STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225058	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Braintree Nursing and Rehabilitation Center	95 Commercial Street Braintree, MA 02184

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interview, and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) program with documentation of the development, implementation, and evaluation of corrective actions or performance improvement activities. Specifically, the facility failed to develop and implement appropriate plans of action for resident concerns regarding food temperatures.Findings include:Review of the facility's policy titled Quality Assurance Performance Improvement Program, last reviewed in January 2025, indicated but was not limited to the following:-Quality Assurance and Performance Improvement (QAPI) principles will drive the decision making within our organization. Focus areas will include all systems that affect resident and family satisfaction, quality of care and services provided and all areas that affect the quality of life for persons living and working in our organization.-The QAPI committee will review data from areas of the organization believes it needs to monitor on a monthly basis to assure systems are being monitored and maintained to achieve the highest level of quality.-Data to be monitored include but is not limited to complaints/facility-reported incidents and Resident/family input-resident council/grievance log.-The facility Administrator is responsible and accountable for developing, leading and closely monitoring our QAPI program.-All QAPI documentation to include tracking of committee activity, performance improvement projects (PIP), forms, resources and worksheets as needed.-Quality Assessment and Assurance (QAA) committee will have the responsibility for reviewing data, suggestions, and input from residents, staff, family members, and other stakeholders.-An important aspect of our PIPs is to determine the effectiveness of our performance improvement activities and whether improvement is sustained.-A systematic approach will be used to determine when an in-depth analysis is needed to fully understand identified problems, causes of the problems, and implications of a change.During initial screening on 2/5/26, the residents on the Windsor 2 unit expressed the following food concerns:- Food is awful, always comes up cold.- Food always comes up cold, never warm.- Food sucks, it's always cold.- Food always cold. Review of Resident Council Minutes and/or Food Committee Minutes from March 2025 to December 2025 indicated the following food concerns:-3/11/25: Cold food, inaccurate meals.-5/21/25: Cold food, inaccurate meals-7/14/25: Cold food-10/20/25: Cold eggs at breakfast, melted ice cream for dessert. The department response noted on the form indicated the Dietician and FSM were aware and would follow-up and a Quality Assurance and Performance Improvement (QAPI) for temperatures to follow. The form was signed by the Executive Director.-11/10/25: Minor concerns were raised regarding food temperatures. Food council meeting scheduled to address concerns.-12/17/25: Ice cream arriving melted when on meal carts.During a group meeting held on 2/10/26 at 10:00 A.M., the 12 residents in attendance shared the following information with the surveyors:-Meals on the units are served cool/cold and the food temperature is better when they eat in main dining room which is adjacent to the main kitchen.-Ice cream is always melted.-Two residents in attendance said they only order ham sandwiches because everything else comes up cold. -Residents report they do not always receive what they ordered. -The residents said they complain about cold food in Resident Council every month and no one ever follows up with them with how they are going to make it better.On 2/9/26 at the (continued on next page)

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

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

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lunch meal and 2/10/26 at the breakfast meal, the survey team conducted test trays which validated the residents' concerns of cold food.During an interview on 2/11/26 at 1:39 P.M., the Food Service Manager (FSM) said she holds monthly Food Committee meetings with residents after the Resident Council Meetings. She said she is aware of the residents' ongoing complaints about food temperatures and accuracy of meals. She said she believes the problem with the food temperatures is due to the length of time it takes staff to distribute the meal trays once the food trucks get to the units. The FSM was unable to explain or provide any documentation of any projects initiated to address the residents' ongoing complaints of cold food and meal accuracy.During an interview on 2/11/26 at 2:30 P.M., the Administrator said he leads the QAPI Committee which meets quarterly as well as four monthly meetings during the year. He said the committee identifies areas of improvement utilizing [NAME] quality measures, five-star measures, a recent Joint Commission of Healthcare Organizations (JCAHO) survey and last year's recertification survey results. He said projects the committee has been working on in 2025 include long stay residents with pressure ulcers, and long stay residents with falls with major injuries. The Administrator said he was aware of the residents' ongoing complaints about cold food from the Resident Council and Minutes, however, has not initiated a QAPI project to address it.