STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225145	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhill Healthcare	76 North Street Middleboro, MA 02346

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure residents had a homelike environment. Specifically, the facility failed to: 1. Ensure Resident #1's fall mats and walls were in good repair and clean; and 2. Ensure residents on the B-Unit and C-Unit had an environment that was in good repair and homelike.Findings include: 1. Resident #1 was admitted to the facility in August of 2018 with diagnoses including cerebrovascular accident (stroke).Review of the Minimum Data Set assessment, dated 10/16/25, indicated on the staff assessment for mental status the Resident has a short-term and long-term memory impairment.On 12/30/25 at 7:59 A.M., the surveyor observed the following in Resident #1's room:- Resident #1 in bed with a ripped fall mat with approximately a 6-inch by 14-inch area of stained foam exposed on the left side of the Resident's bed.-Two missing floor tiles on the right side of the bed-An area of the wall with brown stains approximately two and a half feet in width.The surveyor made the same subsequent observations on:12/30/25 at 10:56 A.M.,12/30/25 at 11:17 A.M.,12/30/25 at 12:34 P.M.,12/30/25 at 1:52 P.M., and12/30/25 at 3:30 P.M.During an interview on 12/30/25 at 10:50 A.M., Nurse #2 said if there was something emergent that needed to be fixed or cleaned, she would call Maintenance or Housekeeping. She said if it wasn't urgent but needed to be addressed, she would input the request into an electronic tracking log. She said there are no outstanding maintenance requests she is aware of on the unit.Review of the Maintenance Log, dated December 1-30, indicated no requests for Resident #1 were made prior to the surveyor inquiring about the Resident's environment with facility staff.During an interview on 12/30/25 at 3:14 P.M., Housekeeping Staff #1 said she has finished cleaning Resident #1's room for the day.During an interview on 12/30/25 at 3:42 P.M., Nurse #7 said he didn't know the process for maintenance requests because he doesn't work at the facility regularly. He said he wasn't sure how long the stains had been on the wall, and he said it looks to be the same color as Resident #1's liquid tube feed. He said the room needs attention from Housekeeping and Maintenance.During an observation with an interview on 12/31/25 at 7:19 A.M., the surveyor observed the same light brown stain on the wall and ripped floor mat. During this time the surveyor observed the Maintenance Director enter the room. He said he was made aware of the broken floor tiles and dirty wall. He said it should not look like this. The surveyor observed the ripped floor mats after Maintenance had attended to the room on:-12/31/25 at 8:45 A.M.,-1/5/26 at 7:42 A.M., and-1/6/26 at 10:40 A.M.During an interview at 1/6/26 at 10:44 A.M., the Administrator said the Resident's equipment and room should be in good repair and homelike. 2. On 1/6/26 at 7:48 A.M., the surveyor observed the following on the B-Unit:-room [ROOM NUMBER]'s screen door was ripped off of the hinge and duct tape was along the edge of door on the inside. -room [ROOM NUMBER]'s curtain to outside sliders was off track.-room [ROOM NUMBER]'s bottom drawer was missing a handle, and the closet door was without a handle.-room [ROOM NUMBER]'s wall was stained with drip stains behind the bed.-room [ROOM NUMBER]'s two bottom drawers were without hand pulls.-room [ROOM NUMBER]'s two bottom drawers were without hand pulls. On 1/6/26 at 8:04 A.M., the surveyor observed the following on the C-Unit:-room [ROOM NUMBER]'s closet door was in disrepair and falling off the track.-room [ROOM (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NUMBER] had a missing closet door.-room [ROOM NUMBER] had a missing closet door.-room [ROOM NUMBER] had a missing closet door.During an interview on 1/6/26 at 10:40 A.M., the Maintenance Director said he is new at the building and did not realize that a homelike environment meant furnishings being in good repair. He said he believed that Housekeeping was responsible for maintaining the floor mats. During an interview on 1/6/26 at 10:44 A.M., the Administrator said all areas of the building should be in good repair, clean, and homelike. He said the electronic system used for maintenance requests should be utilized for concerns like these and he expects them to be identified and addressed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of practice for one Resident (#27), out of a total sample of 19 residents, when they did not implement a physician's order for referral to psychiatric services following a monthly medication regimen review. Findings include: Review of the facility's policy titled Medication Regimen Review, dated 8/2020, indicated but was not limited to the following:- resident specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's active medical record and reported to the Director of Nurses (DON), Medical Director, and or prescriber, as appropriate-recommendations are acted upon and documented by the facility staff and/or the prescriber Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.