STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225137	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dexter House Healthcare	120 Main Street Malden, MA 02148

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#95) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 25 residents. Specifically, for Resident #95 the facility failed to ensure nursing scheduled medications around his/her dialysis days. Findings include: Review of the facility policy titled, End Stage Renal Disease, dated as revised July 2023, indicated the facility assures that each resident receives care and services for provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. Resident #95 was admitted to the facility in September 2023 with diagnosis including acute on chronic diastolic heart failure, end stage renal disease, and benign prostate hypertrophy. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/3/25, indicated that Resident #95 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #95 required dialysis. Review of Resident #95's nursing note, dated 7/24/25, indicated new dialysis schedule on Monday, Wednesday, and Friday. Review of Resident #95's nursing progress noted, dated 7/29/25, indicated:-Resident is starting new dialysis center on Wednesday. New Schedule starting Monday, Wednesday, Friday. Review of Resident #95's physician's orders, dated 7/30/25, indicated: -Dialysis on Monday, Wednesday, and Friday at 6:00 A.M., scheduled at 6:00 A.M. Review of Resident #95's physician's orders, dated 9/11/24, indicated:-metoprolol succinate extended-release (ER) tablet, give 12.5 milligrams (mg) one time a day every Monday, Wednesday, Friday, and Sunday. Further review of the order indicated for the medication to be administered at 8:00 A.M. Review of Resident #95's Medication Administration Record, dated September 2025, indicated on 9/1/25, 9/3/25, 9/5/25, 9/8/25, 9/10/25, 9/12/25, 9/15/25, 9/17/25, 9/19/25, 9/22/25, and 9/24/25, nursing did not administer the metoprolol as ordered and documented the medication as out of facility. Review of Resident #95's physician's orders, dated 5/31/25, indicated: -Isosorbide Mononitrate ER tablet, give 15 milligrams (mg), one time a day for atherosclerotic heart disease. Further review of the order indicated for the medication to be administered daily at 8:00 A.M. Review of Resident #95's Medication Administration Record, dated September 2025, indicted on 9/1/25, 9/3/25, 9/5/25, 9/8/25, 9/10/25, 9/12/25, 9/15/25, 9/19/25, 9/22/25, and 9/24/25, nursing did not administer the medication and documented as out of facility. Review of Resident #95's plan of care related to dialysis, dated as revised 9/9/25, indicated:-Administer/monitor effectiveness of medications of medications as ordered.-Dialysis on Monday, Wednesday, and Friday at 6:00 A.M. During an interview on 9/25/25 at 9:40 A.M., Nurse #4 said that antihypertensives should not be given prior to dialysis but should be scheduled to be administered on non-dialysis days. During an interview on 9/25/25 at 9:44 A.M., Resident #95 said that he/she goes to dialysis on Mondays, Wednesdays, and Fridays. Resident #95 said that his/her blood pressure sometimes goes below 100 (hypotensive) during dialysis, and the staff need to lay him/her down during dialysis treatment. Resident #95 said he/she should not get blood pressure medications prior to dialysis, and he/she should take them on non-dialysis days. During an 9/25/25 on 10:26 A.M., the Nurse Practitioner said that Resident #95 takes the isosorbide for heart disease and the management of chest pain, and the metoprolol is (continued on next page)