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) Committee which included the required members at their meetings. Specifically, the facility's Infection Preventionist failed to attend three of three QAPI meetings reviewed.Findings include:Review of the facility's policy titled Quality Assurance on (sic) Performance Improvement (QAPI) Program, dated as revised January 2025, indicated but was not limited to:-The facility Administrator is responsible and accountable for developing, leading and closely monitoring our QAPI program.-QAPI activities will be governed and monitored by the Quality Assurance and Assessment (QAA) committee which will include: -The Medical Director, or designee -The Director of Nursing Services -The Administrator, or corporate leadership in his/her absence -Infection Preventionist -Two additional staff membersReview of the facility's QAPI Attendee sign-in sheets for September 2025 indicated the Infection Preventionist was not in attendance.Review of the facility's QAPI Attendee sign-in sheets for December 2025 indicated the Infection Preventionist was not in attendance.Review of the facility's quarterly QAPI Attendee sign-in sheets for January 2026 indicated the Infection Preventionist was not in attendance.During an interview on 2/11/26 at 1:28 P.M., the Infection Preventionist said she does not attend QAPI meetings.During an interview on 2/11/26 at 2:30 P.M., the Administrator reviewed the September 2025, December 2025 and January 2026 QAPI attendance sheets and could not identify the IP's signature. He said it is hard to get everyone together to attend the meetings.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council Minutes, a resident group meeting, and interviews, the facility failed to ensure grievances/complaints brought forward from the Resident Council were addressed and resolved in a timely manner to ensure the residents felt their concerns were acted upon and included the facility response to the group.Findings include:Review of the facility's policy titled Resident Council Meetings, last reviewed December 2024, indicated but was not limited to the following:- The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the CouncilReview of the facility's policy titled Complaint/Grievance Policy and Procedure, dated September 2023, indicated but was not limited to the following:-Voiced grievances (e.g. those about treatment, care management of funds, lost clothing, or violation of rights) are not limited to a formal, written process and may include a resident's verbalized complaint to facility staff.Review of Resident Council notes, Resident Council Department Response Forms and Food Committee Meeting Minutes representing five of seven units in the facility, provided by the facility, from March 2025 to December 2025, indicated resident food complaints as follows: -3/11/25: Cold food and incorrect meals. The Food Service Manager (FSM) noted cold food complaints and indicated the issue has a lot to do with how fast they hand out meal trays. The form was signed by the department head and the Executive Director.-4/1/25: No follow-up to the residents' complaints of cold food and incorrect meals brought forward during the 3/11/25 Resident Council and Food Committee meeting.-5/21/25: Cold lunch, not getting the right foods. No follow-up to the residents' complaints of cold food and incorrect meals brought forward during previous Resident Council and Food Committee meetings.-6/17/25: No follow-up to the residents' complaints of cold food and incorrect meals brought forward during the 5/21/25 Resident Council and Food Committee Meetings.-7/14/25: Cold food.-8/20/25: No follow-up to the residents' complaints of cold food brought forward during the 7/14/25 Resident Council meeting.-No September 2025 Resident Council or Food Committee minutes were provided to the survey team for review.-Food Committee Meeting minutes, dated 10/15/25, failed to indicate any follow-up to complaints voiced during the 7/14/25 meeting.-10/20/25: Cold eggs at breakfast, melted ice cream for dessert. The department response noted on the form indicated the Dietitian and FSM were aware and would follow-up and a Quality Assurance and Performance Improvement (QAPI) for temperatures to follow. The form was signed by the Executive Director.-11/10/25: Meeting conducted by the Administrator and Director of Nursing and minor concerns were raised regarding food temperatures.Food Committee Meeting Minutes, dated 11/20/25, failed to indicate the residents' concerns regarding food temperatures brought forward during the 11/10/25 Resident Council Meeting was addressed.-12/17/25: Ice cream arrives melted when delivered on meal carts. Meeting conducted by the Administrator; plan identified to review handling procedures to ensure products arrive properly frozen within 14-30 days.During a group meeting held on 2/10/26 at 10:00 A.M., the 12 residents in attendance shared the following information with the surveyors:-Meals on the units are served cool/cold and the food temperature is better when they eat in main dining room which is adjacent to the main kitchen.-Ice cream is always melted.