME] at 11:00 A.M. On 2/6/26, from when breakfast ended at approximately 9:30 A.M. to when lunch began at approximately 11:45 A.M., the surveyor observed the activity room. The activities listed on the activity calendar did not take place. There were three residents that were provided with individual activities on the table. The rest of the residents were lined up in front of the television while the Golden Girls sitcom was playing. This show played for the entirety of the time. Several of the residents were observed to be sleeping. The Certified Nursing Assistants (CNAs) who were supervising the room throughout this time period did not engage with the residents and there was not an activity staff member present during this time. Review of the activities calendar for 2/10/26 indicated the following activities were scheduled:-Refreshments at 10:15 A.M.-Animal [NAME] at 11:00 A.M. On 2/10/26, from when breakfast ended at approximately 9:30 A.M. to when lunch began at approximately 11:45 A.M., the surveyor observed the activity room. The activities listed on the activity calendar did not take place. There were three residents that were provided with individual activities on the table. The rest of the residents were lined up in front of the television while a movie played and several of the residents were sleeping. The Certified Nursing Assistants (CNAs) who were supervising the room throughout this time period did not engage with the residents and there was not an activity staff member present during this time. During an interview on 2/13/26 at 10:45 A.M., the Activity Director said she has been working at the facility for a month, and she is the only activity staff member. The Activities Director said there is an activity assistant, but she is out on medical leave, and she does not know when she will be returning to work. The Activities Director said she primarily spends her time on the North and Central Units, and the [NAME] Unit activities are supposed to be run by the CNAs when she is not on that unit. The Activity Director said she cant be everywhere at once so she typically will set up residents on the [NAME] Unit with activities but then leaves to go to the other units to run activities. The Activity Director said the [NAME] Unit has a lot of residents who have dementia and has its own activity calendar to meet the (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive needs of those residents. The Activity Director said since she is the only staff member she has not been able to spend as much time on the [NAME] Unit to learn the needs of those residents and has not trained any of the CNAs to run the activities while they are supervising the room. The Activity Director said the [NAME] Unit residents are not having their activity needs met.

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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. Based on observation, record review and interview, the facility failed to ensure that one Resident (#48) out of a total sample of 34 residents received proper treatment and assistive devices to maintain hearing abilities. Specifically, the facility failed to facilitate an audiology appointment for Resident #48 who was hard of hearing routinely and when his/her hearing aids went missing. Findings include: Review of the facility policy titled, Dental and Audiology Services, dated 3/25/25, indicated the following:-If a resident has an issue with hearing or diagnosis needing hearing aids, (the consulting audiology service) will be notified and tracked. If a hearing tool is found missing, nursing or the assistant administrator will notify (the consulting audiology service) or the appropriate physical found in the resident's record.-Residents have the right to select dentists and audiology doctors of their choice when dental care or audiology services are needed.-Social service representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental or audiology services under the state plan, if eligible.-Direct care staff will assist with inserting hearing aids as needed.-Lost or damaged dentures or hearing aids will be replaced at the resident's expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures. Resident #48 was admitted to the facility in December 2024 with a diagnosis of unspecified hearing loss, bilateral (both sides). Review of the most recent Minimum Data Set (MDS) assessment, dated 12/26/25, indicated that Resident #48 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 0 out of 15. Further review of the MDS indicated the Resident's hearing was highly impaired/had an absence of useful hearing and that hearing aides were not used in completing the assessment. On 2/5/26 at 8:36 A.M., the surveyor observed Resident #48 in his/her room, the Resident was dressed and sitting in a chair but did not have any hearing assistive devices on. Resident #48 said he/she could not hear the surveyor and that his/her hearing aides were not present. During an observation on 2/6/26 at 8:11 A.M., the surveyor observed Resident #48 in his/her room, the Resident was dressed and sitting in a chair but did not have any hearing assistive devices on. During an observation on 2/6/26 at 1:30 P.M., the surveyor observed Resident #48 in his/her room, the Resident was dressed and sitting in a chair but did not have any hearing assistive devices on. During an observation on 2/10/26 at 7:37 A.M., the surveyor observed Resident #48 walking with a staff member to a common area, the Resident did not have any hearing assistive devices on. During an observation on 2/10/26 at 10:46 A.M., the surveyor observed Resident #48 in the common area participating in activities, the Resident did not have any hearing assistive devices on. During an observation on 2/10/26 at 11:52 A.M., the surveyor observed Resident #48 leaving the common area with a staff member, the Resident did not have any hearing assistive devices on. During an observation on 2/10/26 at 2:21 P.M., the surveyor observed Resident #48 in his/her room, the Resident was dressed and sitting in a chair but did not have any hearing assistive devices on. Review of Resident #48's progress note, dated 7/2/25 and written by the Director of Nursing (DON), indicated the following: Will check to make sure he/she (Resident #48) has his/her hearing aids in his/her ears. The Resident is very hard of hearing and does not hear without the aids. Review of Resident #48's Nurse Practitioner progress note, dated 7/7/25, indicated the Resident had hearing loss and used hearing aids. Review of Resident #48's care plans indicated the Resident had hearing deficits with the following intervention:Speak to the Resident with a louder voice as he/she is HOH (hard of hearing). Review of Resident #48's Request of Service form, signed 12/11/24, indicated the Resident requested to be seen for the following services:Audiology, dental, eye care and podiatry. Review of Resident #48's physician orders indicated the following active orders:Dental consult as needed, initiated on 12/11/24.Ophthalmology consult as needed, initiated 12/11/24.Optometry consult as needed, initiated 12/11/24.Podiatry consult as needed, initiated 12/11/24.May be seen, evaluated, and treated by services for services by Audiology, as necessary (sic.), initiated 2/6/26.Further review of Resident #48's physician orders indicated the order for audiology services was initiated (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the surveyor brought concerns regarding audiology services to the facilities' attention. Review of Resident #48's physical and electronic medical record failed to indicate the Resident had ever been seen by audiology services or that the Resident had ever refused his/her hearing aids. Review of the Audiology Group Schedule with a visit date of 2/20/26 indicated Resident #48 was not scheduled to be seen by audiology services during the upcoming visit. During an interview on 2/6/26 at 10:41 A.M., Resident #48's Health Care Proxy (HCP) said she made Resident #48's medical decisions. The HCP said Resident #48 would not be able to hear people without an assistive hearing device and that she did not like the idea of Resident #48 not being able to hear as this could be isolating; the HCP said the Resident was friendly and enjoyed talking with people. The HCP said the last time she visited, around October of last year, the Resident could not hear at all. The HCP said the Resident had hearing aids when he/she was admitted to the facility but that they had gone missing at some point, that she was not notified that the hearing aids went missing and that the Resident had not been seen by audiology services while admitted to the facility. The HCP said she had bought the Resident a pocket amplifier but that the Resident had refused to use it. The HCP said her biggest concern about Resident #48's care was his/her hearing, and that she used to be able to call to speak with the Resident but now can't because he/she can't hear her. During an interview on 2/10/26 at 4:48 A.M., Resident #48 said he/she would be willing to receive and use a pair of hearing aids. During an interview on 2/6/26 at 10:55 A.M., Certified Nursing Aide (CNA) #6 said Resident #48 could not hear all the time and that the Resident did not currently have any hearing devices. CNA #6 said the Resident previously had a pocket amplifier but that the Resident had refused to wear it. During an interview on 2/10/26 at 10:46 A.M., CNA #2 said he was currently assigned to Resident #48 and that the Resident was sometimes hard of hearing. CNA #2 said the Resident did not use hearing assistive devices because the Resident did not have any. During an interview on 2/6/26 at 10:19 A.M., Nurse #6 said that when a Resident needs audiology services somebody upstairs will place the Resident on a list to be seen and that audiology services come every few months. Nurse #6 said that if a Resident lost hearing aids he would tell the Unit Manager and that the Unit Manager would follow up and notify the family. Nurse #6 said he was not sure if Resident #48 had ever been seen by audiology or if the Resident had an upcoming audiology appointment. Nurse #6 said he did not remember if Resident #48 used assistive hearing devices but that if the Resident did it would be listed in the Resident's treatment orders; after looking through Resident #48's treatment records, Nurse #6 said Resident #48 did not have a treatment order for any assistive hearing devices. Nurse #6 said Residents assistive hearing devices should be listed in the care plan and physician orders so that nurses would be aware of them. During an interview on 2/10/26 at 10:42 A.M., Nurse #7 said if a Resident's hearing aids went missing that she would look for them and if she could not find them, she would tell the Unit Manager who would reach out to the family. Nurse #7 said she was Resident #48's nurse today. Nurse #7 said the Resident was hard of hearing, but she did not know if the Resident used any assistive hearing devices. Nurse #7 checked the medication and treatment cart which did not contain Resident #48's hearing aids. During an interview on 2/6/26 at 10:29 A.M., Unit Manager #1 said the next time audiology services were coming to the building was on 2/20/26. Unit Manager #1 said if a Resident needed to be seen by audiology services that they would need a physician order and that the Unit Manager could email the audiology services if a Resident had an issue and needed to be seen, such as if the Resident had lost his/her hearing aids. Unit Manager #1 reviewed the upcoming appointments and said that Resident #48 did not have an upcoming audiology appointment and that she was not sure if the Resident used assistive hearing devices but that she would check with the DON. During an interview on 2/6/26 at 1:35 P.M., the DON said there should have been a physician order and care plan for Resident #48's assistive hearing devices. The DON said he had checked Resident #48's room and could not find hearing aids but that he did find hearing aid batteries in the Residents drawer; the DON said that the hearing aid batteries indicated the Resident used to have hearing aids. The DON said staff should have notified him when the hearing aids went missing but didn't, as they could have (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signed the Resident up to be seen by audiology on their next facility visit. During an interview on 2/10/26 at 11:59 A.M., the Operational Director said Resident #48 had never been seen by audiology services during his/her admission. During an interview on 2/10/26 at 2:13 P.M., the Social Worker said any Resident who mentions concerns, is hard of hearing and/or uses an assistive hearing device, would be seen by audiology services. The Social Worker said Resident #48 was hard of hearing and had hearing aids and that if the Resident's hearing aids had gone missing that she would have contacted audiology services. The Social Worker said she was not aware that the Resident's hearing aids had gone missing and that she would have expected staff to have notified her when the hearing aids went missing. The Social Worker said any staff member could place a request for a Resident to be seen by audiology. The Social Worker said that Resident #48 would need assistance with his/her hearing devices and that staff should help put on the Resident's assistive hearing devices in the morning and that they should look for the hearing devices each night to remove them; the Social Worker said Resident #48 did not refuse his/her hearing aids and that any refusals would be documented. The Social Worker said she would expect a physician order for the use of hearing aids. The Social Worker said there was no reason for the Resident to have not been seen by audiology services and that the Resident was not referred to audiology services but should have been. During a follow-up interview on 2/10/26 at 2:57 P.M., the DON said he was not sure why Resident #48 was not seen by audiology services but that the Resident should have been referred to audiology services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews and record review, the facility failed to maintain a safe environment for one Resident (#38) out of 34 total sampled residents. Specifically, the facility failed to ensure that Resident #38 was not left unattended in his/her room in accordance with plan of care. Findings include:Review of the facility policy titled ?Falls Policy', revised 9/15/18, indicated:-The Fall Committee may suggest several preventative measures that will be individually tailored to meet each resident's needs.