STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225134	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foremost at Sharon LLC	259 Norwood Street Sharon, MA 02067

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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 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. Based on observation, interview, and record review, the facility failed to develop, implement and individualize comprehensive care plans for one Resident (#41), out of a total sample of 15 residents. Specifically, the facility failed to ensure a comprehensive care plan was developed to address the use of Buspirone (anti-anxiety), Trazodone (antidepressant also used to treat anxiety) and Sertraline (selective serotonin reuptake inhibitor used to treat anxiety) that identified Resident specific targeted behaviors, non-pharmacological interventions, and measurable goals of treatment. Findings include: Review of the facility's policy titled Comprehensive Care Plans, revised April 2022, included but was not limited to: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -The comprehensive, person-centered care plan will include: -measurable objectives and timeframes; -describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -reflect treatment goals, timetables, and objectives in measurable outcomes; -identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are the endpoint of an interdisciplinary process. Resident #41 was admitted to the facility in April 2025 and has diagnoses including generalized anxiety disorder. Review of the Minimum Data Set assessment, dated 4/19/25, indicated Resident #41 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 8 out of 15, required partial to moderate assistance with activities of daily living and received antianxiety and antidepressant medication daily. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated Physician's Orders for: -Buspirone HCl 15 milligrams (mg), one tablet two times a day for anxiety (4/12/25, discontinued 5/20/25) -Buspirone HCl 15 mg, one tablet three times a day for anxiety (5/20/25) -Trazodone 50 mg, give 0.5 tablet one time a day for anxiety (4/12/25) -Sertraline 100 mg one time a day for anxiety (4/13/25) Review of April 2025 through June 2025 Medication Administration Records (MAR) indicated Buspirone, Trazodone, and Sertraline were administered as ordered by the physician. Review of comprehensive care plans included but was not limited to: -Focus: The resident uses psychotropic medications. Trazodone, Buspirone and Sertraline related to anxiety (initiated: 4/13/25). -Interventions: Administer psychotropic medications as ordered by the physician. Monitor for side effects and effectiveness every shift. Observe/document/report PRN (as needed) any adverse reactions. Observe/record occurrence of target behavior symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol. -Goal: The resident will remain free from psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. The resident will reduce the use of psychotropic medication through the review date. Review of a Social Service Assessment, dated 4/12/25, indicated #41 was pleasant and social, attends group activities of his/her choosing, is alert and oriented to person and place, has short-term memory fluctuations. The assessment failed to indicate Resident #41 exhibited disrobing, inappropriate response to verbal communication, and violence/aggression towards staff or others. Review of a Nursing Evaluation, dated 4/12/25, indicated a section titled Neurological/Cognitive/ Facility Orientation/ Antipsychotics/Psychotropics. Under the care plan section of this field, a box was checked with pre-populated interventions: Observe/Record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. There was no section under the care planning section to type in resident-specific targeted behaviors. Further review of comprehensive care plans failed to indicate a care plan had been developed for the use of Buspirone, Trazodone and Sertraline that identified Resident specific targeted behaviors, Resident-specific interventions, including non-pharmacological approaches, and measurable goals of treatment to meet the Resident's needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25 at 8:56 A.M., Nurse #1 and the surveyor reviewed Resident #41's comprehensive care plans. She said Resident #41 likes to walk around both on and off the unit, will occasionally refuse medications and can perseverate (repeated thoughts) on things such as wanting to use the telephone. She said she is not aware of any behaviors of disrobing, inappropriate response to verbal communication, violence or aggression toward staff and others and does not know why his/her symptoms of anxiety were not included in the Resident's care plan. During an interview on 6/5/25 at 11:45 A.M., the Director of Nursing (DON) and the surveyor reviewed Resident #41's comprehensive care plans for the use of psychotropic medications. She said the Resident does not have a history of disrobing, inappropriate response to verbal communication, violence/aggression toward staff and others and has not exhibited that since being admitted . She said the listing of behaviors may be part of a batch order in the electronic medical record and the care plan should only include signs, symptoms and behaviors specific to Resident #41. She said the care plan is supposed to also include non-pharmacological interventions and measurable goals of treatment