-Two residents in attendance said they only order ham sandwiches because everything else comes up cold. -Residents report they do not always receive what they ordered. -The residents said they complain about cold food in Resident Council every month and no one ever follows up with them with how they are going to make it better.During an interview on 2/11/26 at 10:38 A.M., the Activity Director (AD) said she coordinates the monthly Resident Council meeting and documents the meeting minutes. She said when any concerns arise during the meeting, she usually completes a Resident Council Department Response form and gives it to the appropriate department head for follow-up. She said the FSM usually holds a Food Committee Meeting with residents on the same day as Resident Council. The AD said residents have brought forward complaints about cold food in Resident Council every month since she started working at the facility a (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year ago. She said she used to provide the FSM a completed Resident Council Department Response form with the residents' concerns on it. However, the residents still complain about cold food. The AD said she doesn't always document the residents' ongoing complaints of cold food voiced during the Resident Council minutes anymore and instead informs the Administrator directly. The AD said she was not aware of any changes made by the FSM or Administrator to address the residents' complaints of cold food.Review of the facility's grievance book failed to indicate any grievances were formulated for any ongoing concerns brought forth by resident council as a group. During an interview on 2/11/26 at 1:39 P.M., the FSM said she holds monthly Food Committee meetings with residents after the Resident Council Meetings. She said she is aware of the residents' ongoing complaints about food temperatures and accuracy of meals. She said she believes the problem with the food temperatures is due to the length of time it takes staff to distribute the meal trays once the food trucks get to the units. The FSM was unable to explain or provide any documentation of any approaches developed and implemented to address the residents' ongoing complaints of cold food and meal accuracy.During an interview on 2/11/26 at 2:30 P.M., the Administrator and surveyor reviewed the food complaints brought forward by residents during the Resident Council Meeting held on 2/10/26 as well as repeated complaints over the past year. He said he was aware of the ongoing food concerns but had not put a performance improvement plan in place to address it until the survey team identified food temperature issues from test trays. He said the FSM needs to work on these issues. He said they need to make sure concerns brought up during Resident Council are documented and brought through the grievance process to ensure they are addressed, and the problem is resolved.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews and record review, the facility failed to ensure that individualized, comprehensive care plans were developed and consistently implemented for one Resident (#5), out of a total sample of 34 residents. Specifically, the facility failed to ensure resident specific, individualized care plans were developed to address the medical, physical, mental and psychosocial needs of a residents identified with a history of suicidal ideation/attempt/gestures. Findings include:Review of the facility's policy titled Comprehensive Care Plans, last revised May 2025, indicated but was not limited to:-It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.-The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: a. the attending physician or non-physician practitioner designee involved in the resident's care, if able to participate in the development of the care plan.b. A registered nurse with responsibility for the resident.c. A nurse aide with responsibility for the resident.d. A member of the food and nutrition services staff.e. The resident and the resident's representative, to the extent practicable.f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.-The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment.-The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternate interventions will be documented, as needed.Resident #5 was admitted to the facility in October 2022 and had diagnoses including bipolar disorder, schizoaffective disorder and suicidal ideations.Review of the MDS assessment, dated 11/24/25, indicated Resident #5 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) for 4-6 days during the review period and had a diagnosis of suicidal ideation. The assessment indicated Resident #5 had an activated Health Care Proxy (HCP- someone designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions).Review of comprehensive care plans failed to indicate a care plan was developed to address the Resident's diagnosed history of suicidal ideation.Review of a Nurse Practitioner Note (NP), dated 1/24/25, indicated Resident #5 presented with agitation/suicide attempt. The nurse reported to the NP that Resident #5 threw a food tray at staff after breakfast because he/she didn't like the food. He/she was later seen by housekeeping staff holding a butter knife to his/her wrist as if contemplating to cut him/herself. The kitchen was immediately notified to remove all knives and sharp objects from his/her tray moving forward. The Resident told the NP that the people in the television wanted to hurt him/her and wanted him/her dead, so he/she was going to hurt him/herself before they got to him/her. The NP and consultant psychiatric NP assessed the Resident and adjusted his/her psychotropic medications, initiated 15-minute safety checks when the Resident is alone in his/her room, keep the television off in his/her room and no sharp objects.Further review of comprehensive care plans failed to indicate any care plan