-These procedures will stay in place to ensure that the resident is safe from falls until such a time that the resident can be fully evaluated by the Director of Nursing. Resident #38 was admitted to the facility in March 2025 with diagnoses including dementia and hemiplegia (one-sided paralysis). Review of the most recent Minimum Data Set (MDS) assessment, dated 1/27/26, indicated Resident #38 was rarely/never understood and a Staff Assessment for Mental Status indicated he/she had severe cognitive impairment. Review of Resident #38's plan of care related to falls, revised 2/2/26, indicated:-Focus: I am high risk for falls r/t (related to) to right side paralysis.-Intervention: Do not leave Resident unattended in the room by himself/herself. On 2/5/26 at 8:19 A.M., the surveyor observed Resident #38 in bed without any staff in his/her room or visible from the hallway. At 8:21 A.M., Nurse #1 entered the Resident's room and said she was checking on him because he should never be left alone in the room. Nurse #1 said staff must stay with him/her because he/she is a fall risk and is always trying to get out of bed. On 2/5/26 at 10:26 A.M., the surveyor observed Resident #38 in bed without any staff in his/her room or visible from the hallway. On 2/5/26 from 7:48 A.M. to 7:58 A.M., the surveyor observed Resident #38 in bed without any staff in his/her room. During this time the door to the hallway was closed. On 2/10/26 at 1:12 P.M., the surveyor observed Resident #38 in bed without any staff in his/her room. At this time the door to the hallway was closed. During an interview on 2/10/26 at 1:13 P.M., Certified Nurse Assistant (CNA) #6 said any interventions in a resident's fall care plan should always be followed. CNA #6 said he was unaware Resident #38's care plan indicated he/she should not be left unattended in his/her room, and they often leave him/her unattended there. During an interview on 2/10/26 at 1:15 P.M., Nurse #7 said any interventions in a resident's fall care plan should always be followed. Nurse #7 said she was unaware Resident #38's care plan which indicated he/she should not be left unattended in his/her room. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said any fall interventions in a resident's care plan should be implemented. The DON further said if any interventions were not appropriate, they should be clarified and/or resolved before stopping the intervention. The DON said Resident #38 should not have been left unattended in his/her room if his/her care plan indicated this was an intervention.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to identify and address a significant weight loss for one Resident (#51) out of a total sample of 34 residents. Specifically, once a weight loss was identified, the facility failed to refer the Resident to the dietitian, assess the Resident and add nutritional interventions. Findings include:Review of the facility policy titled, Weight Management, dated 3/21/25, indicated the following:-It is the policy of (the facility) that the resident and/or when appropriate, the resident or the responsible party receives details from the Registered Dietitian on modified diets specific to the resident's assessed needs and abilities. -In the event where a resident shows a significant weight loss of 3lb (pounds) or more in one week or the weight appears to be inaccurate, or 5% weight loss in one month then the resident shall be weighed again as soon as possible if the weight loss is verified common the following completed: 1) Weights are recorded monthly and taken by certified nursing assistants.2) If a resident shows a decline in weight, the weights can be monitored weekly to ensure that the care plan is updated and being followed. The unit manager will ensure that weights are being taken on time. 5) Nursing will report weight loss to the dietician within 24 hours. 6) Report weight loss to the physician during physician's next visit.7) If weight loss is verified, the Dietitian will seek the appropriate care plan adjustments to include snacks and supplements in order to curtail the weight loss.9) If the weight loss is over the CMS guidelines, then a full assessment will be required and performed by the Dietitian. Resident #51 was admitted to the facility in August 2025 with diagnoses including dementia, adult failure to thrive and schizoaffective disorder. Review of Resident #51's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she is cognitively intact. The MDS also indicated Resident #51 required setup assistance for self-feeding tasks and maximal assistance for all other activities of daily living. On 2/5/26 at 8:26 A.M., Resident #51 was observed in his/her room. He/she was not eating the breakfast provided. During an interview at this time, Resident #51 said I weighed 140 pounds and now I'm 60 pounds. I'm not eating because they are poisoning me. I know this because it was making me sick. During an interview on 2/9/26 at 8:13 A.M., Resident #51 said the cereal the facility was providing during the breakfast meal was fake and the coffee was poisoned. The Resident said the coffee cake looked good, but he/she felt he/she couldn't eat sugar. Review of Resident #51's weights indicated the following:-On 9/1/25, Resident #51 weighed 149 pounds. -On 11/7/25, Resident #51 weighed 145.6 pounds. -On 12/15/25, Resident #51 weighed 132.6 pounds, an 8.93% significant weight loss in one month and 11% significant weight loss in three months. -On 2/7/26, Resident #51 weighed 122.6 pounds, a further significant 7.54% in one month and a total of 17.72% loss in five months. Review of Resident #51's nutritional care plan, initiated on 9/2/25, indicated the following intervention:-RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed). Review of Resident #51's physician orders indicated the following order:-Controlled Carb diet. Regular texture, Regular/ Thin consistency, for Diet Chopped Meats. There were no diet orders for any additional nutritional supplements. Review of Resident #51's medical record failed to indicate the Resident was seen by the facility Dietitian since 11/24/25, prior to the documented weight loss. The medical record failed to indicate any evidence the Resident was referred to the Dietitian once the weight loss occurred. Review of the Nurse Practitioner note dated 2/5/26, indicated the following:-Weight loss Clinical Notes: Continue on encouraging oral intake supplements, (he/she) does not want any supplements. Further review of the medical record failed to indicate supplements were ever trialed, initiated or encouraged by nursing staff. During an interview on 2/11/26 at 2:16 P.M., the Nurse Practitioner said he typically looks at all residents' weights to identify possible weight loss and if weight loss is identified, he will refer the resident to the dietitian and will look at the resident's labs. The Nurse Practitioner said he was aware of Resident #51's weight loss and contributed it to (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/her not eating. The Nurse Practitioner said he told nursing to document the Resident's noncompliance with eating and to notify the family. The Nurse Practitioner did not say that he ordered additional supplements for Resident #51 or that he referred the Resident to the dietitian. During an interview on 2/12/26 at 11:29 A.M., Nurse #1 said that if a resident has had a weight loss, the resident needs to first be reweighed to verify the loss. Nurse #1 said if the weight loss is confirmed the physician is immediately notified because they may want to order a supplement and a referral is made on that date to the facility's nutritionist. Nurse #1 said the staff should also attempt to find out what foods the resident prefers and try to get that food from the kitchen. Nurse #1 said that she is aware of Resident #51's weight loss. She said that she works once a week and that it is very common for Resident #51 to refuse food, however, the Resident will eat foods he/she prefers and the staff have to go to the kitchen to get those foods. Nurse #1 said she does this on days she works but is not sure if other staff members do this. Nurse #1 said Resident #51 will eat scrambled eggs for breakfast and peanut butter and jelly for lunch if the kitchen will send it. Nurse #1 added that there are certain staff that Resident #51 trusts, so if you have one of those staff deliver what the kitchen brings he/she will eat it. During an interview on 2/12/26 at 11:00 A.M., the Registered Dietitian (RD) said she works at the facility two days a week and has only been working at the facility for about three weeks. The RD said she reviews the weight variance report when at the facility as well as looking at individual residents' weights as ways to identify those residents who have had a significant weight change. The RD said a significant weight change would be a loss of three pounds in a week or 5% in a month, 7.5% in 3 months and 10% in 6 months. The RD said that if a significant weight loss is confirmed, the RD would notify the team at the at-risk interdisciplinary team meeting, and the team would then notify the physician and the family/health care proxy. The RD said she would then assess the resident and would add nutritional interventions as appropriate. These interventions would include finding and ensuring food preferences were met, referring the resident to speech therapy, adding increased food and adding nutritional supplements. The RD said she was unaware of Resident #51's significant weight loss but said she would check the previous RD's weight report and at-risk meeting notes to see if the Resident was previously identified for the significant weight loss. During a follow-up interview on 2/12/26 at approximately 11:15 A.M., the RD provided the surveyor with the previous RD's at-risk meeting notes which indicated Resident #51 had been identified as having a significant weight loss. The RD said that although the Resident's significant weight loss had been identified, she was unaware of this, and an assessment was never completed and nutritional interventions were not added. The RD said that even though Resident #51 had a psychiatric diagnosis and was paranoid about being poisoned, there were nutritional interventions that could be trialed. During an interview on 2/12/26 at 1:36 P.M., the Director of Nursing said weights are typically obtained for residents once a month and if a significant weight loss has been identified, the nursing staff should obtain a reweight to confirm the weight loss. The Director of Nursing said once the weight loss is confirmed, the nursing staff notifies the dietitian who then immediately assesses the resident and makes recommendations for nutritional interventions. The Director of Nursing said he was aware Resident #51 had a weight loss but was unaware it was such a significant loss and contributed it to the Resident's psychological presentation. The Director of Nursing said he was also unaware nutritional interventions were not added to Resident #51's plan of care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide oxygen as ordered to two Residents (#21 and #9) out of a total sample of 34 residents. Findings include:Review of the facility policy titled, Suicidal Ideation, dated September 2021, indicated the following:-The facility maintains a zero-tolerance approach to unaddressed suicidal ideation or self-harm behaviors. All staff are responsible for recognizing warning signs and initiating immediate intervention in accordance with this policy. -Level of interventions: care plan update. 