and does not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide residents with adequate supervision and effective interventions to prevent avoidable accidents. Specifically, the facility failed to develop effective interventions to prevent nine falls for one Resident (#26), out of a total sample of 15 residents. Findings include: Review of the facility's policy titled Falls and Fall Risk Managing, revised 3/2022, indicated, but was not limited to, the following: -Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. -The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. -If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. -If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on an assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of falling is identified as unavoidable. -The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. -If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help staff reconsider possible causes that may not have been previously identified. Review of the facility's policy titled Comprehensive Care Plans, revised 4/2022, indicated, but was not limited to, the following: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Assessments of residents are ongoing and care plans are revised as information about the residents and residents' conditions change. -The interdisciplinary team must review and update the care plan: *when there has been a significant change in the resident's condition; *when the desired outcome is not met; *when the resident has been readmitted to the facility from a hospital stay; *at least quarterly, in conjunction with the required quarterly MDS assessment. Resident #26 was admitted to the facility in October 2024 with diagnoses including dementia and atrial fibrillation on anticoagulation (blood-thinning medication). Review of the Minimum Data Set (MDS) assessment, dated 4/7/25, indicated that Resident #26 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Further review of Resident #26's MDS assessment indicated the Resident had two or more falls since admission or the prior assessment. Review of Resident #26's medical record indicated Resident #26 had nine falls from 11/4/24 to 6/1/25. Review of Resident #26's Morse Fall Scale Evaluations, completed on 10/1/24, 11/4/24, 1/1/25, 1/16/25, 2/4/25, 4/16/25, 5/4/25, and 6/2/25 indicated the Resident was at high risk for falls. Review of Resident #26's progress notes indicated, but was not limited to, the following: a. Nurses' notes -11/4/24 at 12:29 A.M.: Nurse notified by CNA (Certified Nursing Assistant) that Resident #26 was sitting on the floor holding the right side of his/her head. Upon examination, the Resident had a raised lump on the right side of his/her head and his/her right thumb appeared slightly swollen. The Nurse Practitioner (NP) was notified and ordered the Resident be transferred to the hospital for evaluation. -11/4/24 at 4:43 A.M.: The Resident returned from the hospital, all tests and x-rays were negative. Resident was seen by nurse leaning out of bed to pick his/her eyeglasses up off of the floor and the nurse explained to the Resident the importance of safety and using call bell. -11/18/24 at 8:13 P.M.: The Resident was observed sitting on the floor in the hallway. -1/14/25 at 2:07 P.M.: The Resident was transferred to hospital after he/she fell and hit his/her head and reported pain in his/her head, back, and side. The Resident was taking a blood thinning medication. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/17/25 at 5:45 A.M.: The Resident was observed sitting on the floor by staff at 7:30 P.M. The Resident stated he/she was fixing his/her sandals. -1/17/25 at 6:22 A.M.: The Resident was readmitted to the facility on [DATE] at 6:00 P.M. after he/she was hospitalized after an unwitnessed fall. CT imaging (computed tomography, a medical imaging technique that combines a series of x-ray images and uses computer processing to create cross-sectional images of bones, blood vessels, and soft tissues inside the body) showed evidence of an acute L3 fracture (a broken third lower back bone). -2/4/25 at 5:19 P.M.: Around 12:40 P.M., the Resident was seen by staff scooting on his/her buttocks. The Resident reported to have fallen off his/her bed. The on-call NP was notified and close monitoring was recommended. -3/2/25 at 9:54 P.M.: The Resident had a witnessed fall without a head strike. -5/4/25 at 6:25 P.M.: At 4:30 P.M., the Resident came to the nursing station and reported to the nurse that he/she fell while fixing belongings in his/her closet. -6/1/25 at 3:21 P.M.: At about 10:00 A.M., the Resident's roommate notified the nurse the Resident fell in his/her room. The nurse found the Resident in the room on the floor. -6/1/25 at 10:12 P.M.: At 5:00 P.M., an Activities staff member reported to the nurse the Resident was sitting on the floor. The Resident stated he/she was looking for his/her shoes. Review of Resident #26's fall incident reports indicated, but was not limited to, the following: -11/4/24 at 12:54 A.M.: CNA alerted nurse that Resident was sitting on the floor. The Resident was noted to have a baseball sized lump on the right side of his/her head and his/her right thumb was bruised and slightly swollen with limited movement. The Resident stated he/she had to go to the bathroom and tripped. The Resident was transferred to the hospital for evaluation -11/18/24 at 7:00 P.M.: Resident was observed sitting on the floor on the hallway [sic]. Resident stated he/she