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered for cardiomyopathy, and she said that nursing should administer these medications around the dialysis schedule. During an interview on 9/25/25 at 11:11 A.M., the Director of Nursing (DON) said cardiac medications are important for Resident #95 and the isosorbide and the metoprolol should be given around the dialysis schedule. The DON said that the nurses who documented the resident was out of the facility should have updated the providers and make obtain new orders with Resident #95's dialysis schedule.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record reviews for three Residents (#70, #46, and #34) out of five residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. Three out of four nurses observed made four errors out of 25 opportunities resulting in a medication error rate of 16%. Specifically,a.) For Resident #70, Nurse #1 administered the incorrect form of multiple vitamin.b.) For Resident #46, Nurse #2 administered the incorrect form of aspirin, and she did not follow manufacture's recommendations and crushed a medication that indicated do not crush. c.) For Resident #34, Nurse #3 administered an enoxaparin (medication used for blood clot prevention) injection intramuscularly (by holding the needle at a 90-degree angle into the muscle, allowing rapid absorption into the blood stream) into the vastus lateralis muscle (outer side of the thigh, part of the quadriceps muscle) instead of subcutaneously (injecting into pinched skin at a 90-degree into the fat) in accordance with the physician's orders. Findings include:Review of the facility policy titled, Administering Medications, dated as revised September 2024, indicated medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation b. Medications are administered in accordance with prescriber's orders.e. The individual administering medications checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. a.) On 9/24/25 at 8:44 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #70. Nurse #1 administered the following:-one Multiple Vitamin tablet. Review of Resident #70's physician's order, dated 1/30/25, indicated for nursing to administer one tablet of multiple vitamins with minerals. During an interview on 9/24/25 at 1:42 P.M., Nurse #1 she didn't have multiple vitamins with minerals on her medication cart, and she gave the Resident a standard multiple vitamin without minerals. Nurse #1 checked the medication storage room with the surveyor, and she said there were no multiple vitamins with minerals available. During an interview on 9/24/25 at 3:19 P.M., the Director of Nursing (DON) said that nursing should have obtained the correct multiple vitamins. b.) On 9/24/25 at 8:58 A.M., the surveyor observed Nurse #2 prepare and administer mediations to Resident #46. Nurse #2 crushed and administered the following: -aspirin 81 milligrams (mg) enteric coated, and-Carbidopa-Levodopa Extended Release 50-200 mg. Review of Resident #46's physician's orders indicated the following:-aspirin 81 mg chewable tablet, dated 11/24/24. Not the enteric coated aspirin Nurse #2 administered. -Carbidopa-Levodopa Extended Release (ER) 50-200 mg. Review of the medication card indicated, HIGH ALERT, DO NOT CRUSH OR CHEW. During an interview on 9/24/25 at 1:59 P.M., Nurse #2 said that she should have administered the correct aspirin, and she should have followed the manufactures directions and not crushed Resident #46's Carbidopa-Levodopa ER tablet. During an interview on 9/24/25 at 3:21 P.M., the Director of Nursing said the nursing should have administered the correct aspiring and she should have not crushed the Carbidopa-Levodopa ER tablet. c.) On 9/24/25 at 9:15 A.M., the surveyor observed Nurse #3 prepare and administer medications for Resident #34. Nurse #3 administered one injection of enoxaparin intramuscularly into Resident #34' right vastus lateralis muscle. Nurse #3 held Resident #34s skin taught and she injected the enoxaparin injection into the muscle. Nurse #3 said enoxaparin should be administered intramuscularly. Review of Resident #36's physician's order, dated 1/29/25, indicated:-enoxaparin sodium solution 40 milligrams (mg), give 40 mg subcutaneously one time a day for prevent blood clotting. During an interview on 9/24/25 at 1:54 P.M., Nurse #3 said she should have administered Resident #34's enoxaparin injection subcutaneously into his/her abdomen and not intramuscularly into his/her thigh. During an interview on 9/24/25 at 3:22 P.M., the Director of Nursing said that Nursing should have administered Resident #34 the enoxaparin injection subcutaneously into the abdomen.