1. Resident #21 was admitted to the facility in February 2022 with diagnoses including chronic obstructive pulmonary disease (COPD), dementia and heart failure. Review of Resident #21's most recent Minimum Data Set (MDS) dated [DATE] indicated Resident had a score of 0 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she is severely cognitively impaired. The MDS also indicated Resident #21 is dependent on staff for activities of daily living. Review of Resident #21's physician orders, indicated the following order:-Oxygen 2 liters continuous via nasal cannula to keep o2 sat at or above 90%. Call MD/NP (medical doctor/nurse practitioner) if O2 (oxygen) sat (saturation) is below 90%. every shift for Hypoxemia Oxygen 2 liters continuous via nasal cannula to maintain sat at or above 90%. Call MD if sat is below 90%. Review of Resident #21's asthma and chronic lung disease care plan revised 9/19/25, indicated the following interventions:- Give nebulizer treatments and oxygen therapy as ordered. - Monitor vital signs, skin color, pulse oximetry, airway functioning and degree of restlessness which may indicate hypoxia. Review of Resident #21's COPD (chronic obstructive pulmonary disease) care plan last revised 9/19/25, indicated the following intervention:-Evaluate pulse oximetry On 2/5/26 at 8:04 A.M., Resident #21 was observed lying in bed with oxygen administered at 1 liter via a nasal cannula. On 2/6/26 at 7:34 A.M., Resident #21 was observed being brought to dining room by staff without his/her oxygen on. The portable oxygen tank was attached to the back of his/her wheelchair, however the tubing was wrapped around the tank and not placed on the Resident's nose. At 8:44 A.M., the Resident was observed with the oxygen nasal cannula on his/her nose, however the portable tank was observed to be empty. From 8:44 A.M. until 12:13 P.M., Resident #21 continued to sit with the nasal cannula on but with an empty tank. Throughout this observation time, Resident #21 was never observed attempting to take of the nasal cannula and was compliant with his/her oxygen wearing. On 2/6/26 at 12:13 P.M., the surveyor asked Nurse #13 to check Resident #21's portable oxygen tank. Nurse #13 checked the portable tank and told the surveyor it was empty. Nurse #13 said he did not know the level of oxygen Resident #21 was ordered to be receiving and had not assessed the Resident's oxygen yet today. Nurse #13 said the Certified Nursing Assistants (CNAs) are supposed to monitor the tanks throughout the day and refill them as needed. At 12:18 P.M., Nurse #9 said he should check Resident #21's oxygen level, however he did not have a working oximeter on the unit. Nurse #13 then left the Resident and the unit to obtain an oximeter on a different nursing unit. At 12:20 P.M., Nurse #13 returned to the unit, placed the oximeter on Resident#21's index finger and his/her oxygen level reading was 85%. At 12:25 P.M., the Director of Nursing entered the unit and was informed of the above observations by the surveyor. The Director of Nursing said the CNAs should be filling the portable oxygen tanks and the nurse should be checking Resident #21's oxygen level throughout the shift and ensuring the oxygen is being provided at the level ordered by the physician. At 12:32 P.M., the Director of Nursing took Resident #21's oxygen level with the oximeter again, at his/her reading at this time was 74%. At 12:33 P.M., the Director of Nursing said the level may be low because the oximeter may need a new battery and he left the unit to obtain a new battery for the oximeter. At 12:38 P.M., the Director of Nursing returned to the unit with the oximeter and again took Resident #21's oxygen level and the reading was now 80%. At this time, the Director of Nursing said oxygen levels should be above 90% unless otherwise stated by the physician. During an interview on 2/6/26 at 12:15 P.M CNA #12 said the CNAs fill portable oxygen tanks prior to (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their shift but do not check the tanks to see if they are still full because that is the responsibility of the nurse. CNA #12 said she had been in the dining room with Resident #21 during the above observation times but did not check the oxygen tank because the nurse should be checking it. During an interview on 2/6/26 at 12:39 P.M., the Director of Nursing said oxygen should always be provided to residents as ordered by the physicians. The Director of Nursing said Resident #21's portable oxygen tank should be checked throughout the day to ensure it is functioning properly and the Resident is receiving the level of oxygen needed. The Director of Nursing said a tank should never be left empty for that amount of time and both the CNAs and Nurse on the floor should be monitoring this. During an interview on 2/9/26 at 9:59 A.M., the Nurse Practitioner said Resident #21 should wear his/her oxygen at the level ordered by the physician and staff should be regularly checking the oxygen equipment to ensure it is functioning properly. 2. Resident #9 was admitted to the facility in June 2020 with diagnoses including chronic obstructive pulmonary disease (COPD), pulmonary nodule and heart failure. Review of Resident #9's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident score 0 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #9 is dependent on staff for all activities of daily living and mobility tasks. Review of Resident #9's physician order indicated the following order:-Oxygen at 2-3 L (liters) per minute. every shift for COPD Check PSO2 (oxygen saturation) each shift & as necessary and record. Review of Resident #9's care plan indicated the following interventions:- Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD (medical doctor) PRN (as needed): Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, -OXYGEN SETTINGS: I have O2 (oxygen) via nasal cannula 2L continuously. Review of Resident #9's COPD care plan last revised 11/19/25, indicated the following intervention:-give me oxygen as ordered by the physician. On 2/6/26 at 12:10 P.M. Resident #9 was observed sleeping in dining room. He/she had a portable oxygen tank attached to his/her recliner and a nasal cannula in his/her nose. The portable oxygen tank was observed to be empty. On 2/6/26 at 12:13 P.M., the surveyor asked Nurse #13 to check Resident #9's portable oxygen tank. Nurse #13 checked the portable tank and told the surveyor it was empty. Nurse #9 said he did not know the level of oxygen Resident #13 was ordered to be receiving and had not assessed the Resident's oxygen yet today. Nurse #13 said the Certified Nursing Assistants (CNAs) are supposed to monitor the tanks throughout the day and refill them as needed. At 12:18 P.M., Nurse #13 said he should check Resident #9's oxygen level, however he did not have a working oximeter on the unit. Nurse #13 then left the Resident and the unit to obtain an oximeter on a different nursing unit. At 12:21 P.M., Nurse #13 returned to the unit, placed the oximeter on Resident#9's index finger and at 12:26 P.M., 5 minutes later, Nurse #13 was able to get an oxygen reading of 74%. At 12:25 P.M., the Director of Nursing had entered the unit and was informed of the above observations by the surveyor. The Director of Nursing said the CNAs should be filling the portable oxygen tanks and the nurse should be checking Resident #9's oxygen level throughout the shift and ensuring the oxygen is being provided at the level ordered by the physician. At 12:33 P.M., the Director of Nursing said the level may be low because the oximeter may need a new battery and he left the unit to obtain a new battery for the oximeter. At 12:38 P.M., the Director of Nursing returned to the unit with the oximeter and again took Resident #9's oxygen level at 12:40 P.M., and the reading was now 80%. At this time, the Director of Nursing said oxygen levels should be above 90% unless otherwise stated by the physician. During an interview on 2/6/26 at 12:15 P.M CNA #12 said the CNAs fill portable oxygen tanks prior to their shift but do not check the tanks to see if they are still full because that is the responsibility of the nurse. CNA #12 said she had been in the dining room with Resident #9 during the above observation times but did not check the oxygen tank because the nurse should be checking it. During an interview on 2/6/26 at 12:39 P.M., the Director of Nursing said oxygen should always be provided to residents as ordered by the physicians. The Director of Nursing said Resident #9's portable oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tank should be checked throughout the day to ensure it is functioning properly and the Resident is receiving the level of oxygen needed. The Director of Nursing said a tank should never be left empty for that amount of time and both the CNAs and Nurse on the floor should be monitoring this. During an interview on 2/9/26 at 9:59 A.M., the Nurse Practitioner said Resident #9 should wear his/her oxygen at the level ordered by the physician and staff should be regularly checking the oxygen equipment to ensure it is functioning properly.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, record review, and interview, the facility failed to ensure that care and services for pain management consistent with professional standards of practice were provided for one Resident (#3) out of a total sample of 34 residents. Specifically, the facility failed to provide pain management interventions as ordered by the Nurse Practitioner for a pain consult to manage chronic pain. Findings include: Review of the facility's policy titled Pain Management, dated June 2025, indicated but was not limited to the following: -It is the policy of (the facility) to ensure that all attempts are made to keep residents as pain free as possible. We believe that, in accordance with the mission statement of the facility to preserve dignity at all stages of the life experience, the control of pain is essential to the continued dignity of life. -Attempts to control pain will be employed until the resident reaches an acceptable comfort level. -The interdisciplinary team along with the resident and/or significant family members shall collaborate to develop the plan of pain management and the ongoing reassessment of plan. Resident #3 was admitted to the facility in September 2022 with diagnoses including osteoarthritis, left shoulder pain, fatigue, and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/7/25, indicated that Resident #3 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 13 out of a possible 15. The MDS further indicated the Resident required moderate to maximum assistance for performing activities of daily living (ADLs). During an interview on 2/5/26 at 12:08 P.M., Resident #3 said he/she has pain in both shoulders that ranges anywhere from a scale of zero to ten (zero being the least and ten being the most severe pain) and limits his/her ability to lift his/her arms. Resident #3 said he/she feels his/her current pain management regimen is not working despite communicating this with the staff, and staff responded by telling him/her to take more medication. During a further interview on 2/6/26 at 7:35 A.M., Resident #3 said he/she is depressed about the pain and fed up with it because of his/her inability to use his/her arms. Review of Resident #3's pain care plan, initiated 1/12/23, indicated but was not limited to the following interventions: -Administer pain medication as per MD (physician) orders and note the effectiveness. -Give PRN (as needed) meds for breakthrough as per MD (medical doctor) orders and note the effectiveness. Review of Resident #3's physician orders indicated the following: -Schedule Pain management Consult and follow up appt (appointment) with orthopedics to address pain in multiple joints, dated 12/9/25. Review of Resident #3's medical record failed to indicate that a pain management consult was completed. During an interview on 2/9/26 at 10:13 A.M., Unit Manager #1 said when the provider orders a pain management consult, she or one of the nurses confirms the order in the Electronic Health Record (EHR) and the facility will email the pain doctor directly. Unit Manager #1 said she believes the Director of Nursing (DON) emailed the pain doctor regarding Resident #3. During an interview on 2/10/26 at 11:27 A.M., Nurse Practitioner (NP) #1 said pain management has been a big issue for Resident #3 despite increasing his/her pain medications. NP #1 said Resident #3 has pain in his/her shoulders and knees, and he/she is immobile due to uncontrolled pain. NP #1 said he feels Resident #3's pain cannot be managed alone by pain medication, leading him to make referrals to multiple specialties including pain management. NP #1 said the pain management consult is still pending, but he would have preferred for the Resident to be evaluated as soon as possible to prevent decline. During an interview on 2/10/26 at 3:03 P.M., the Director of Nursing (DON) said the pain management consult was not yet completed. The DON said there was a two-month delay in communicating the pain management consult to the pain doctor which would be considered a delay in care, as his expectation is that the consult would be completed as soon as possible. The DON provided the surveyor a copy of his email requesting a consult to the pain doctor dated 2/9/26, exactly two months after the original physician order was written by the NP. During an interview on 2/11/26 at 4:56 P.M., Resident #3's activated Health Care Proxy (HCP) #2 said he feels Resident #3's pain management regimen is not effective, his/her pain has been worsening over the last one to two years, and he/she has declined as (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evidenced by the Resident staying in bed more. HCP #2 said when he was visiting approximately one month ago, he witnessed Resident #3 unable to hold a cup of water or feed himself/herself due to the pain. HCP #2 said he was not aware of any consults in place to evaluate Resident #3's pain but would want to be updated about any changes to the Resident's plan of care.