forgot his/her walker. -1/14/25 at 2:12 P.M.: Resident was found by activities staff on the floor in emotional distress. Resident reported that he/she fell and was experiencing pain in his/her head, back, and hip and hit his/her head when he/she fell. The Resident was transferred to the hospital for evaluation. Imaging done at the hospital showed evidence of an acute L3 fracture. -1/16/25 at 11:22 P.M.: Resident was observed sitting on the floor. Resident stated he/she was fixing his/her sandals. [Note: the incident report is timed 11:22 P.M., but staff statements indicated the fall occurred at 7:30 P.M.] -2/4/25 at 12:40 P.M.: Resident was seen by staff sitting on the floor of his/her room scooting on his/her buttocks. Resident stated that he/she fell off the bed and that he/she was getting up in order to bring a stuffed animal to his/her roommate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/2/25 at 10:30 A.M.: Resident slipped out of his/her bed onto the floor while trying to dress self. Fall was witnessed by the nurse on duty and the Resident was assisted to sit on the side of the bed and assisted with dressing. -5/4/25 at 4:30 P.M.: Resident came to the nursing station and reported he/she fell while fixing belongings in his/her closet. -6/1/25 at 6:02 A.M.: Activities staff was hanging calendars on the Resident's unit and when she entered the Resident's room she saw the Resident on the floor sitting by his/her bed. The Resident said he/she was unable to get up [Note: the incident report is timed 6:02 A.M., but neurological assessment monitoring indicated the fall occurred at 10:00 A.M.] Of note, only one incident report was provided to the surveyor for 6/1/25; however, review of the Resident's medical record indicated Resident #26 had fallen twice on 6/1/25, once at approximately 10:00 A.M. and once at approximately 5:00 P.M. Review of Resident #26's Care Plans indicated, but was not limited to, the following: 1. Focus: FALL RISK: [Resident #26] is at risk for falls due to uses assistive device (walker) for walking, takes psychotropic drugs -Interventions: *02/4/2025 Resident is frequently monitored for safety and use of walker is encouraged at all times *02/6/2025 Resident is assisted with toileting. *1/16/2025 Be sure walker is placed at bedside as a reminder for resident to use when getting out of bed. *1/14/24 [sic] Medical work up - To follow up with Rehab *3/2/25 Staff to provide supervision and assistance with ADLs (activities of daily living) *5/6/25 PT eval *6/2/25 Resident will be assisted with changing clothing *Anticipate and meet the Resident's needs (initiated 2/4/25) *Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed The resident needs prompt response to all requests for assistance (initiated 2/4/25) *Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs (initiated 10/1/24) *Follow facility fall protocol (initiated 10/1/24) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Focus: new compression fracture of the L2 (a broken second lower back bone) -Interventions: *Assist with ambulation as he/she allows as needed (initiated 1/21/25) *Refer to rehab as indicated for eval and treatment (initiated 1/21/25) *Requires assist of two bed mobility [sic] (initiated 1/21/25) Further review of Resident #26's Care Plans failed to indicate new fall prevention interventions were implemented after the Resident had falls on 11/4/24 and 11/18/24 and only one new intervention was implemented after the Resident's two falls on 6/1/25. During an interview on 6/5/25 at 12:33 P.M., Certified Nursing Assistant (CNA) #2 said if a resident has a fall, the staff who finds the resident stays with them and calls for help. After the nurse has assessed the resident, the nurse will tell/inform the CNAs on the unit the resident had a fall and let them know if there are any new interventions implemented. During an interview on 6/5/25 at 12:37 P.M., CNA #3 said when a resident has a fall, the nurse does a report in the electronic health record and the CNAs are able to see if the resident has fallen and specific fall interventions put in place. During an interview on 6/5/25 at 12:44 P.M., Nurse #1 said when a resident has a fall, the nurse assesses the resident and completes an incident report. Nurse #1 said the nurse does not update the resident's care plan at that time. Nurse #1 said the Director of Nursing (DON) will review the incident report to make sure it is complete and the circumstances of the fall are identified. Nurse #1 said the DON will review the fall with others on the management team and the team will implement a new intervention. During an interview on 6/5/25 at 2:03 P.M., the DON said when a resident falls, the nurse completing the incident report should implement a new fall prevention intervention and update the resident's care plan. The DON said every fall should have a new care plan intervention implemented afterward and the nurse should evaluate the circumstances of the fall and implement an intervention that relates to the cause of the fall. The DON said if the intervention implemented is not appropriate, the care plan can be revised later when the fall is reviewed with the management team. The DON said the CNAs can see fall prevention care plan interventions in the electronic medical record and the nurse should also verbally communicate new interventions to the CNAs. The DON said a new fall prevention care plan intervention should have been implemented every time Resident #26 had a fall.