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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. Based on observation and interview, the facility failed to properly follow food storage and food handling practices to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Specifically, the facility failed to properly store food items in the kitchen to prevent the risk of foodborne illness.Findings include:Review of the facility policy titled Food and Supply Storage, dated and revised June 2018, indicated the following:- Labeling and rotating food supply:- Refrigerated Time/Temperature Control for Safety Food, ready-to-eat food prepared on site that is held longer than 24 hours should be properly labeled with the common name, the preparation date (day 1) and use-by date (maximum 7 days)- Discard food that exceeds their use-by date or is spoiled.During the initial walkthrough of the kitchen on 9/24/25 at 7:01 A.M., the surveyor observed the following:- In the walk-in refrigerator:- A box of bell peppers with white and black spots that resembled mold and were soft to the touch.- A box of three cucumbers that were covered in white spots resembling mold that were shriveled and very soft to touch.- A container of cantaloupe melon with a melon having a dark black spot resembling mold, it was very soft to touch.- A container labeled [NAME] Crackers with no packaged date or use by date.- A container of Chocolate Frosting with only one date of 9/20.- An opened bag of shredded cheese with only one date of 9/16.- In the Reach-in Refrigerator:- Three pre-poured jugs containing what resembled juice, there were no labels of what the item was or any dates.- A container of Apple Sauce with a use by date of 9/22.During the re-visit to the kitchen on 9/25/25 at 7:38 A.M., the surveyor observed the following:- A box of bell peppers with white and black spots that resembled mold and were soft to the touch.- A box of three cucumbers that were covered in white spots resembling mold that were shriveled and very soft to touch.- A container of cantaloupe melon with a melon having a dark black spot resembling mold, it was very soft to touch.- A container labeled [NAME] Crackers with no packaged date or use by date.- A container of Chocolate Frosting with only one date of 9/20.During an interview on 9/25/25 at 7:47 A.M., the Foodservice Director said all prepared and opened foods should be labeled as what they are and have two dates, the prepared date and the use-by date. The Foodservice Director then said the produce should have been discarded after observing it with the surveyor.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain informed consent from the responsible party of one Resident (#11) out of a total sample of 25 residents. Findings include:Review of the facility policy titled Pyschotropic Medication, revised 07/2023, indicates the following: A written informed consent from the resident (or legally authorized individual in the case of resident incompetence) is required for administration of psychotropic medication. Resident #11 was admitted in February 2023 with diagnoses including dementia and psychotic disorder with delusions. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #11 scored a 3 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Review of the physician's orders for Resident #11 indicated that he/she has active orders for the medications Risperdal (an antipsychotic medication used to treat Schizophrenia) and Fluoxetine (a psychotropic medication used to treat depression). Review of the psychotropic consent administration forms for Fluoxetine and Riperdal indicate that both were signed on 11/4/24 by Resident #11. Review of the health care proxy invocation form indicated that Resident #11's health care proxy was invoked on 8/1/22, indicating that Resident #11 could no longer make his/her own decisions due to dementia. During an interview on 9/25/25 at 11:07 A.M., the Director of Nursing said that Resident #11 should not be signing his/her own consents for medication if he/she has an invoked health care proxy.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one Resident (#84) was assessed for and free from restraints out of a total sample of 25 residents. Specifically, the facility failed to ensure Resident #84 was free from a restraint in the form of bolsters that ran from the head of the bed to the foot of the bed on both sides to keep the Resident in bed.Findings include:Review of the facility's policy titled Use of Restraints, dated and revised January 2024, indicated the following:- Guidelines: Prior to placing a resident in restraints, there shall be a pre-restraining evaluation and review to determine the need for restraints. The evaluation shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms.- Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.Resident #84 was admitted to the facility in April 2025 with diagnoses including unspecified fracture of the right humerus, type 2 diabetes mellitus and Alzheimer's disease.Review of Resident #84's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 1 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident requires substantial/maximum assistance from staff for activities of daily living and partial/moderate assistance when transferring out of bed.The surveyor made the following observations:- On 9/24/25 at 7:51 A.M., Resident #84 was sleeping in his/her bed. On the left and right side of the bed, bolsters were observed to be tucked under Resident #84's sheet and running from the head of the bed to the foot of the bed, covering the length of the Resident in bed.