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review and interview the facility failed to ensure one Resident (#36) was provided a trauma informed plan of care out of a total sample of 34 residents. Specifically, the facility failed to ensure a trauma care plan was updated to mitigate potential triggers following Resident #36's report of sexual abuse by a peer. Findings include:The facility policy titled Trauma Informed Care, revised 6/26/25, indicated: -Trauma informed care recognizes that a person's constant interdependent needs for safety, connection and ways to manage emotions, impulses and behaviors is essential to their well-being. -We recognize five (5) guiding principles for trauma informed care. Our organization strives to reflect those 5 values in each contact, physical setting, relationship and activity in all interactions with residents, staff, families, consultants, health care providers and vendors. The 5 Guiding Principles include:Emotional and Physical Safety for all.Trustworthiness: Clear and consistent policies and the honest delivery of service.Choice: Activities offer residents choice and control. The nursing staff offer choices to residents regarding all aspects of ADLs.Collaboration: An inclusive approach including residents in the process of care planning and problem solving.Empowerment: [NAME] an environment of self-esteem and skill building where appropriate. Review of the facility's policy titled Behavior Assessment, Management and Monitoring & Trauma Informed Care, dated as revised 11/28/23, indicated the following:2. Identifying Trauma history in our residents:d) A history of sexual assaultManagement1.The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and other residents from harm.4. Action steps to prepare for Trauma Informed Care:e) Identify which staff person(s) should be notified if a resident is exposed to a traumatic event during their stay. g) Implement trauma-informed practices and policies. h) Ensure you have a behavioral health provider with training and experience in recognizing and treating trauma who can provide consultation and psychological services for residents whom a trauma history has been identified. 8. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. 10. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms.Monitoring:2. If the resident triggers due to a traumatic event, observe the following:d) Create an emotionally and physically safe environment. e) Refer for behavioral health services in order to provide an appropriate assessment and treatment by a competent professional. Resident #36 was admitted to the facility in April 2025 and has diagnoses that include anxiety disorder, paraplegia and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/2/26, indicated that on the Brief Interview for Mental Status exam Resident #36 scored a 15 out of 15, indicating intact cognition. The MDS further indicated that Resident #36 had no behaviors and is dependent on staff for care and transfers. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., Resident #36 said that there is a resident in the building that is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. Resident #36 said that one time he/she had to call the police because of it and that it is an ongoing issue that he/she has reported to the facility on multiple occasions. During a follow-up interview on 2/10/26 at 8:22 A.M., Resident #36 said the following:-He/she has an ongoing issue with another resident who he/she describes as a disgusting pervert. Resident #36 said that on October 15, 2025 he/she was seated in the hall with several other residents when the resident approached him/her and said you know you want me to **** you, you want this **** in your mouth and other vulgar things.-That at that time he/she emailed the Director of Nursing (DON) and Nursing Home Administrator (NHA) to tell them what was happening and said that if it was not stopped he/she would call the cops. Resident #36 said that shortly after sending the email he/she called the cops. Resident #36 said that later that same (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day the DON and the Operational Director (OD) came to the unit to speak with him/her. Resident #36 relayed to them what the resident had said and Resident said that the OD did not believe him/her and responded, I can't believe he/she could put that many words together in a sentence. Resident #36 said that the resident making these threats was taken by the responding police offers to the hospital but returned the next day, and the behaviors have continued since then. -Resident #36 said that he/she lives in fear the other resident will take it further and hurt me and touch me and I can't protect myself or get up and run. Review of Resident #36's care plan indicates a Trauma Care Plan, developed and last updated on 4/28/25. This care plan indicates that Resident #36 has a history or a reported history of trauma due to an accident and is a paraplegic. Review of the medical record failed to indicate the trauma sustained by Resident #36 on 10/15/25 was addressed by the facility or that the trauma care plan was updated following the sexual threats on 10/15/25 with resident specific triggers and interventions. The interventions on this care plan, all initiated 4/28/25, are:-Administer medication as prescribed.-Encourage resident to identify trauma triggers.-Encourage resident to verbalize their feelings. -Monitor effectiveness of medication and any subsequent symptoms and behaviors.-Nursing staff will report any changes in Resident #36's response in relation to his/her physiological and/or psychological response to his/her condition such as failure to eat, increased anxiety, conflict with any family member, anger, or request for increased pain medication. -Provide additional support to resident when there are loud noises: provide verbal warning prior to a fire drill, provide extra support to resident if another resident is yelling or screaming or acting aggressively. Review of the record failed to indicate the care plan was updated following the sexual abuse on 10/15/25. During an interview on 2/10/26 at approximately 12:00 P.M., Certified Nursing Assistant (CNA) #1 said that Resident #36's mood is generally stable except whenever CNA #1 is providing care to him/her, Resident #36 will hear the (accused resident) in the hallway and ask CNA #1 to stop care and make sure he/she goes away because he/she feels scared and uncomfortable. During an interview on 2/10/26 at 1:59 P.M., the Social Worker (SW) said that Resident #36 should have a trauma care plan in place that addresses how to support Resident #36. The SW said the care plan should be in place because Resident #36 has been upset with the accused resident for a long time because the resident has predatory behavior, is sexually inappropriate and wanders in and out of Resident #36's room regularly. During an interview on 2/10/2026 at 2:21 P.M., the Director of Nursing said that Resident #36's trauma care plan should have been updated to address the 10/15/25 sexual abuse incident Resident #36 experienced. During an interview on 2/11/26 at 12:02 P.M., the Nursing Home Administrator said that at the time of the sexual abuse on 10/15/25 and in the months following, safeguards should've been put in place to protect Resident #36 and that a trauma care plan should have been updated to address this traumatic event.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, record review and interview the facility failed to provide appropriate treatment and services for 1 Resident (#47) out of a total sample of 34 residents who is diagnosed with Dementia, to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Specifically, the facility failed to provide dementia interventions to adequately supervise Resident #47 when he/she was sexually inappropriate, paced the hallways and wandered in and out of peers' rooms. Findings include:Review of the facility policy titled Dementia - Clinical Protocol, dated as reviewed 6/15/25, indicated the following:1.) For the individual with confirmed dementia, the IDT (Interdisciplinary Team) will identify a resident-centered care plan to maximize remaining function and quality of life. 5.) The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. a. Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses' notes and documentation tools). b. Progressive or persistent worsening of symptoms and increased need for staff support will be reported to the IDT Review of the facility policy titled Behavioral Assessment, intervention and Monitoring, dated December 2016, indicated:1.) The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm Resident #47 was admitted to the facility in March 2025 and has diagnoses that include Dementia with other behavioral disturbance, wandering in diseases classified elsewhere and traumatic brain injury. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/19/25, indicated that on the Brief Interview for Mental Status exam Resident #47 scored a 1 of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #47 had no behaviors aside from wandering 1-3 days a week. Review of Resident #47's clinical progress notes indicated the following notes:-A 2/6/26 nursing progress note indicated Resident #47 displayed: intrusive wandering and another resident reported Resident #47 pulled down his/her sheet and was pulling down his/her pants.-A 1/26/26 nursing progress note indicated Resident #47: was very disruptive refused to follow directive, was very difficult to redirect, wandered into other resident's rooms, exits seeking. Resident remained disruptive, throughout the remaining of the shift, redirected multiple times with no change. -A 1/19/26 nursing progress note indicated Resident #47: was very disruptive refused to follow directive, was very difficult to redirect, wandered into other resident's rooms, exits seeking. Disrobing in hallways; Redirected multiple times with no change.-A 1/12/26 nursing progress note indicted Resident #47: was very disruptive refused to follow directive, was very difficult to redirect, wandered into others resident's rooms, exits seeking. Disrobing in hallways, redirected many times.-An 11/3/25 nursing progress note indicated Resident #47: was very disruptive and combative, refused to follow directive, was very difficult to redirect, wandered into other resident's rooms-A 10/15/25 progress note written by the Director of Nursing (DON) indicated: Police department, Officer (name redacted), arrived stating that someone here called the police to report strange behavior by Resident #47. According to the note the Police Officer spoke to other residents who informed them that Resident #47 was exposing him/herself to them and saying things such as you want this, do you want this inside of you. The DON further documented that the Psychiatrist was present during this episode and was informed that the male/female resident's do not feel safe in their rooms with Resident #47 wandering and being sexually disgusting as the male/female residents stated. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., a resident said that Resident #47 is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. The resident said that one time he/she called the police because of Resident #47's behavior. During an interview on 2/10/26 at 8:22 A.M., another (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident said the following: That he/she has an ongoing issue with Resident #47 who he/she describes as a disgusting pervert. The other resident reported that Resident #47 approached him/her and said, you know you want me to **** you, you want this **** in your mouth and other vulgar things. Review of Resident #47's care plan indicated the following care plans: 1.) A cognitive care plan that indicated I have impaired function/dementia or impaired thought process r/t (related to) dementia. (dated 7/10/25). Interventions included:-Administer meds as ordered (dated 7/10/25);-COMMUNICATION: use my preferred name. Identify yourself at each interaction. Face me when speaking and make eye contact. Reduce any distractions-turn off tv, radio, close door, etc .I understand, the resident understands consistent, simple directive sentences. Provide me with necessary cues - stop and return if agitated. (sic) (dated 7/10/25). 2.) A psychotropic medication care plan that indicated Resident #47 would be followed by psych services as warranted. Interventions included:-Administer medications as ordered. Monitor/document for side effects and effectiveness (dated 3/7/25);-Consult with pharmacy, MD to consider dosage reduction when clinically appropriate (dated 3/7/25);-Discuss with MD, family re ongoing need for use of medication (dated 3/7/25);-Educate me/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of (Specify: psychoactive medication drugs being given) (dated 3/7/25);-Monitor/record occurrence of for (sic) target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, and document per facility protocol. (dated 3/7/25);-Monitor/record/report to MD PRN (as needed) side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person (dated 3/7/25); 3.) A care plan I have the potential for becoming physically aggressive with other residents when I may not understand what is happening. Resident has (sic) a physically aggressive altercation with another resident (dated as revised 7/9/25). Interventions include:-Educate me concerning the problems I have with physical aggression, knowing that I have a TBI (traumatic brain injury) and dementia (dated 7/8/25);-Monitor/record occurrence of behavior and prodromal symptoms of agitation, pacing, inappropriate response to verbal communication, violence/aggression toward staff/others, and document per facility protocol (dated 7/8/25);-My medications shall be monitored in relation to any increase of aggression and the Psych NP (nurse practitioner)/NP/MD shall be notified for any order changes (dated 7/18/25);-Resident is to be closely monitored by staff to prevent recurrence of altercation of aggression (dated 7/9/25). 