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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. Based on interviews and record review, for one Resident (#26), of 15 sampled residents, the facility failed to provide timely dental services. Specifically, for Resident #26, the facility failed to initiate replacement of a broken/missing partial upper denture timely. Findings include: Review of the facility's policy titled Dental Services, revised 1/2025, indicated, but was not limited to, the following: -If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink 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 #26 was admitted to the facility in October 2024 with diagnoses including dementia and atrial fibrillation. Review of the Minimum Data Set (MDS) assessment, dated 4/7/25, indicated that Resident #26 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Further review of MDS Section L, Oral/Dental Status, failed to identify any concerns with Resident #26's dental condition. Review of a document in Resident #26's medical record titled Care Plan Meeting, dated 1/15/25, indicated the Resident's partial upper denture was broken and dental services were requested by the Resident/Resident Representative. Review of Resident #26's Comprehensive Nutritional Evaluations, dated 1/4/25 and 3/31/25, failed to indicate the Resident's partial upper denture had broken or was missing. Review of Resident #26's progress notes indicated, but was not limited to, the following: -On 10/22/24, a piece of the Resident's partial upper denture broke and the Resident requested to see the dentist. The note indicated the dentist would come on 11/19/24. -On 10/24/24, the Resident's family was contacted to obtain information on the Resident's dentist and the family would provide the appointment date. -On 10/25/24, the Resident's family informed the facility that they were not able to obtain information on the Resident's dentist. Nurse #1 indicated in the note that they were going to find a dentist in the area and she would contact the Resident's physician for a dental referral. -On 11/22/24, the Resident misplaced her partial dentures in the bathroom trash. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/15/25, while the Resident was out of the facility at the hospital, the Resident's scheduled care plan review was done with the Resident's Representative, who requested a dental consult due to the Resident's complaint that his/her partial upper denture was broken. The note indicated the issue would be addressed when the Resident returned to the facility. -On 1/16/25, the Resident returned to the facility. -On 5/1/25, the Resident went to a dental appointment and returned with no new orders. Review of Resident #26's medical record indicated he/she signed a consent form for consultant dental services in the facility on 10/1/24. Review of a patient billing ledger from an outside dental provider indicated Resident #26 was seen for a comprehensive oral evaluation on 5/1/25. Review of Resident #26's initial exam report from the consultant dentist in the facility, dated 5/15/25, indicated the Resident's partial upper denture was lost. The dentist indicated an x-ray visit would be initiated to aid in the prior authorization for a new partial upper denture to be ordered. Review of Resident #26's medical record failed to include care plan information about the Resident's use of a partial upper denture or that the partial upper denture had been broken. Further review of the medical record failed to indicate that the Resident had been evaluated to ensure that he/she was able to eat and drink adequately while awaiting dental services. During an interview on 6/3/25 at 9:18 A.M., Resident #26 said he/she was missing a partial upper denture composed of five teeth. Resident #26 said he/she had recently seen a dentist but could not remember on what date. During an interview on 6/4/25 at 2:18 P.M., the Director of Nursing (DON) said Resident #26 was seen by a consulting dentist at the facility after he/she was seen by the outside dentist on 5/4/25. During an interview on 6/5/25 at 8:24 A.M., Nurse #2 said that when a Resident's dentures get broken, the facility's consultant dentist should be called and the dentures sent out to be repaired. During an interview on 6/5/25 at 11:23 A.M., Resident Representative #1 said Resident #26's issues with his/her partial upper denture began months ago and there was a delay in the facility addressing the issue. Resident Representative #1 said there was much phone and email correspondence with the facility over the course of months before the Resident was able to be seen by a dentist in May. Resident Representative #1 said she was not sure why it took so long for the Resident to be seen by a dentist. As of the survey exit on 6/5/25, Resident #26's record failed to indicate that a new partial upper denture had been ordered.