- On 9/25/25 at 8:34 A.M., Resident #84 was eating his/her breakfast in bed. On the left and right side of the bed, bolsters were observed to be tucked under Resident #84's sheet and running from the head of the bed to the foot of the bed, covering the length of the Resident in bed.- On 9/25/25 at 1:22 P.M., Resident #84 was not in his/her bed. Beside his/her bed were fall mats on the floor, on top of the fall mats were two bolster pads.Review of Resident #84's physician's orders does not indicate an order for the use of bed bolsters.Review of Resident #84's falls care plan indicated the following intervention dated 5/22/25: Scoop Mattress, requested by the family.Review of Resident #84's fall care plan and all active care plans, failed to indicate the use of bed bolsters.Review of a progress note written by the Nurse Practitioner dated 5/30/25 at 10:35 P.M., indicated the following but is not limited to: Patient continues with poor safety awareness with multiple attempts to get out of bed without help. He/she is on a scoop mattress to help deter self-transfers from bed.Review of Resident #84's medical record failed to indicate an assessment for the use of any restraint including bed bolsters or a scoop mattress.During an interview on 9/26/25 at 7:11 A.M., Certified Nursing Assistant (CNA) #1 said Resident #84's mattress has raised edges because he/she is a fall risk, and he/she tries to swing his/her legs over the bed, and the edges help keep him/her in bed.During an interview on 9/26/25 at 7:13 A.M., Nurse #6 said Resident #84 has bolsters on his/her bed by his/her family's request. Nurse #6 said bolsters need to be assessed for the use as a restraint because Resident #84 should be able to get out of bed if he/she wants to. Nurse #6 and the surveyor observed Resident #84 in bed, Nurse #6 lifted Resident #84's sheet and observed the bolsters in place.During an interview on 9/26/25 at 9:13 A.M., the Assistant Director of Nursing (ADON) said Resident #84's family brought in the bed bolsters and have been putting them under the sheets. The ADON then said the facility should have completed a restraint assessment as the bolsters are a potential restraint. The ADON and the surveyor reviewed Resident #84's medical record and did not identify a restraint assessment or evaluation.During an interview on 9/26/25 at 10:02 A.M., the Director of Nursing (DON) said a restraint assessment should have been completed before the use of bed bolsters for Resident #84.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure standards of quality of care were implemented for one Resident (#110) out of a total sample of 25 residents. Specifically, the facility failed to ensure a treatment was in place for a non-pressure wound of the left, first toe and ensure the treatment orders were completed as written.Findings include:Review of the facility policy titled Prevention and management of Pressure Ulcers/Injuries, dated and revised November 2024, indicated the following:- Develop the resident-centered care plan and interventions based on the risk factors identified, the condition of the skin, the resident's overall clinical condition.Resident #110 was admitted to the facility in July 2025 with diagnoses including fracture of the left femur and chronic obstructive pulmonary disease.Review of Resident #110's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental score of 15 out of 15 indicating intact cognition. Further review of the MDS indicated that Resident #110 was at risk of developing pressure ulcer/injuries, has unhealed pressure ulcers/injuries including one unstageable pressure ulcer, does not reject care and requires staff assistance with all activities of daily living.The surveyor made the following observations:- On 9/24/25 at 7:45 A.M., Resident #110 was sleeping in his/her bed and his/her left foot was visible. On his/her left first toe was a scabbed and open area about the size of a dime. No treatment was in place.- On 9/25/25 at 6:54 A.M, 8:21 A.M., 10:45 A.M. and 1:17 P.M, Resident #110 was lying in his/her bed with his/her left foot visible. On his/her left first toe was a scabbed, open area about the size of a dime. No treatment was in place.- On 9/26/25 at 6:50 A.M., Resident #110 was sleeping in his/her bed with his/her left foot visible. On his/her left first toe was a scabbed, open area about the size of a dime. No treatment was in place.Review of Resident #110's Wound Evaluation and Management Summary dated 9/23/25, performed by the wound doctor, indicated the following:- Non-Pressure wound of the left, first toe with an etiology of trauma/injury.