was developed for suicidal ideation/gestures/ideation following his/her actual suicide attempts/gesture/ideation on 1/24/25.Review of a Behavior Note, dated 11/1/25, indicated Resident #5 exhibited increased (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behaviors and verbalized wanting to pull the fire alarm. The nurse attempted to redirect the Resident when he/she pulled out a piece of broken glass and held it to his/her right wrist saying he/she was going to cut his/her wrist. The broken glass was immediately removed, the Resident was placed on 1:1, the physician was notified and ordered the Resident to be sent to the hospital for evaluation.Review of hospital documentation indicated Resident #5 was admitted to the hospital's geriatric psychiatry unit from 11/4/25 to 11/17/25 for evaluation and treatment of paranoid ideation and attempts at self-injurious behaviors. The documentation indicated that Resident #5 reported multiple psychiatric hospitalizations in the past, self-injurious behaviors in the past by cutting and reports of past suicide attempt 30 years ago. The Resident's psychiatric status was stabilized following an adjustment to his/her medication regimen and therapy utilizing DBT (Dialectical Behavior Therapy-a type of talk therapy for people who experience emotions very intensely) and discharged back to the facility on [DATE].Further review of comprehensive care plans failed to indicate any care plan was developed for suicidal ideation/gestures/ideation following his/her actual suicide attempts/gesture/ideation on 11/1/25.During an interview on 2/9/26 at 11:25 A.M., Certified Nursing Assistant (CNA) #1 said she provides care to Resident #5 on a regular basis. She said the Resident can be accusatory of staff believing they are taking his/her belongings. CNA #1 said she was never told that Resident #5 had ever attempted to hurt him/herself and has not seen anything about it on the CNA care card.During an interview on 2/9/26 at 11:44 A.M., Unit Manager (UM) #2 said she has been the UM on Resident #5's unit since January 2025. She said the Resident can be accusatory toward staff. UM #2 reviewed Resident #5's medical record and said the Resident has had two incidents of suicidal ideation with attempts of self-harm with a knife and broken glass. She said the Resident was sent out to the hospital in January after housekeeping found the Resident with a knife and threatening to cut his/her wrist and was sent out again in November after holding a piece of broken glass to his/her wrist and saying he/she was going to cut him/herself. The UM reviewed Resident #5's comprehensive care plans and said there is no care plan that addresses the Resident's suicidal ideations and/or suicide attempts/gestures.During an interview on 2/9/26 at 12:45 P.M., the Director of Nursing (DON) said a care plan should be developed for any resident that has a history of suicidal ideation/attempts and has an actual suicide attempt or gesture. The DON reviewed Resident #5's medical record including comprehensive care plans and said a care plan should have been developed with individualized interventions for Resident #5's history of suicidal ideation/attempts and actual suicide attempts/gestures and was not.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure residents received food at appetizing temperatures for two of two test trays completed.Findings include:During initial screening on 2/5/26, the residents on the Windsor 2 unit expressed the following food concerns:- Food is awful, always comes up cold.- Food always comes up cold, never warm.- Food sucks, it's always cold.- Food always cold. Review of Resident Council Minutes from October 2025 through December 2025 indicated the following food concerns:-10/20/25: Cold eggs at breakfast, melted ice cream for dessert.-11/10/25: Minor concerns were raised regarding food temperatures. Food Council Meeting scheduled to address concerns.-12/17/25: Ice cream arriving melted when on meal carts.Food Council notes from 10/15/25 and 11/20/25 failed to include information on food temperature concerns.During observation of breakfast meal passes on the Kensington 2 Unit, surveyors made the following observations:-On 2/6/26 at 8:00 A.M., the food truck containing meal trays for all residents on the unit, arrived at the unit. At 8:45 A.M., the food truck still contained four breakfast trays that had not been passed.-On 2/9/26 at 8:36 A.M., the food truck contained seven breakfast trays that had not yet been passed. At 8:57 A.M., the food truck contained three breakfast trays that had not been passed. The last tray from the food truck was passed at 9:05 A.M. On 2/9/26 at 11:24 A.M., the surveyor requested a test tray to the Windsor 2 unit and made the following observations: -At 12:59 P.M., the food truck containing the test tray left the kitchen for the Windsor 2 unit. -At 1:01 P.M., the food truck containing the test tray arrived on the Windsor 2 unit and staff began passing trays.- At 1:24 P.M., the last tray was delivered to a resident from the food truck.On 2/9/26 at 1:26 P.M., the surveyor and the Regional Food Service Director (FSD) completed the test tray together and the food temperatures (in degrees Fahrenheit (F) were as follows:- Marinated Chicken Thigh: 112F, tepid/lukewarm to taste- Mixed Vegetables: 118F, tepid/lukewarm to taste- Parmesan Noodles: 110 F, tepid/lukewarm to tasteDuring an interview on 2/9/26 at 1:28 P.M., the Regional FSD said all of the hot food items on the tray could have been warmer. The Regional FSD said he would expect all trays to be passed from the food truck within 15 minutes of the truck arriving to the unit.On 2/10/26 at 7:05 A.M., the surveyor requested a second test tray to the Kensington 2 unit and made the following observations:- At 7:54 A.M., the food truck containing the test tray left the kitchen for the Kensington 2 unit.