-In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Resident #27 was admitted to the facility in October 2025 and had diagnoses including: Extrapyramidal and movement disorder, Unspecified dementia without behavioral disturbance, nightmare disorder, and delusional disorder. Review of the Minimum Data Set assessment signed as completed in November 2025 indicated Resident #27 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Review of the monthly Medication Regimen Review (MRR) for Resident #27 from October 2025 indicated a consultant pharmacist recommendation to prescriber was left for the Physician and indicated the following:-10/6/25: Resident is receiving the following antipsychotic for insomnia - Seroquel. Although effective, antipsychotic medications are not normally indicated for sleep, due to increased potential for significant adverse reactions, especially in the elderly.-If medication is being used for an indication other than sleep, please clarify.Physician/Prescriber response:-10/10/25 Agree: Dx: Progressive supranuclear palsy; nightmare disorder. Refer to psych (psychiatric services). Review of the medical record indicated but was not limited to the following:-consent and information checklist offering services dated 10/3/25; the form failed to indicate the option for behavioral health services was discussed and the document was unsigned by Resident #27.-the medical record failed to indicate Resident #27 was offered the Physician ordered psych services or that services had been rendered During an interview on 1/2/26 at 11:25 A.M., the Director of Nurses (DON) said the October MRR clearly indicated an order to refer Resident #27 to psychiatric behavioral health services. She reviewed the medical record and said there is no indication in the medical record that the referral ever took place, and she did not know why the services were not offered to the Resident with a signed consent. During an interview on 1/2/26 at 12:06 P.M., the Licensed Mental Health Counselor (LMHC) from the facility's contracted psych services said Resident #27 was not on services and on review of the psych services computer system had never been referred or offered services. During an interview on 1/2/26 at 12:23 P.M., the Unit Manager said the process for MRR is that once they are sent to the DON by the pharmacist she reviews them with the Physician or Nurse Practitioner (NP), has them document any changes or new orders on the form, and then follows up by completing the changes and implementing the orders as indicated by her initials on the document. The Unit Manager reviewed the October 2025 MRR for Resident #27 and said she had initialed the NP orders to refer to psych services (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and add a diagnosis. She said on review of the medical record she did not carry out the order to refer Resident #27 to psych services and should have implemented the order as written and documented whether or not the Resident was agreeable.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. Based on record review and interview, the facility failed to ensure that specialized rehabilitation services were provided to assist in maintaining the highest practicable level functioning for one Resident (#33), out of a total sample of 19 residents. Findings include: Review of the Rehabilitation Consultant Company policy titled Policy: 8.1 - Evaluations, revised 7/21/25, indicated but was not limited to the following:POLICY:-all patients identified as needing an assessment of functional status or assessment of indicators impacting quality of life and having potential to benefit from rehabilitation, habilitative, and/or skilled functional maintenance therapy be evaluated to determine an appropriate plan of care;-an evaluation is an assessment of the patient's physical and functional status used to determine if Physical Therapy (PT), Occupational Therapy (OT), or Speech Therapy (ST) services are medically necessary, gather baseline data including objective findings, and establish a treatment plan with reasonable and attainable goals to be targeted within a defined time frame;-evaluations are administered with appropriate and relevant assessments, preferably standardized, using objective measures and/or tools;-an evaluation is required prior to implementing any skilled treatment plan. PROCEDURE:-scope of evaluations include case history, prior level of function, determination of medical necessity, onset of functional decline, as well as contraindications and precautions.