4.) A care plan Problematic manner in which resident acts characterized by inappropriate sexual behavior verbal and physical related to: resident makes inappropriate remarks, sexual gestures towards residents/staff, disrobing, resident touches staff inappropriately (dated as initiated 3/20/25 and revised on 2/6/26). Interventions include:-Avoid type of conversation that could encourage or initiate inappropriate behavior (dated 3/20/25);-Determine what triggered / lead up to the behavior (dated 3/20/25);-Document a summary of each episode (dated 3/20/25);-Explain and explore with resident effects of his/her behavior on other residents and staff (dated 3/20/25);-Protect other residents if unable to protect themselves (dated 3/20/25);-Remain calm and avoid angry reactions toward resident (dated 3/20/25);-Set limits for acceptable behavior (specify) (dated 3/20/25). Review of Resident #47's care plans and interventions failed to indicate that they were reviewed following his/her sexual abuse toward a peer on 10/15/25 and failed to indicate the care plan was reviewed and revised when interventions are documented as ineffective. During an interview with the Psychiatrist on 2/10/26 at 11:11 A.M., he said he manages medication in the building and that he is trying to manage Resident #47's hypersexual behavior with medication. The Psychiatrist said that Resident #47 would be a good candidate for a facility that has a specialized dementia unit to manage his/her behaviors. The Psychiatrist said that he has discussed Resident #47's need for a facility that can manage his/her behavioral needs with the DON and advised (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him that Resident needs to reside on a Dementia Specialty Care Unit (DSCU). During an interview on 2/10/26 at 1:10 P.M., Certified Nursing Assistant (CNA) #2 said Resident #47 has regular behavior of undressing in the common areas and wandering in and out of resident rooms which upsets residents. CNA #2 said that when Resident #47 is exhibiting these behaviors he/she is usually able to be redirected but shortly after goes back to the same behavior. CNA #2 is not aware of any other intervention to use other than redirection.During an interview on 2/10/26 at 1:23 P.M., CNA #3 said that Resident #47 wanders all the time, in and out of other resident's rooms and that many of them get upset. CNA #3 said that one time a resident called the police because Resident #47 was saying sexual things to him/her, but CNA #3 cannot remember the details of what occurred. CNA #3 said that Resident #47's response to redirection varies and that sometimes he/she will accept the redirection and other times he/she becomes combative and agitated. CNA #3 is not aware of any other intervention to use other than redirection During an interview on 2/10/26 at 2:06 P.M., the facility Social Worker (SW) said that Resident #47 is not appropriate this facility and should reside on a Dementia Specialty Care Unit (DSCU). The SW said that she applied to a facility that has a DSCU for Resident #47, but that he/she was placed on a wait list a few months ago, but that she has not followed up recently to get on update on the waitlist status and has not looked into other options. The SW said that in order to maintain the safety of the residents in the facility Resident #47 should have 1:1 supervision by staff daily, but that is not possible at this facility. The SW said that Resident #47 poses as a threat to the other residents because he/she is unpredictable and is a sexual predator and that many of the residents in the facility cannot physically protect themselves, including the resident he sexually threatened in October 2025. During an interview on 2/10/26 at 2:21 P.M., the DON said that Resident #47 is not appropriate for this facility and belongs in a facility that can manage his/her dementia and behavioral needs. The DON said that he has discussed this with the Psychiatrist but defers to the SW for what is being done to address this need.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide social services to attain the highest practicable mental and psychological well-being for one Resident (#36), out of a total sample of 34 residents. Specifically, for Resident #36, the facility failed to follow up after Resident #36 was sexually threatened by another resident to ensure effective interventions were implemented to prevent additional incidents of sexual abuse, resulting in Resident #36 living in fear and experiencing repeated abuse by this peer. Findings include: Review of the facility's policy titled Resident Rights at Pine [NAME] Nursing Center, dated as reviewed 6/15/25, indicated the following:1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the following resident's right to:b. be treated with respect, kindness and dignity;c. be free from abuse, neglect, misappropriation of property and exploitation.5. Inquiries concerning residents' rights should be referred to the Social Service Director or Administrator. Review of the facility's Social Service Job description indicated . Resident #36 was admitted to the facility in April 2025 and has diagnoses that include anxiety disorder, paraplegia and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/2/26, indicated that on the Brief Interview for Mental Status exam Resident #36 scored a 15 out of 15, which indicated he/she had intact cognition. The MDS further indicated that Resident #36 had no behaviors and is dependent on staff for self-care and transfers. During the Resident Group Meeting with the Surveyors on 2/6/26 at 10:30 A.M., Resident #36 said that there is a resident in the building that is a pervert, he/she walks up to him/her and says nasty things and has even pulled his/her genitals out. Resident #36 said that this is an ongoing issue that he/she has reported to the facility on multiple occasions. During a follow-up interview on 2/10/26 at 8:22 A.M., Resident #36 said the following:-That he/she has an ongoing issue with another resident who he/she describes as a disgusting pervert. Resident #36 said that on October 15, 2025 he/she was seated in the hall with several other residents when the resident approached him/her and said you know you want me to **** you, you want this **** in your mouth and other vulgar things.-That at that time he/she emailed the Director of Nursing (DON) and Nursing Home Administrator (NHA) to tell them what was happening and said that if it was not stopped he/she would call the cops. Resident #36 said that shortly after sending the email he/she called the cops. Resident #36 said that later that same day the DON and the Operational Director (OD) came to the unit to speak with him/her. Resident #36 relayed to them what the resident had said and Resident said that the OD did not believe him/her and responded, I can't believe he/she could put that many words together in a sentence. Resident #36 said that the resident making these threats was taken by the responding police offers to the hospital but returned the next day, and the behaviors have continued since then. -Resident #36 said that he/she lives in fear the other resident will take it further and hurt me and touch me and I can't protect myself or get up and run. --Resident #36 said that the facility Social Worker (SW), has never followed up with him/her about the situation or offered any emotional support. Resident #36 said that the SW does not try to help, and that she doesn't ask how I feel or try to support me. Resident #36 provided the surveyor with emails from January 2026 between him/herself and the Nursing Home Administrator (NHA), Director of Nursing (DON) and the Social Worker (SW). The emails included:1. Email #1, dated 1/18/26, from Resident #36 to the NHA, DON and SW: (the resident) and (another resident): THESE TWO NEED TO BE REMOVED FROM THIS AREA. They are out of control. You have (the resident) constantly speaking nasty to you. I had to call the cops on him one night because he/she was so bad. Neither one of them should be allowed down in our area. You have the Nurse and Certified Nursing Assistants (CNAs) take them away a couple of times but then they just let them go and ignore them because they are tired of dealing with them. Then you have days when the two of them are hanging in the hallway dancing around naked. 2. Email #2, dated 1/20/26, from the facility (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW to Resident #36, the DON and NHA: We try to redirect the wanderers that are in and out of rooms and dressed inappropriately on a daily basis. It takes redirection and reattempting to address the concerns throughout the day. They have rights too, however, we will try to do better with supervising them, especially when they are roaming the hallways. It is hard to make everyone happy, but we are trying to address many of these concerns so that everyone feels safe and comfortable in their home. Resident #36 said that although the SW responded by email on 1/20/26, the SW never came to speak with him/her regarding the concerns he/she had reported in the 10/15/25 or 1/18/26 emails. Review of the medical record failed to indicate the abuse sustained by Resident #36 was addressed by the facility SW. Review of Resident #36's care plan fails to indicate any resolved or current care plans regarding the incident on 10/15/25 or the report made on 1/18/26. There is an unrelated psychosocial care plan in place, that was last reviewed and revised in April 2025 which indicated: Focus: psycho-social well-being: (Resident #36) is at risk for an alteration in psychological well-being due to self-isolation, adjustment to a nursing home environment, progression of disease process, depression. cognitive decline/ deficit, mobility decline/ deficit, relocation (revised 4/25/25). Interventions:-Encourage loved ones to keep in contact. (4/25/25)-Encourage self-control and problem-solving skills including; imitating new behavior, awareness of behavior, directing/ redirecting energies into stress-reducing activities and behaviors. (4/25/25)-Explain procedures before beginning them (4/25/25)-Observe and report any changes in mental status (4/25/25) During an interview on 2/10/26 at 11:17 A.M., the Psychiatrist said that he would expect Resident #36 to receive support from the facility SW to address his/her feelings regarding the abuse. During an interview on 2/10/26 at 1:59 P.M., the SW said that Resident #36 has been upset with the accused resident for a long time because the resident has predatory behavior, is sexually inappropriate and wanders in and out of Resident #36's room regularly. The SW said that she was never informed about the incident on 10/15/25 or that Resident #36 called the police because of the abuse. The SW said that communication is lacking in the building and therefore she does not always find out about things like this but should. The SW said that she did respond to Resident #36's 1/18/26 email, by email on 1/20/26 because she was out of the building but did not follow-up in person. The SW said that she does not personally provide talk therapy to residents in the facility and that the facility's psychotherapist left in December of 2024 and has not been replaced. The SW said that her role is not to develop non-pharmacological interventions to support residents in the building, her role is to call family or loved ones if someone is behavioral. She said that she should check in with a resident who is impacted by another resident's behaviors but that she has not done so for Resident #36. The SW said that she thinks that the psychological effect of someone repeatedly wandering in their room could cause distress and anxiety. She added thinks that the facility needs more support to adequately manage the behaviors and support of residents in the facility. Review of the record indicates that following this interview with the SW, on 2/11/26 the SW added a late entry note that she met with Resident #36 on 1/20/26, contrary to her interview. During an interview on 2/10/26 at 2:21 P.M., the DON said that it is his expectation that the facility SW utilize non-pharmacological interventions to support Resident #36 since the initial allegation of sexual abuse on 10/15/25 and that this support should be documented in progress notes in the medical record. During an interview on 2/11/26 at 12:02 P.M., the NHA said that at the time of the sexual abuse on 10/15/25 and in the months following, safeguards should've been put in place to protect Resident #36 and that this would involve the SW verbally advocating for the Resident and meet with Resident #36 to talk about his/her feelings and to support him/her. During an interview on 2/12/26 at at12:55 P.M., the Medical Director said that it is his expectation that the SW be available to provide support to residents who are distressed, in fear or who have been sexually threatened such as Resident #36.