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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 observation, interviews, and record review, the facility failed to adhere to infection control standards of practice to prevent contamination and the potential spread of infections for one Resident (#41), out of a total sample of 15 residents. Specifically, the facility failed to implement Enhanced Barrier Precautions (EBP: infection prevention practice of wearing gown and gloves to reduce transmission of multi-drug-resistant organisms [MDRO's - bacteria that are resistant to three or more types of antimicrobial drugs]) when the Resident was identified as having wounds on his/her right foot. Findings include: Review of the facility's policy titled Enhanced Barrier Precautions, last revised 9/2022, indicated but was not limited to: -Enhanced barrier precautions are an infection prevention intervention designed to reduce the transmission of multidrug resistant organisms in the facility. The precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those with an increased risk of contracting an MDRO. -Use of enhanced barrier precautions includes but is not limited to residents with indwelling medical devices or wounds (regardless of MDRO colonization or infection status) in addition to those residents with confirmed colonization or infection with an MDRO. Resident #19 was admitted to the facility in February 2021 and had diagnoses including diabetes mellitus and atherosclerotic heart disease. Review of the Minimum Data Set assessment, dated 5/15/25, indicated Resident #19 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 00 out of 15 and had three venous/arterial ulcers and an infection in his/her foot. Review of a Nurse's Note, dated 5/3/25, indicated Resident #19 was noted with necrotic areas on the bottom of the second and third right foot. The Nurse Practitioner has an order to apply Betadine daily as well as Bacitracin ointment between right little toe for open area (sic). Review of a Physician's encounter note, dated 5/7/25, indicated the Resident had several wounds that were scabbed, a few necrotic areas on his/her right foot likely due to peripheral vascular disease. The note indicated the Resident had a superimposed infection and would start the Resident on antibiotic treatment. Review of Physician's orders indicated the Resident was prescribed the antibiotic Keflex three times a day from 5/7/25 to 5/14/25. Further review of the medical record failed to indicate EBP was put into place upon identification of the wounds and infection to Resident #19's right foot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225134	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foremost at Sharon LLC	259 Norwood Street Sharon, MA 02067

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 8:16 A.M., the surveyor observed no EBP sign posted outside of Resident #19's room and no personal protective equipment (PPE: items such as gown and gloves worn by the staff member to decrease the chance of spread of infection) was readily available. On 6/3/25 at 8:18 A.M., the surveyor observed Certified Nursing Aide (CNA) #1 reposition Resident #19 while he/she was lying in bed. The CNA was not wearing a gown and/or gloves while providing high contact care. Review of the medical record indicated a Physician's order for EBP was initiated on 6/3/25, 31 days after the wounds were identified to Resident #19's right foot. During an interview on 6/4/25 at 9:41 A.M., Nurse #1 said the Resident was placed on EBP due to wounds on his/her foot. She could not explain why the EBP were not put into place when the wounds were first identified on 5/3/25. During an interview with the Infection Preventionist (IP) on 6/5/25 at 8:56 A.M., the surveyor shared the 6/3/25 observation of no EBP sign posted at Resident #19's door, no PPE readily accessible in the vicinity of the Resident's room, and CNA #1 repositioning Resident #19 in bed without wearing PPE. The IP said any resident with a wound is supposed to be on EBP and she could not explain why the Resident was not placed on EBP on 5/3/25 when the wounds were identified to his/her right foot. During an interview on 6/5/25 at 9:40 A.M., the surveyor shared the observation made on 6/3/25 at 8:18 A.M. of no EBP sign posted at Resident #19's door, no PPE readily accessible in the vicinity of the Resident's room, and CNA #1 providing high contact care to Resident #19 without wearing PPE. The DON said Resident #19 has a wound and should be on EBP. She could not explain why Resident #19 was not placed on EBP when the wounds were first identified on 5/3/25.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review, and interview, the facility failed to complete an inspection of the bed rails, to identify areas of possible entrapment for three Residents (#1, #19, and #24), out of a sample of 15 residents. Specifically, the facility failed to: 1. For Residents #1 and #19, complete a new assessment of the bed, side rails and mattresses in active use for potential entrapment when the bed mattress was changed from the previously assessed mattresses, placing the Residents who had limited mobility and utilized bilateral side rails, at risk for possible entrapment; and 2. For Resident #24, to ensure the mattress bolster/extender (an object used to fill gaps between the mattress and footboard of a bed) was in place to fill the gap between the mattress and the footboard with the metal bed frame exposed, leaving the Resident at risk for entrapment and/or injury. Findings include: Review of the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/2006, indicated: The term entrapment describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Resident entrapments may result in death and serious injuries. There are 7 zones of bed entrapment: Zone 1 (within the