- At 7:55 A.M., the food truck arrived on the Kensington 2 unit and staff began passing trays.- At 8:39 A.M., the last tray was delivered to a resident from the food truck.On 2/10/26 at 8:40 A.M., the surveyor and Regional FSD completed the test tray together and the food temperatures were as follows:- Oatmeal: 122F, tepid/lukewarm to taste- Scrambled Eggs with Cheese: 96F, cold to taste- Toast: 90F; cold temperature, soggyDuring an interview on 2/10/26 at 8:42 A.M., the Regional FSD and surveyor reviewed the second test tray results from the Kensington 2 unit. The Regional FSD said the eggs tasted good but were cool and the oatmeal was warmish. The Regional FSD said a tray pass of more than 40 minutes was too long. During an interview on 2/10/26 at 8:45 A.M., Unit Manager #1 said the Kensington 2 unit had a lot of residents who needed assistance with eating and staff could only assist so many residents at a time. Unit Manager #1 said she had asked for more help with the tray pass but hadn't gotten it and thought it might be better if trays for residents that required assistance with eating were sent to the unit on a different food truck and not all at once with the other trays.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to follow professional standards of practice for food safety to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure food items were properly dated and stored in 3 of 7 kitchenette refrigerators.Findings include:Review of the facility's policy titled Foods Brought by Family/Visitors, dated 1/2025, indicated but was not limited to the following:-Perishable foods must be stored in resealable contains with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the use by date.-The nursing staff is responsible for discarding perishable foods on or before the use by date.-The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example mold growth, foul odor, past due packaging expiration dates).Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:3-501.17 Ready to-Eat, Time/Temperature Control for Safety Food, Date Marking.(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date of day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3-29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by-date if the manufacturer determined the use-by-date based on FOOD safety.On 2/5/26 at 9:19 A.M., the surveyor reviewed the [NAME] unit kitchenette and observed the following:-One container of honey consistency thickened orange juice, opened and not marked with the date opened or use by date, in the refrigerator. Review of the container's label indicated the juice should be discarded within 10 days of opening.-One container of nectar consistency thickened apple juice, opened and not marked with the date opened or use by date, in the refrigerator. Review of the container's label indicated the juice should be discarded within 7 days of opening.-One container of nectar consistency thickened cranberry juice, opened and not marked with the date opened or use by date, in the refrigerator. Review of the container's label indicated the juice should be discarded within 7 days of opening.On 2/10/26 at 10:15 A.M., the surveyor reviewed the Windsor 2 unit kitchenette and observed the following:-A container of Vita [NAME] coconut water, opened and unlabeled, in the freezer-A container of Core water, opened and unlabeled, in the refrigerator-A can of Vanilla Coca Cola, opened and unlabeled, in the refrigerator-A plastic shopping bag containing a bowl of soup and a ladle, unlabeled, in the refrigeratorOn 2/11/26 at 11:12 A.M., the surveyor reviewed the Sunshine unit kitchenette and observed the following:-A disposable to-go style container containing a slice of cake-like product, unlabeledDuring an interview on 2/10/26 at 2:20 P.M., the Food Service Director (FSD) said there should be no unlabeled/undated personal food items in the unit kitchenettes. The FSD said she had checked the unit kitchenettes that morning and had not seen any unlabeled/undated items. The FSD said all thickened liquids should be labeled with the opened on and use by dates and she had created labels to put on the containers as a reminder for staff.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation and interview, the facility failed to provide an ongoing program of individual and group activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of residents on one (Kensington 2 unit) of seven nursing units. Specifically, the facility failed to ensure staff provided a meaningful and engaging activity program, including materials for self-directed activity, for residents residing on the Kensington 2 unit (secured).Findings include:Review of the facility's policy titled Activities, last revised December 2025, indicated but was not limited to:-Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being.-Activities will be designed with the intent to:a. Enhance the resident's sense of well-being, belonging and usefulness.b. Create opportunities for each resident to have a meaningful life.c. Promote or enhance physical activity.d. Promote or enhance cognition.e. Promote or enhance emotional health.f. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence.g. Reflect a resident's interest and age.h. Reflect cultural and religious interests of the residents.i. Reflect choices of the residents.-Activities may be conducted in different ways:a. One-to-One Programsb. Person Appropriate-activities relevant to the specific needs, interests, culture and background, etc., for the resident they are developed for.c. Program of activities-to include a combination of large and small groups. One-to-one, and self-directed as the resident desires to attend.During the entrance conference on 2/5/26 at 8:51 A.M., the Administrator said the Kensington 2 (K2) Unit was a secure unit with several residents with a diagnosis of dementia.Review of the Matrix for Providers (Centers for Medicare and Medicaid Services document used to identify pertinent care categories) provided by the facility on 2/5/26, indicated 25 of 25 residents residing on the K2 unit had a diagnosis of dementia.On the following days of survey, the surveyor made the following observations of the K2 unit activity/dayroom:-2/5/26 from 2:00 P.M. to 2:25 P.M., seven residents were seated in the dayroom at tables with nothing to do. Two residents were wandering throughout the unit. Staff were in the vicinity, but there was no interaction with the residents. The television was on, but the sound was low and inaudible with only three residents facing the television. The activity calendar posted on the wall indicated Family Feud Trivia on the unit at 2:00 P.M. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity.During an interview on 2/6/26 at 11:22 A.M., Unit Manager #1 said they don't have materials or supplies to provide residents with independent activity. She said they could give them a pencil and coloring page, but Activities staff come up to the unit three times a day and provide activities for them.-2/9/26 from 9:15 A.M. to 10:14 A.M., 10 residents were seated in the dayroom at tables with no staff in the immediate vicinity and no staff interaction. The television was on, but only two residents were facing the television. Two residents were sleeping and eight residents were awake with nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity.- 2/10/26 at 9:30 A.M., nine residents were seated in the dayroom at tables with no staff in the immediate vicinity and no staff interaction. The television was off. A speaker positioned on top of a refrigerator in the dayroom was on and playing music but could only be heard by the surveyor when standing directly in front of the refrigerator. The activity calendar posted on the wall indicated room visits at 9:00 A.M. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity.-2/11/26 at 10:00 A.M., 12 residents were seated in the dayroom at tables with no staff in the immediate vicinity and no staff interaction. The television was not on. Two residents were sleeping. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity.During an interview on 2/11/26 at 10:38 A.M., the surveyor reviewed activity observations on the K2 unit with the Activity Director (AD). She said the activity staff only go up to the K2 unit a few times a day for a short period of time and no one else does anything with the residents. She said she (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is frustrated because there are no supplies available to put together busy boxes for the residents. She said she puts together a list of what she needs to fulfill the activity programming on the calendar and sends it to the Administrator and will get only about 50% of the items.-2/11/26 at 12:46 P.M., 14 residents were seated at tables in the dayroom. All residents were awake and sitting idly with nothing in front of them for self-directed activity. Unit Manager #1 was in the dayroom and instructed the Certified Nursing Assistants (CNA) to begin toileting each resident.During an interview on 2/11/26 at 12:47 P.M., the Unit Manager said activity staff would be coming up to the unit around 2:00 P.M., and residents would have something to do at that time.During an interview on 2/11/26 at 1:00 P.M., CNA #3 said she does not know if any supplies or materials are available to give to residents to use for independent activities instead of sitting idly with nothing to do.During an interview on 2/11/26 at 1:02 P.M., CNA #4 said she did not know if any activity supplies were available to give to residents. She asked UM #1 if there were any activity supplies available for residents to use and the UM said that activity staff are supposed to come up at 2:00 P.M. and they provide activities for them.During an interview on 2/11/26 at 12:51 P.M., Activity Aide #1 said there is a small closet outside of the unit where activity supplies are stored. She brought the surveyor through the unit door into a vestibule, then through another door to a landing at the top of a stairwell. She opened a door to a small closet and pointed out activity materials that are for use by all seven units in the facility, not just the K2 unit. Items stored on shelves in the closet included magazines, books, board games (inappropriate for cognitively impaired residents), a beach ball, a rubber ball, a bag of pool noodles and silk flowers. A fidget sensory busy board was leaning against the back wall of the closet behind the bag of pool noodles and balls. A large plastic storage bin with a secured lid contained several baby clothing items and three busy mats/sensory blankets. The Activity Aide said only activity staff have access to these items and other staff don't use them.