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to address and implement licensed Pharmacist recommendations in a timely manner for one Resident (#3) out of a total sample of 34 residents. Specifically, the facility failed to ensure the Consultant Pharmacist's recommendation from December 2025 to separate eye drops by at least five minutes during administration was reviewed and responded to in a timely manner. Findings include: Review of the facility's policy titled Medication Therapy, revised September 2025, indicated but was not limited to the following: -Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the Consultant Pharmacist) will review an individual's current medication regimen, to identify whether: -The frequency of administration and duration of use are appropriate. -Periodically, and when circumstances are present that represent a greater risk for medication-related complications, the staff and practitioner will review the medication regimen for continued indications, proper dosage and duration, and possible adverse consequences. -The Medical Director and Consultant Pharmacist shall collaborate to address issues of medication prescribing and monitoring with the practitioners and staff. Resident #3 was admitted to the facility in September 2022 with diagnoses including glaucoma, dementia, and bipolar disorder. Review of the physician orders indicated Resident #3 was prescribed the following eye drop medications: -Latanoprost 0.005% Ophthalmic Solution, Instill 1 drop in both eyes in the evening for Glaucoma, start date 8/4/23 -Artificial Tears Ophthalmic Solution 1%, Instill 1 drop in both eyes three times a day for dried (sic) eye, start date 3/6/24 Review of the Consultant Pharmacist's Medication Regimen Review (MRR) indicated the following repeated recommendations: -12/10/25: Resident is ordered multiple different eye drops. Please make sure eye drops are separated by at least 5 MINUTES during administration [sic]. -2/4/26: Resident is ordered multiple different eye drops. Please make sure eye drops are separated by at least 5 MINUTES during administration [sic]. Review of Resident #3's clinical record failed to indicate the Consultant Pharmacist's recommendation dated 12/10/25 was reviewed and/or responded to by the Provider. During an interview on 2/10/26 at 3:03 P.M., the Director of Nursing (DON) said the Consultant Pharmacist conducts the MRRs and sends him a report of recommendations which he keeps in his office. The DON said he will give the reports to the Provider who will either agree or disagree with the recommendations and sign the report form, and nursing will then input the orders into the Electronic Health Record (EHR). The DON said once the orders are written in the EHR, he will shred the signed paper report and does not upload it to the EHR. The DON said typically the Provider agrees with the Consultant Pharmacist's recommendations and a two-month delay in implementing recommendations would be considered a delay in care.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure four Residents (#13, #8, #33, and #3) were free from unnecessary psychotropic medications out of a total sample of 34 residents. Specifically, 1. For Resident #13, the facility failed to follow the recommendation from the psychiatrist to lower the dose of the Resident's antipsychotic. 2. For Residents #8, #33 and #3, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale) assessment to determine possible adverse reactions to antipsychotic medications. Findings include: Review of the facility policy titled, Antipsychotic/Psychotropic Medication Use, dated 4/11/25, indicated the following: -Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. -residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 1. Resident #13 was admitted to the facility in May 2023 with diagnoses including anxiety, dementia with psychotic disorder, unspecified psychosis, major depression, generalized anxiety, and restlessness and agitation. Review of Resident #13's most recent Minimum Data Set, dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #13 required substantial assistance from staff for self-care and mobility tasks. Resident #13 was unable to participate in an interview during survey. In addition, the Resident's health care proxy was called and was not able to be reached. Review of the psychiatrist note dated 10/27/25 indicated the following: -Rec (recommend): decrease Seroquel (an antipsychotic medication) to 12.5 mg (milligrams) q (every) 1pm + 75 mg hs (every night). d/c (discontinue) a.m. (morning) dose. -At the bottom of the recommendation, nursing had noted the recommendation as reviewed. Review of Resident #13's medical record failed to indicate the nursing staff notified the Resident's physician of this recommendation or that the recommendation was put into effect. Review of Resident #13's physician orders indicated the following orders: -Seroquel Oral Tablet 25 MG (Quetiapine Fumarate).Give 3 tablet orally at bedtime for Unspecified psychosisAND Give 1 tablet orally in the afternoon for Unspecified Psychosis, initiated 7/25/24. -Seroquel Oral Tablet 25 MG (Quetiapine Fumarate). Give 12.5 mg by mouth one time a day for enspecific psychosis in am. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/2026 at 8:08 A.M., Nurse #10 said the facility has a psychiatrist that comes to the facility weekly and makes recommendations for psychotropic medications. Nurse #10 said the psychiatrist writes down the recommendations on his paper note, flags the recommendation in the chart (raises it higher than other papers for nurse to see) and then the nursing staff is responsible for notifying the physician or nurse practitioner of the recommendation. Nurse #10 said the Director of Nursing also receives the recommendation and he ensures the recommendation is followed. Nurse #10 reviewed the recommendation made for Resident #13 and then reviewed the Resident's current orders. Nurse #10 said Resident #13's antipsychotic dose was never lowered as recommended and the Resident is still taking the morning dose of Seroquel. During an interview on 2/9/26 at 2:35 P.M., the Director of Nursing said he was unaware of the recommendation from the psychiatrist to discontinue Resident #13's morning dose of Seroquel. The Director of Nursing reviewed the recommendation with the surveyor and confirmed that nursing had noted the recommendation as reviewed and said he did not know why the nursing staff did not adjust the Resident's orders to reflect the recommendation by the psychiatrist. During an interview on 2/10/26 at 9:40 A.M., the Unit Manager said the psychiatrist comes the facility one to two times a week and makes recommendations for psychotropic medications. The Unit Manager said all recommendations are then told to the physician by the nursing staff and she is unaware of an instance where the physician has disagreed or refused the recommendation. The Unit Manager said she was unaware of the recommendation to lower Resident #13's Seroquel and was unaware the recommendation was never put into effect. During an interview on 2/10/26 at 11:03 A.M., the Psychiatrist said when he makes recommendations for changes to psychotropic medications, he will flag the recommendation in the chart and also explains the recommendation verbally to the nursing staff. The Psychiatrist said it is rare that the physician would disagree with his recommendations and he has never been notified by anyone at this facility that one of his recommendations was refused. The Psychiatrist said he was unaware Resident #13's dose of Seroquel was never lowered. During a phone interview on 2/10/26 at 1:30 P.M., the Nurse Practitioner said he remembered the Psychiatrist's recommendation to lower Resident #13's Seroquel and that he was in agreement with the recommendation. The Nurse Practitioner said he was unaware that the recommendation was never put into effect and that the Resident's Seroquel dose never lowered. 2a. Resident #8 was admitted to the facility in June 2020 with diagnoses including schizophrenia, unspecified mood disorder, and anxiety disorder. Review of Resident #8's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status score of 15 out of a possible 15, which indicated he/she had intact cognition. The MDS also indicated Resident #8 required assistance from staff for self-care and mobility tasks. Review of Resident #8's physician orders included the following order: -Ziprasidone (an antipsychotic mediation) 80 MG (milligrams) cap (capsule). Give 1 capsule orally two times a day for psychosis related to unspecified psychosis not due to a substance or known physiological condition with breakfast and dinner. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's medical record failed to indicate the facility had completed an AIMS assessment since 7/4/25, when the psychiatrist indicated no AIMS symptoms in a note dated that day. During an interview on 2/9/2026 at 8:08 A.M., Nurse #10 said she does not know what the AIMS assessment is or how often the AIMS assessment is required to be completed. During an interview on 2/10/26 at 10:36 A.M., the Director of Nursing said AIMS assessments should be completed upon admission and quarterly. The Director of Nursing said the AIMS should be completed so staff have a baseline of how the resident presents while taking an antipsychotic medication. The Director of Nursing said there is never a reason for the AIMS assessment to not be done. The Director of Nursing said he would expect the social worker to complete the assessment, but it is an interdisciplinary task and nursing can also complete the assessment. The Director of Nursing said Resident #33 should have had and AIMS completed at admission and he was unaware the assessment had not been completed. During an interview on 2/10/26 at 11:03 A.M., the Psychiatrist said he does not complete a formal AIMS assessment but does indicate in his notes if a resident is having involuntary movements/adverse reactions to medications. During an interview on 2/10/26 at 1:44 P.M., the Social Worker said she has no involvement with completing AIMS assessments at the facility and does not know who completes the assessment. 2b. Resident #33 was admitted to the facility in December 2025 with diagnoses including schizoaffective disorder bipolar type and schizophrenia. Review of Resident #33's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 14 out of a possible 15 on the Brief Interview for Mental Status which indicated he/she was cognitively intact. The MDS also indicated Resident #33 required substantial assistance from staff with activities of daily living. Review of Resident #33's physician orders included the following order: -Clozapine (an antipsychotic medication) Oral Tablet 100 MG (milligrams). Give 300 mg orally at bedtime for Antipsychotic Behavior. Review of Resident #33's psychotropic medication care plan indicated the following intervention: -Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of Resident #33's medical record failed to indicate an AIMS assessment was completed upon admission. During an interview on 2/9/2026 at 8:08 A.M., Nurse #10 said she does not know what the AIMS assessment is or how often the AIMS assessment is required to be completed. During an interview on 2/10/26 at 10:36 A.M., the Director of Nursing said AIMS assessments should be completed upon admission and quarterly. The Director of Nursing said the AIMS should be completed upon admission, so staff have a baseline of how the resident presents while taking an (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antipsychotic medication. The Director of Nursing said there is never a reason for the AIMS assessment to not be done. The Director of Nursing said he would expect the social worker to complete the assessment, but it is an interdisciplinary task and nursing can also complete the assessment. The Director of Nursing said he was unaware Resident #8 did not have a recent AIMS completed. During an interview on 2/10/26 at 11:03 A.M., the Psychiatrist said he does not complete a formal AIMS assessment but does indicate in his notes if a resident is having involuntary movements/adverse reactions to medications. During an interview on 2/10/26 at 1:44 P.M., the Social Worker said she has no involvement with completing AIMS assessments at the facility and does not know who completes the assessment. 2c. Resident #3 was admitted to the facility in September 2022 with diagnoses including dementia, bipolar disorder, unspecified psychosis, anxiety, and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/7/25, indicated that Resident #3 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 13 out of a possible 15. The MDS further indicated the Resident required moderate to maximum assistance for performing activities of daily living (ADLs). Review of Resident #3's Physician Orders included the following: -Risperidone (an antipsychotic medication) 0.5 mg (milligram) tablet. Give 1 tablet orally one time a day for bipolar disorder, initiated 8/4/23. -Risperidone 2 mg tablet. Give 1 tablet orally in the evening for bipolar disorder, initiated 2/24/24. Review of Resident #3's psychotropic medication care plan, initiated 2/20/25, indicated but was not limited to the following interventions: -Administer medications as ordered. Monitor/document for side effects and effectiveness. -Monitor/record/report to MD (medical doctor) PRN (as needed) side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (extrapyramidal symptoms) (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Review of Resident #3's medical record failed to indicate the facility had completed an AIMS assessment since 4/16/24. During an interview on 2/9/26 at 10:13 A.M., Unit Manager #1 said she is unsure who completes the AIMS assessments, but they should be done upon admission and every six months. During an interview on 2/10/26 at 1:44 P.M., the Social Worker said she has no involvement with completing AIMS assessments at the facility and does not know who completes the assessment.^ During an interview on 2/10/26 at 3:03 P.M., the Director of Nursing (DON) said his understanding is (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the AIMS is completed by social services but can be done by any competent licensed staff. The DON said the purpose of the AIMS assessment is to monitor residents on antipsychotics for adverse side effects and the AIMS for Resident #3 should have been completed. ^