- Dressing Treatment Plan: Primary Dressing - A+D (an ointment that goes on the skin) apply once daily and as needed. For 30 days; Gauze sponge non-sterile apply once daily and as needed. Secondary Dressing - Gauze roll 4.5 apply once daily and as needed for 30 days.Review of Resident #110's Skin Integrity Care Plan indicated the following intervention dated 7/15/25: Consult and treatment by Wound MD (medical doctor) or Certified Wound Nurse PRN (as needed) and as ordered.Review of Resident #110's Norton Scale for Predicting Risk of Pressure Ulcers dated 9/23/25/ indicated that the Resident is at risk for developing pressure ulcers.Review of Resident #110's physician's orders dated 9/23/25 indicated the following order:- L (left) 1st toe- A & D, gauze, and tape daily AMT (amount): SC = Scant, SM = small, M = Medium, L = large. DRN (drainage): C = clear, SS = serosang, S = serous, P = purulent. WB: G = granulation, S = slough, N = necrotic. SAW: I = intact, P = pink, E = Erythema, M = moist, D = dry. OUT: B = better, W = worse, NC = no change. Change every shift.Review of Resident #110's Treatment Administration Record for September 2025 failed to indicate that the above parameters were being documented and each date was only documented with a check mark, but did not acknowledge the written parameters as ordered.During an interview on 9/26/25 at 9:03 A.M., Nurse #1 and the Assistant Director of Nursing (ADON) said Resident #110's treatment orders for his/her left toe should have been implemented since they were recommended by the wound doctor. The ADON then said when she input the order to track the progress of Resident #110's left toe wound, it got input wrong resulting in no place for staff to document the progress of the wound.During an interview on 9/26/25 at 10:02 A.M., the Director of Nursing (DON) said Resident #110's treatment orders should be followed so his/her wound does not worsen, and the Resident's treatment order needs to be updated so the treatment parameters can be documented by staff.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to follow recommendations of the wound doctor and implement the plan of care for one Resident (#110) out of a total sample of 25 Residents. Specifically, the facility failed to ensure Resident #110's feet were offloaded as recommended by the wound doctor and the plan of care.Findings include:Review of the facility policy titled Prevention and management of Pressure Ulcers/Injuries, dated and revised November 2024, indicated the following:- Develop the resident-centered care plan and interventions based on the risk factors identified, the condition of the skin, the resident's overall clinical condition.Resident #110 was admitted to the facility in July 2025 with diagnoses including fracture of the left femur and chronic obstructive pulmonary disease.Review of Resident #110's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental score of 15 out of 15 indicating intact cognition. Further review of the MDS indicated that Resident #110 was at risk of developing pressure ulcer/injuries, has unhealed pressure ulcers/injuries including one unstageable pressure ulcer, does not reject care and requires staff assistance with all activities of daily living.The surveyor made the following observations:- On 9/24/25 at 7:45 A.M., Resident #110 was sleeping in his/her bed with his/her right foot wrapped in a bandage. Both the Resident's left and right foot were directly on the mattress. No pillow or device were present to offload his/her feet.- On 9/25/25 at 6:54 A.M, 8:21 A.M., 10:45 A.M. and 1:17 P.M, Resident #110 was lying in his/her bed with his/her right foot was wrapped in a bandage. Both the Resident's left and right foot were directly on the mattress. No pillow or device were present to offload his/her feet.Review of Resident #110's potential alteration in skin integrity care plan indicated the following interventions dated 7/17/25: Follow MD (medical doctor) orders for skin care and treatments, heels offloaded when in bed.Review of Resident #110's Norton Scale for Predicting Risk of Pressure Ulcers dated 9/23/25 indicated that the Resident is at risk for developing pressure ulcers.Review of Resident #110's Wound Evaluation and Management Summary dated 9/23/25, performed by the wound doctor, indicated the following:- Unstageable deep tissue injury with an etiology of pressure on the left heel, approach: off-loading. Additional Wound detail: Recommend aggressive offloading/repositioning.Review of Resident #110's physician's orders failed to indicate an order for Resident #110 to offload his/her feet.During an interview on 9/26/25 at 9:03 A.M., Nurse #1 and the Assistant Director of Nursing (ADON) said Resident #110's feet should be elevated while he/she is in bed and the recommendations from the wound doctor should be followed as well as the care plans.During an interview on 9/26/25 at 10:02 A.M., the Director of Nursing (DON) said Resident #110's feet should be elevated when he/she is in bed if that is what the wound doctor recommended so his/her pressure ulcers do not worsen.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure enteral nutrition provided via a gastrostomy tube (a tube surgically inserted through the abdominal wall directly into the stomach with the purpose of delivering food, typically in the form of liquid formula) was provided according to professional standards for two Residents (#36, #8) out of a total sample of 25 Residents. Specifically, the facility failed to ensure a tube feeding was labeled and dated when opened for Residents #38 and #8.Findings include: 1.Resident #36 was admitted to the facility in January 2025 with diagnoses including cerebral infarction, diabetes, and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/25, indicated that Resident #36 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #36 did not eat, had a feeding tube in place, and