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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 interview and record review, the facility failed to maintain a safe environment, free of accident hazards for one Resident (#74), out of 35 sampled residents. Specifically, the facility failed to ensure Resident #74's smoking materials were stored securely, and a smoking assessment was completed. Findings include:Review of the facility's policy tilted Smoking Policy and Procedure, undated, indicated but was not limited to:- It is the policy of [Corporate Name] to provide a safe environment for residents, staff and visitors through the enforcement of a smoking policy designed to reduce risks to residents who smoke tobacco products, reduce the risks of passive smoking for others and reduce the risk of fire.- Independent Smoker: a resident who has been assessed by the IDT (Interdisciplinary Team) to be able to smoke safely in the designated area without staff supervision. The Independent Smoker will adhere to all guidelines for safe smoking outlined in this policy and, if there are any infractions, will be re-assessed for safe smoking. The resident must keep all lighting materials at the designated secure area.- All residents expressing the desire to smoke tobacco products or use E-Cigarettes will be assessed upon admission to the center, when there is a change in status and quarterly. Once the facility has assessed the resident, safety interventions will be implemented and added to the resident's plan of care.- A specific care plan will be designed to meet the individual needs of the resident and will be reviewed quarterly and/or with changes in condition. All appropriate safety interventions will be included in this care plan, such as smoking apron, adaptive device, etc.- Tobacco products will be stored in a box on each unit. Each box will have a written list of residents who need safety measures taped inside the box. Resident #74 was admitted to the facility in November 2024 with diagnoses including chronic obstructive pulmonary disease (COPD) and nicotine dependence. Resident #74 was identified by the facility as an independent smoker. Review of the Minimum Data Set (MDS) assessment, dated 10/29/25, indicated Resident #74 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #74's Physician's Orders indicated but were not limited to:- 12/29/25: may go LOA (leave of absence) independently. Review of Resident #74's medical record failed to include an active comprehensive care plan related to smoking. Review of Resident #74's comprehensive care plans indicated he/she had a smoking care plan which was resolved on 12/6/24. Review of Resident #74's medical record failed to indicate a smoking assessment was completed. During an interview on 2/5/26 at 11:42 A.M., Resident #74 said he/she was an independent smoker and would sign themselves out three times a day after meals to smoke outside. Resident #74 said his/her cigarettes and lighter are kept in the top drawer of his/her dresser across from their bed. During an interview on 2/11/26 at 8:15 A.M., Resident #74 said he/she keeps his smoking materials, including lighter and cigarettes, in a sock in his dresser drawer. Resident #74 said no one was able to get the materials in the drawer and declined to let the surveyor observe the location of the smoking supplies. During an interview on 2/11/26 at 8:16 A.M., Nurse #1 said Resident #74 is an independent smoker who signs him/herself out in the unit binder when he/she leaves the facility to smoke. Nurse #1 said Resident #74 was assessed by staff for independent smoking and education was completed with him/her. Nurse #1 said Resident #74 is able to keep smoking supplies in his/her room and they are not kept by nursing staff. During an interview on 2/11/26 at 9:15 A.M., the Director of Nursing (DON) said Resident #74 is an independent smoker and was assessed by nursing staff for his/her safe ability to smoke. The DON said Resident #74's smoking supplies are to be locked up by the nursing staff and given to the Resident when he/she goes out to smoke. The DON said the Resident should return the supplies to the nursing staff when he/she returns to the facility after smoking. The DON and the surveyor reviewed the information gathered throughout the survey. The DON said smoking supplies should be locked and given to staff after returning from smoking and should not be kept in the Resident's dresser. The DON said Resident #74's smoking care plan was accidently resolved by staff and needs to be reinstated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored in accordance with acceptable standards for one Resident (#94), out of a total sample of 35 residents. Specifically, the facility failed to ensure Resident #94's three inhaler medications were stored securely. Findings include:Review of the facility's policy titled Self-Administration of Medications, undated, indicated but was not limited to the following:- Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.- Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. Review of the facility's policy titled Bedside Medication Storage, undated, indicated but was not limited to the following:- Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team.- For residents who self-administer medications the following conditions are met for the bedside storage to occur: 1) The manner of storage prevents access by other residents. Review of the facility's policy titled Storage of Medications, undated, indicated but was not limited to the following:- The facility stores all drugs and biologicals in a safe, secure, and orderly manner.- Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Resident #94 was admitted to the facility in December 2025 with diagnoses including chronic obstructive pulmonary disease (COPD), emphysema and weakness. Review of Resident #94's Minimum Data Set (MDS) assessment, dated 12/24/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #94's Physician's Orders indicated but were not limited to:- 2/8/26: May have inhalers at bedside; may self-administer- 12/19/25: Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT (micrograms per actuation - dosage of medication delivered per puff); one puff inhale orally one time a day for COPD; administered by clinician at 10:00 A.M.- 12/19/25: Combivent Respimat Inhalation Aerosol Solution 20-100 MCG/ACT; one puff inhale orally four times a day for COPD; administered by a clinician at 10:00 A.M./1:00 P.M./7:00 P.M./9:00 P.M.- Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT; 2 puff inhale orally every four hours as needed for shortness of breath (SOB); unsupervised self-administration On 2/5/26 at 10:36 A.M., the surveyor made the following observations:- Resident #94 was asleep in bed.- Resident #94's Albuterol inhaler and Combivent inhaler were on top of his/her bedside nightstand, not secured. On 2/5/26 at 11:58 A.M., the surveyor made the following observations:- Resident #94 was asleep in bed.- Resident #94's Albuterol inhaler and Combivent inhaler were on top of his/her bedside nightstand, not secured. On 2/10/26 at 11:20 A.M., the surveyor made the following observations:- Resident #94 was awake but lying in bed on his/her left side facing his/her nightstand. Resident #94's overbed table was positioned behind him/her.- Resident #94's Albuterol inhaler was on top of his/her bedside nightstand, not secured.- Resident #94's Trelegy inhaler and Combivent inhaler were on top of his/her overbed table in bags, not secured. During an interview on 2/10/26 at 11:20 A.M., Resident #94 said he/she can use their Albuterol inhaler independently and he/she keeps it on their nightstand. Resident #94 said he/she usually leaves the inhaler on top of nightstand but does not lock it away or secure it. Resident #94 said the Trelegy inhaler and Combivent inhalers are brought to him/her each day by the nurse to be administered and are not stored in his/her room. Resident #94 said the nurse must have forgotten to take the medications after he/she took them. On 2/10/26 at 1:50 P.M., the surveyor made the following observations:- Resident #94 was awake but lying in bed on his/her left side facing his/her nightstand.- Resident #94's Albuterol inhaler was on top of his/her bedside nightstand, not (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	secured. On 2/11/26 at 8:10 A.M., the surveyor made the following observations:- Resident #94 was awake but lying in bed on his/her left side facing his/her nightstand.- Resident #94's Albuterol inhaler was on top of his/her bedside nightstand, not secured. Review of Resident #94's Self-Administration of Medication assessment, dated 1/15/26, indicated he/she was fully capable of self-administration and approved for self-administration of medications. The assessment failed to indicate any specific medications the Resident was able to administer by his/herself. During an interview on 2/11/26 at 8:20 A.M., Nurse #1 said Resident #94 is able to complete his/her Albuterol inhaler at bedside after being assessed and receiving education by staff regarding self-administration. Nurse #1 said Resident #94 receives two other inhaler medications during morning medication pass that are administered with the nurse. Nurse #1 said she was not sure if medications needed to be locked or safely secured at the bedside. Nurse #1 said she was told the Resident could have his/her medication at the beside and it could be kept out. Nurse #1 said if the medication needed to be secured or locked the order would reflect the storage of the medication. During an interview on 2/11/26 at 9:08 A.M., the Director of Nursing (DON) said Resident #94 has a rescue inhaler for shortness of breath that he/she was assessed for self-administration. The DON said Resident #94 was determined to properly complete self-administration of the rescue inhaler and it is able to be left at the bedside. The DON said the inhaler should be kept in the nightstand but does not need to be locked because it is a rescue inhaler that would need to be used quickly if the Resident required it. The DON and the surveyor reviewed the observations made throughout the survey. The DON said she would not expect the Trelegy or Combivent inhalers to be left at the bedside unsecured.