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to provide dental services and replace missing dentures for one Resident (#18) out of a total sample of 34 residents. Findings include:Review of the facility policy titled, Dental Services at (the facility), undated, indicated the following:-Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. -Routine and 24-hour emergency dental services are provided to our residents through a. A contract agreement with the licensed dentist that comes to the facility monthly, b. Referral to the resident's personal dentist, c. Referral to community dentists; or d. Referral to other healthcare organizations that provide dental services.-Residents have the right to select dentists of their choice when dental care or services are needed.-Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible.-Direct care staff will assist residents with denture care, including removing, cleaning and storing dentures.-Dentures will be protected from loss or damage, to the extent practicable, while being stored.-Lost or damaged dentures will be replaced at the residence expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures.-If dentures are damaged or lost, residents will be referred for dental services within three days. If the referral is not made within three days, documentation will be provided regarding what is being done to ensure the resident is able to drink and eat adequately while awaiting the dental services; and the reason for the delay.-All dental services provided are recorded in the resident's medical record. Resident #18 was admitted to the facility in October 2022 with diagnoses including unspecified dementia, mood disturbance, anxiety and major depression. Review of Resident #18's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status score of 1 out of a possible 15, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #18 is dependent on staff for activities of daily living and requires supervision for mobility tasks. During an interview on 2/9/26 at 1:27 P.M., Resident #18's daughter and health care proxy said the Resident's dentures went missing about a year ago. Resident #18's daughter said nursing staff have told her they are kept in the treatment cart but she has not seen the Resident wearing the dentures in a very long time. Resident #18's daughter says she believes the Resident has lost weight and this could possibly be due to not wearing his/her dentures. Resident #18 was unable to participate in an interview during the survey period due to his/her cognitive status. Throughout all days of survey, Resident #18 was observed in the dining room for breakfast and lunch meals and did not have dentures in place. Review of an email provided by Resident #18's daughter and dated 3/11/25, indicated the Resident's daughter emailed the facility social worker regarding the missing dentures and the social worker replied Staff have tried to locate the missing bottom dentures and cannot find them. We put in a request for (Resident #18) to be seen by the dentist. Sorry about the inconvenience. Review of Resident #18's physician orders indicated the following order initiated 10/26/23:-Dental consult as needed. Review of Resident #18's medical record indicated a consent form for dental services, undated, and signed by Resident #18's daughter/health care proxy requesting dental services. The medical record failed to indicate Resident #18 was ever seen by the dentist or dental hygienist. Review of Resident #18's alteration in self-care care plan, revised 8/1/25 indicated the following intervention:-Oral hygiene and brushing 3xday. I have dentures I wash them daily please ensure that clean and wash in my mouth. During an interview on 2/10/26 at 9:46 A.M., the Unit Manager said she was unaware if Resident #18 had dentures. At the time of the interview, the Unit Manager and surveyor looked both in Resident #18's bedroom and the treatment cart for the Resident's dentures. Inside the treatment cart was a container labeled with the Resident's name containing a pair of lower dentures. The Unit Manager again said she was completely unaware (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #18 had dentures and that the Resident should be wearing the dentures if he/she had them. The Unit Manager was unable to find the Resident's top dentures. At this time, the Unit Manager called Resident #18's sister on the phone who said Resident #18 had a full set of dentures at the facility at one time and they had been lost for some time. The Unit Manager said that all residents who request to see the dentist are typically seen, whether they wear dentures or not. The Unit Manager did not know why Resident #18 had not been seen by the dentist. During an interview on 2/10/26 at 10:17 A.M., Certified Nursing Assistant (CNA) #10 said she provided care to Resident #18 that morning. CNA #10 said she was unaware if the Resident had dentures and that she does not assist residents with placing dentures in. During an interview on 2/10/26 at 1:44 P.M., the Social Worker said she was unaware Resident #18 had dentures and did not recall the email sent to the Resident's daughter regarding the lost dentures and the need for a dental appointment. The Social Worker said if the Resident consented to be seen by the dentist, he/she should have been seen. The Social Worker was unaware that Resident #18 had not been seen by the dentist. During interviews on 2/10/26 at 10:36 A.M., and 2:00 P.M., the Director of Nursing said he was unaware Resident #18's dentures had gone missing and he was made aware of this today. The Director of Nursing said the facility could only locate the Resident's lower dentures and the upper dentures could not be found. The Director of Nursing said that every resident who has consented to be seen by the dentist should be seen at least yearly and was unaware Resident #18 has not been seen by the dentist while at the facility.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, document review, and policy review, the facility failed to develop, implement, and maintain a Quality Assurance and Performance Improvement (QAPI) program which addressed the full range of care and services, was comprehensive and data-driven, and focused on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility failed to use a systematic approach to determine underlying causes of problems impacting larger systems, develop corrective actions, and monitor effectiveness of its performance improvement activities to ensure improvements are sustained. Findings include: Review of the facility policy titled, Quality Assurance Performance Improvement, dated 12/18/25, indicated the following:-The aim of this Quality Assurance Performance Improvement Policy is to affirm (the facility's) commitment to maintain a high standard of quality in the way we work, the services we deliver, our relationships with staff and consultants and ensure continuous improvement. -(The Facility's) Policy is to maintain an effective and efficient quality assurance process planned and developed in conjunction with all management and staff functions and consultants which is designed to eliminate deficiencies and inaccuracies and to ensure high quality standards. The assurance of quality is fundamental for work undertaken by (the facility) and should be implemented by all staff in their work to that effect (the facility) shall:- Maintain consistency and work method throughout in accordance with set policies, procedures, regulations and codes of practice and without significant deviation.-Ensure that all policies, procedures, relevant regulations and codes of practice are implemented and systematically reviewed to reflect (the facility's) values.-Regularly monitor and measure the quality of its work methods, outputs and outcomes with a view to ensuring high quality standards, best value and continuous improvement. Five elements of QAPI:The design and scope: AQ API program will address clinical care, quality of life, resident choice and care transitions, utilizing the best available evidence to define and measure goals.Governance and leadershipFeedback, Data and Monitoring: gather information from residents, staff, families and visitors to provide information feedback on issues and changes at (the facility). The information should be used to clarify issues or problems which will prevent a reoccurrence of a problem.Performance improvement projects: (the facility) will conduct performance improvement projects on a particular problem, using a root cause analysis to perform upgrades and improvements for the residents of (the facility).System analysis: (the facility) uses a systematic approach to determine when in depth analysis is needed to fully understand a problem, it's cause and the implication of making a change. -The administrator shall oversee the committee, prepare periodic weekly sub QA minutes and notes, prepare the team for the quarterly QA meeting and provide policy changes and feedback to ensure (sic) During the recertification survey, the survey team found systemic concerns in the following care areas:- Rehabilitation Services-Contracture Management-Abuse reporting, investigation and prevention Review of the facility's QAPI plan failed to indicate a QAPI was developed for any of the above areas. During an interview on 2/13/26 at 9:35 A.M., the Administrator said he was responsible for overseeing the QAPI program in the facility. The Administrator said the facility used to meet quarterly for QAPI but has recently been meeting monthly. The Administrator provided documentation to the surveyor of the ongoing QAPI program and the facility's recent QAPI projects. The Administrator said recent projects have included environmental improvements and dietary menu accuracy. When asked what clinical areas QAPI has recently worked on, the Administrator could not name any. The Administrator said QAPI projects should be triggered by any adverse events in the facility and although there had been several events related to contracture management, rehabilitation services, and abuse allegations, the facility did not complete a QAPI program on any of these clinical areas even though they were aware these were concerns. The Administrator said he would have expected the Director of Nursing to bring any clinical issues to the QAPI meeting and he has not. The Administrator said the (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management teams discuss clinical issues during the QAPI meetings, but they do not formally write up QAPI projects on these concerns. During an interview on 2/13/26 at 10:30 A.M., the Director of Nursing said he typically identifies issues for QAPI by talking to the nursing staff. The Director of Nursing said he is the one responsible for the clinical part of QAPI and that QAPI projects were not developed for contracture management and rehabilitation services. The Director of Nursing said that looking back now, he feels these would have been two helpful projects because he had recognized there were concerns when there wasn't therapy staff available for necessary treatments earlier last fall.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on one unit (North Unit), out of three units and for two Residents (#74 and #6) residing on North Unit.Specifically, the facility failed to implement Enhanced Barrier Precautions (EBP) when providing care:1. For Resident #74, the facility staff failed to wear the appropriate Personal Protective Equipment (PPE) when providing direct care for the Resident on EBP who had a gastrostomy tube (a medical device inserted through the abdominal wall directly into the stomach to deliver nutrition).2. For Resident #6, the facility staff failed to maintain EBP by bringing the entire treatment cart into the room, where the patient had a pressure ulcer and perform hand hygiene. Findings include:Review of the facility policy titled Enhanced Barrier Precaution, dated 8/2022, indicated the following:-Post clear signage on the door or wall outside of the resident room indicating the type of precaution and required personal protective equipment (PPE) example gown and gloves. For enhanced barrier precautions, signage should also clearly indicate the high contact resident care activities that require the use of gown and gloves. 