required tube feeding. On 9/24/25 at 7:48 A.M., the surveyor observed an open bottle of tube feeding without a date. The bottle of tube feeding indicated the following precautions: -Feeding sets are for single patient use only. -Hang product for up to 48 hours after initial connection when clean technique and only one new feeding set is used. Otherwise, hang no longer than 24 hours. -Use by date on container. On 9/24/25 at 9:35 A.M., the surveyor observed Nurse #36 administer tube feeding formula from an opened an undated tube feeding bottle on the bedside table. Review of Resident #36's physician's order, dated 3/12/25, indicated: -Enteral feed five times day. Glucerna 1.2, bolus (a type of tube feeding administration) 240 cc (milliliters) 5x/day at 6:00 A.M., 10:00A.M., 2:00 P.M., 6:00 P.M., and 10:00 P.M., total volume 1200 milliliters. During an interview on 9/24/25 at 9:36 A.M., Nurse #3 said that Resident #36's tube feeding bottle was opened and undated when she administered the feeding and she said she assumed it was opened by the night nurse, but she was not certain. Nurse #3 said that bottles of tube feed should be dated when opened and used by the expiration date. During an interview on 9/24/25 at 3:29 P.M., the Director of Nursing said that nursing should date and label tube feedings according to manufacturer's directions. During an interview on 9/24/25 at 3:45 P.M., the Director of Clinical Operations said that the facility did not have a policy on enteral feeding administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225137	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dexter House Healthcare	120 Main Street Malden, MA 02148

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #8 was admitted to the facility in May 2025 with diagnoses including acute and chronic respiratory failure with hypoxia, dysphagia and hemiplegia/hemiparesis. Review of Resident #8's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident was unable to complete the Brief Interview for Mental Status exam indicating that the resident is severely cognitive impaired, further review of the MDS indicated that the Resident is currently receiving tube feeding therapy and is dependent on staff for all activities of daily living. The surveyor made the following observation: - On 9/25/25 at 8:14 A.M., Resident #8 was sleeping in his/her bed receiving enteral nutrition via a feeding tube (a tube surgically inserted through the abdominal wall directly into the stomach with the purpose of delivering food, typically in the form of liquid formula). The tube feeding pump was powered on indicating that Resident #8 was receiving tube feeding formula. The tube feeding bag failed to have any identification of what type of formula or the date and time it started. Review of Resident #8's physician's orders indicated the following: - Enteral Feed order: two times a day Nutren 2.0 (an enteral tube feeding formula) cal (calorie) 35 ml/hr (milliliters/hour) for 18 hrs (hours) (7pm-1pm) for total of 630 ml daily – Ordered 5/19/25 - Enteral Feed Order: every shift via Automatic flush by enteral feed pump – give free H2O (water) 50ml every 1 hours x 18 hrs 7pm-1pm – Ordered 9/22/25 Review of Resident #8's Nutrition care plan indicated the following intervention dated 2/15/25: Provide enteral nutrition as ordered. During an interview on 9/25/25 at 8:26 A.M., Nurse #7 said when residents are receiving tube feeding formula, the opened bags need to be labeled and dated so staff members know what each resident is receiving. Nurse #7 and the surveyor observed Resident #8's tube feeding bag and Nurse #7 said it is not labeled nor dated and it should be. During an interview on 9/25/25 at 9:12 A.M., the Director of Nursing said all tube feeding bags need to be labeled and dated so staff know what the solution is and when it was hung and what rate of feeding the Resident is receiving.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225137	A. Building B. Wing	09/26/2025

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Dexter House Healthcare	120 Main Street Malden, MA 02148

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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 - 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 and interview, the facility failed to properly store and dispose of medication on one unit. Specifically, a medication was found behind a broken radiator that was easily accessible to the residents on the unit. Findings include:During an observation on 9/24/25 at 8:55 A.M., a large white pill was found on the floor behind a broken radiator in the hallway on the B unit. The pill was easily accessible to residents wandering on the unit and was outside of the door to one resident's room. The surveyor notified the nurse on the unit and she said that the medication looked like Atorvastatin (a medication used to lower cholesterol), but that she could not be positive that was the medication. The nurse said she would dispose of the medication immediately. During an interview on 9/26/25 at 10:09 A.M., the Director of Nursing said that if a medication is found on the floor in the hallway then the nurse should try to identify where the pill came from and then destroy the pill. She said there should not be a medication on the floor in the hallway and there is a risk that a resident could pick up the pill and ingest it.