rail), Zone 2 (under the rail), Zone 3 (between rail and mattress), Zone 4 (Under the rail, at the ends of the rail), Zone 5 (between split bed rails), Zone 6 (between the end of the rail and the side edge of the head or footboard) and Zone 7 (Between the head or footboard and the mattress end). Review of guidance from the FDA titled Recommendations for Health Care Providers about Bed Rails, dated 07/09/2018, included: - Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and/or depth, the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. - Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. Review of the facility's policy titled Proper Use of Side Rails, last revised 1/2025, indicated but was not limited to the following: -The purposes of this policy is to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. -When used for mobility or transfer, an assessment will include a review of the resident's risk of entrapment from the use of side rails. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1A. Resident #1 was admitted to the facility in January 2025 and had moisture associated skin damage. Review of the Minimum Data Set (MDS) assessment, dated 6/1/25, indicated Resident #1 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15, had moisture associated skin damage and utilized a pressure reducing device in bed. On 6/3/25 at 8:20 A.M., the surveyor observed Resident #1 lying in bed awake, bilateral side rails up and in use, and an air mattress was in place. On 6/5/25 at 1:30 P.M., the surveyor observed Resident #1 sitting upright in bed awake, bilateral side rails up and in use, and an air mattress was in place. Review of comprehensive care plans indicated Resident #1 received an air mattress on 5/16/25 to relieve pressure. B. Resident #19 was admitted to the facility in February 2021 and had wounds to his/her right foot. Review of the MDS assessment, dated 5/15/25, indicated Resident #19 had severe cognitive impairment as evidenced by a BIMS score of 00 out of 15, had three venous/arterial ulcers and an infection in his/her foot and utilized a pressure reducing device in bed. On 6/3/25 at 8:16 A.M., the surveyor observed Resident #19 lying asleep in bed with bilateral side rails up and in use and an air mattress was in place. On 6/4/25 at 9:46 A.M., the surveyor observed Resident #19 sitting upright in bed with bilateral side rails up and in use and an air mattress was in place. Review of the medical record indicated the following Physician's Orders: -Side rails: 1/4 two up as an enabler/positioning (4/2/24) -Place perimeter mattress on bed (1/10/25) Review of comprehensive care plans indicated Resident #19 received an air mattress on 5/16/25 to relieve pressure, setting to resident comfort level. 2. Resident #24 was admitted to the facility in January 2024 and had diagnoses including chronic kidney disease. Review of the MDS assessment, dated 4/9/25, indicated Resident #24 had moderate cognitive impairment as evidenced by a BIMS score of 8 out of 15. On 6/3/25 at 8:00 A.M., the surveyor observed Resident #24 lying in bed asleep on a regular mattress. The metal bed frame was exposed at the foot of the bed with a gap approximately 6 from end of mattress to the footboard. No mattress bolster/extender was installed on the bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 10:50 A.M., the surveyor observed Resident #24 lying in bed awake on a regular mattress. The metal bed frame was exposed at the foot of the bed with a gap approximately 6 from end of mattress to the footboard. No mattress bolster/extender was installed on the bed. On 6/5/25 at 11:00 A.M., the surveyor observed Resident #24 lying in bed awake on a regular mattress. The metal bed frame was exposed at the foot of the bed with a gap approximately 6 from end of mattress to the footboard. No mattress bolster/extender was installed on the bed. On 6/5/25 at 2:00 P.M., the surveyor observed Resident #24 lying in bed awake on a regular mattress. The metal bed frame was exposed at the foot of the bed with a gap approximately six inches from end of mattress to the footboard. No mattress bolster/extender was installed on the bed. During an interview on 6/4/25 at 10:00 A.M., the Maintenance Director said he has only worked at the facility for a few weeks and was not aware that regular side rail safety assessments were required and that safety assessments needed to be conducted whenever a mattress is changed. During an interview on 6/4/25 at 11:40 A.M., the Regional Director of Operations provided the survey team with a three-ringed binder containing side rail safety assessments for 2024. He said he could not find any other side rail safety assessments and the documentation in the binder is all they have. Review of the Bed Entrapment Assessment documentation binder: -failed to indicate Resident #1's bed had ever been measured for risk of entrapment. -failed to indicate Resident #19's bed was measured for risk of entrapment when the Resident received a perimeter mattress on 1/10/25 and an air mattress on 5/16/25. -failed to indicate Resident #24's bed (with a regular mattress) was measured for risk of entrapment. The last assessment, dated 4/30/24, indicated Resident #24 had an air mattress. During an interview with the Maintenance Director and the Regional Maintenance Director on 6/5/25 at 2:10 P.M., the Regional Maintenance Director said bed rail safety inspections should have been conducted when Residents #1, #19 and #24 had a change in mattress. The Regional Maintenance Director said Resident #24's mattress is too small for the bed frame and the gap between the mattress and footboard should not be that big. He said there should be a filler piece in place to fill the gap. He said a filler piece was likely in place at some point and may have gotten removed when the bed was changed and not put back into place.