1.Resident #74 was admitted to the facility in January 2026 with diagnoses including dysphagia and gastrostomy tube. Review of Resident #74's physician orders indicate the following:-Enteral feed order every shift.-Enteral feed order every day shift complete tube site care every day. On 2/5/26 at 9:06 A.M., the surveyor observed the following from the doorway of Resident #74's room, located on North Unit:-An EBP sign posted at the entrance of the Resident's doorway to the room.-A three drawer PPE bin with the necessary PPE required located in the hallway directly outside of the Resident's room. On 2/5/26 at 9:06 A.M., the surveyor observed Certified Nursing Assistant (CNA) #4 provide morning care to Resident #74. CNA #4 was not wearing a gown. On 2/6/26 at 9:02 A.M., the surveyor observed CNA #4 providing morning care to Resident #74. CNA #4 was not wearing a gown. During an interview on 2/6/26 at 9:48 A.M., CNA #4 said the Resident was not on any precautions. Upon being asked why the EBP signage and the PPE bin by the Resident's door, CNA #4 said it belonged to a previous resident. He further said if Resident #74 was on precautions, the nurses would have given him report about it. During an interview on 2/6/26 at 9:56 A.M., Nurse #4 said she did not tell the CNA that Resident #74 was on EBP due to the G-tube. She further said all residents who have wounds and medical devices should be on EBP and PPE should be worn. Nurse #4 said CNA #4 should have worn PPE when providing care to Resident #74. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing said EBP should be followed for residents that have medical devices. 2. Resident #6 was admitted to the facility in May 2020 with diagnoses including dementia and pressure ulcer. Review of Resident #6's physician orders dated 2/11/26 indicated the following:-Stage 4 pressure wound right heel, full thickness. Cleanse with normal saline, apply hydrogel with silver, then apply xeroform gauze, cover with ABD (abdominal) pad, wrap with kerlix gauze and cover with retention tape daily and as needed if soiled, saturated or dislodged x 24 days. On 2/6/26 at 1:21 P.M., the surveyor observed Nurse #4 bring an entire treatment cart into Resident #6's room to perform wound dressing change to the Resident's right heel. During the observation Nurse #4 was observed on multiple occasions removing soiled gloves and not performing hand hygiene before donning (wearing) new gloves. During an interview on 2/6/26 at 1:41 P.M., Nurse #4 said Resident #6 was on EBP and she should not have had the entire treatment cart in the Resident's room. She further said she should have been sanitizing her hands between glove changes. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing said EBP should be followed for residents that have medical devices or wounds. He further said nurses are expected to perform hand hygiene when changing gloves.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility provided the COVID-19 vaccination without consent from the resident or resident health care proxy for one Resident (#18) out of a total sample of 34 residents. Findings include:Review of the facility policy titled, Infection Control - Environmental Services, dated revised in 10/26/25, indicated the following:-The resident, resident representative, or staff member has the opportunity to accept or refuse the COVID-19 vaccine.-Residents and their representatives have the right to refuse the COVID-19 vaccine in accordance with the Resident Rights requirements at 42 CFR 483.10(c)(6) and tag 578. Additionally, the regulation states The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility and exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Therefore, facilities cannot take any adverse action against a resident or representative who refuses the vaccine, including social isolation, denied visitation and involuntary discharge. Review of the facility policy titled, Resident Rights at (the facility), dated 6/15/25, indicated:-Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to e. self-determination and p. be informed of, and participate in, his or her care planning and treatment. Resident #18 was admitted to the facility in October 2022 with diagnoses including unspecified dementia, mood disturbance, anxiety and major depression. Review of Resident #18's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status score of 1 out of a possible 15, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #18 is dependent on staff for activities of daily living and requires supervision for mobility tasks. Resident #18 was not able to participate in an interview during the survey period due to his/her cognitive status. During an interview on 2/9/26 at 1:27 P.M., Resident #18's daughter and health care proxy said the facility administered the COVID-19 vaccination with her consent. Resident #18's daughter said she told the facility she did not want Resident #18 to receive the vaccination and the Resident would not have agreed to the vaccination if cognitively able to. Review of Resident #18's medical record indicated an email the Resident's daughter sent to the social worker on 10/2/24 which indicated I do not want (Resident #18) getting this vaccine in response to an email asking for consent for the COVID-19 vaccination. Review of Resident #18's physician orders indicated the following orders:-Activate Health Care Proxy, retroactive to admission date, initiated 4/28/25. - Comirnaty Intramuscular Suspension Prefilled Syringe 30 MCG/0.3ML (Microgram/milliliter). Inject 1 dose intramuscularly one time only for covid prevention for 3 Days, initiated 10/31/25. Review of the November 2025 Medication Administration Record (MAR) indicated nursing documented 9 on the date of 11/1/25 under the documentation for the above order for the COVID-19 vaccination. The bottom of the MAR indicated 9 and to check the nursing note for that day. Review of the nursing note dated 11/1/25 indicated the following:-Comirnaty Intramuscular Suspension Prefilled Syringe 30 MCG/0.3ML (Microgram/milliliter). Inject 1 dose intramuscularly one time only for covid prevention for 3 Days. Administered. During an interview on 2/10/26 at 10:36 A.M., the Director of Nursing said vaccinations are given by the licensed nurses once consent is given. The Director of Nursing said consents for vaccinations are obtained at the time of admission or prior to the administration of the vaccination. The Director of Nursing said if a resident refuses the vaccination, the facility will document the refusal and ensure the resident's wishes are met. The Director of Nursing said he believes Resident #18 did not receive the COVID-19 vaccination because he can only see evidence of the nursing note, not an order. On a follow-up interview on 2/10/26 at 1:53 P.M., the Director of Nursing said he re-reviewed Resident #18's medical record and saw that there was an order to provide the COVID-19 vaccination and since the nurse documented administration on the MAR, the vaccination must have been given to Resident #18 without the health care proxy's consent.

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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 observation, interview and record review, the facility failed to accurately code in the Minimum Data Set (MDS) for four Residents (#1, #50, and #24) of 34 total sampled residents. Specifically:1.) For Resident #1, the use of restraints was inaccurately coded on the MDS assessment.2.) For Resident #50, the Resident was inaccurately coded on the MDS assessment as rarely/never understood when he/she was able to communicate in Swahili.3.) For Resident #24, the presence of a pressure ulcer was inaccurately coded on two MDS assessments. Findings include:1.) Resident #1 was admitted to the facility in September 2025 with diagnoses including Alzheimer's dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/23/25, indicated Resident #1 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. This MDS also indicated Resident #1 used restraints less than daily. On 2/5/26 at 8:47 A.M. and 2:39 A.M., 2/6/25 at 6:58 A.M., and 2/9/25 at 8:09 A.M., the surveyor observed Resident #1 in a chair without any restraints. Review of Resident #1's physician's order, dated 12/1/25 to 12/23/25, failed to indicate restraint use. Review of Resident #1's plan of care, dated 12/1/25 to 12/23/25, failed to indicate restraint use. Review of Resident #1's nursing progress notes, dated 12/1/25 to 12/23/25, failed to indicate restraint use. During an interview on 2/9/25 at 8:20 A.M., Nurse #8 said this was a restraint free facility. Nurse #8 said she consistently worked with Resident #1 in December 2025 and he/she was never restrained. During an interview on 2/9/25 at 8:55 A.M. the MDS Coordinator said Resident #1 was never restrained in December 2025 and that the MDS assessment, dated 12/23/25, was coded inaccurately. 2.) Resident #50 was admitted to the facility in March 2025 with diagnoses including Alzheimer's dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/11/25, indicated Resident #50 preferred to speak Swahili and needed/wanted an interpreter to communicate with health care staff. The MDS assessment indicated no (resident is rarely/never understood for Should Brief Interview for Mental Status (BIMS) be conducted and Should Resident Mood Interview be conducted and both interviews were not completed. During an interview on 2/6/26 at 10:40 A.M., Certified Nurse Assistant (CNA) #9 said Resident #50 speaks Swahili. CNA #9 said Resident #50 can understand English and is able to respond to basic questions by saying okay and yes. CNA #9 said Resident #50 communicates other needs with Swahili speaking staff in the facility. During an interview on 2/9/25 at 9:30 A.M. the MDS Coordinator said Resident #50 was usually able to understand and make needs known in his/her native language of Swahili. The MDS Coordinator said the RAI (Resident Assessment Instrument) manual indicates a resident should not be coded as rarely/never understood and the BIMS and Mood interviews should have been attempted/completed in the Resident's preferred language. The MDS Coordinator said the Social Worker is responsible for coding the BIMS and Mood interviews in MDS assessments. The MDS Coordinator said the Social Worker coded rarely/never understood inaccurately on the MDS assessment, dated 12/11/25. During an interview on 2/9/26 at 10:04 A.M., the Social Worker said she is responsible for conducting the BIMS and Mood interviews and inputting them into the MDS. The Social Worker said since Resident #50 can communicate in Swahili, he/she is not rarely/never understood and the interviews should have been attempted and completed but were not. The Social Worker said she coded the MDS inaccurately. 3.) Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) version 3.0 Manual, dated October 2025, indicated to code the Resident had a pressure ulcer if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Resident #24 was admitted to the facility in December 2024 with diagnoses including osteoarthritis, heart failure and hypertension. Review of Resident #24's weekly skin assessment, dated 12/4/25, indicated:-Other skin issue: unstageable necrosis; Location: left hand Review of Resident #24's dietitian progress note, dated 12/5/25, indicated the Resident had an unstageable necrosis left hand wound. Review of Resident #24's Medication Administration Record, (continued on next page)

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	03/02/2026

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	dated 12/1/25 to 12/19/25, indicated the following order was implemented on every date Resident was in the facility until discharged to the hospital 12/16/25.-Soak left hand for 10 minutes in antimicrobial soap twice daily. Dry thoroughly following. Pt (patient) can use xeroform gauze pushed into hand between soakings. Review of Resident #24's hospital Discharge summary, dated [DATE], indicated:-Consult/ Wound Care Inpatient-Reason of consult: Patient has a pressure ulcer-Wound Care recommendations: If able, cleanse palm of left hand with VASHE (a type of wound cleanser) soaked gauze allow to dwell in palm for 3 minutes followed by diligent drying of palm. May place mepilex white foam (a type of wound dressing) between fingers and palm to relieve pressure and manage moisture if able. Change daily. 3a.) Review of Resident #24's discharge MDS assessment, dated 12/16/25, failed to indicate Resident #24 had a pressure ulcer. 3b.) Review of Resident #24's Annual MDS assessment, dated 12/19/25, failed to indicate Resident #24 had a pressure ulcer. During an interview on 2/11/26 at 11:01 A.M., Nurse #6 said Resident #24 had a known unstageable pressure ulcer within his/her contracted left hand on 12/16/25, when he/she was discharged to the hospital. Nurse #6 said they were applying the xeroform to this left palm pressure ulcer during the entire month of December 2025. During an interview on 2/9/25 at 9:30 A.M. the MDS Coordinator said Resident #24 had a left palm pressure ulcer when he/she was discharged to the hospital on [DATE], and based on RAI coding guidelines both MDS's, dated 12/16/25 and 12/19/25, were coded inaccurately. During an interview on 2/12/26 at 1:59 P.M., the Director of Nursing (DON) said he would expect the MDS Coordinator to complete all MDS assessments following the RAI manual instructions.