-clinicians will determine and implement a plan of treatment consistent with current best practices in the field of rehabilitation, in collaboration with the patient and family;-evaluation results are the foundation for clinically based decisions regarding rehabilitation potential or the need for skilled functional maintenance therapy and/or habilitative interventions;-the evaluation will be provided to the ordering physician, and a physician signature and date of signature will be obtained for approval of the plan of treatment, within state, federal, and payor-specific guidelines. Review of Standards of Practice for Physical Therapy, dated 8/12/20, indicated but was not limited to:-Physical therapy personnel collaborate with all health services providers and with patients, clients, caregivers, and others as appropriate; and use a team and person-centered approach in coordinating and providing physical therapist services. Resident #33 was admitted to the facility in October 2025 with diagnoses which included adult failure to thrive, muscle atrophy, neuralgia (a nerve condition that can cause muscle weakness and coordination difficulties), neuropathy (a nerve condition with a potential side effect of weakness), and Parkinson's disease with dyskinesia (uncontrollable and involuntary bodily movements). Review of Resident #33's Minimum Data Set (MDS) Assessment, dated 10/16/25, indicated Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the Resident was cognitively intact. The Resident was dependent on or required maximum assistance with Activities of Daily Living (ADLs). Review of the Resident's PT notes indicated Resident #33 was evaluated by PT on 10/13/25 and received skilled services on 10/13/25 and 10/14/25. The PT documentation indicated but was not limited to the following: 10/13/25 PT EVALUATION & PLAN OF TREATMENTPayer: Managed Care Part-BStart of Care: 10/13/25 Diagnoses: Parkinson's disease with dyskinesia with fluctuations, muscle wasting, and atrophy multiple sites Frequency: 4 times per weekDuration: 30 daysCertification Period: 10/13/25-11/11/25 Prior to Onset: Patient was able to independently transfer sit to stand and to independently ambulate with rolling walker in June 2025 prior to hospitalization Patient and Caregiver Goals: wants to improve functional mobility with reduced dependence on caregivers Potential for Achieving Rehab Goals: Patient demonstrates good rehab potential as evidenced by attentive to tasks, active participation in skilled treatment, motivated to participate and supportive caregivers/staff. Focus of Plan of Treatment: Compensation Participation = Patient/Caregiver participated Clinical Impressions: Patient will benefit on PT to increase muscle strength, standing balance/tolerance, range of motion, coordination and endurance to improve functional mobility with reduced physical assistance. The PT evaluation was electronically signed and dated by the Resident's physician, indicating the physician certified the need for these medically necessary services furnished under this plan of treatment while under the physician's care (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from 10/13/25 through 11/11/25. 10/14/25 PT DISCHARGE SUMMARYPayer: Managed Care Part-BPatient Progress and Response to Treatment: Patient has potential to progress and willing to participate.Discharge Reason: Other Review of the Resident's PT Treatment Encounter Notes indicated but were not limited to the following:10/14/25, discharged from PT today due to insurance status. During an interview on 12/30/25 at 12:25 P.M., Resident #33 said he/she used to be able to walk at home and the facility was not providing him/her any therapy services which he/she wanted in order to improve strength and be more independent. During an interview on 12/30/25 at 12:45 P.M., the Director of Rehab (DOR) said rehab services were not provided for Resident #33 due to insurance issues. The DOR said the rehab department/facility has been working since the Resident's admission to see if therapy services will be covered by the Resident's insurance. During an interview on 12/31/25 at 12:59 P.M., Certified Nurse Assistant (CNA) #3 said Resident #33 had asked many times for PT/OT and she notified nursing. She was unsure of the outcome. During an interview on 12/31/25 at 1:17 P.M., Nurse #3 said Resident #33 did not want to get out of bed when he/she was admitted to the facility, but he/she had slowly improved. Nurse #3 said the Resident told her he/she used to walk before he/she was admitted to the facility, so Nurse #3 requested therapy to assess the Resident, but therapy said they could not provide services due to an insurance issue. Review of Nursing Request for Rehab Screen forms indicated nursing requested a PT screen on 10/10/25. The DOR responded on the form that the Resident would be evaluated by PT on 10/13/25. Nursing submitted a PT/OT screen on 10/23/25 for independent feeding and adaptive utensils. The DOR responded on the form the Resident was not appropriate for therapy services at this time, will re-assess. During an interview on 12/31/25 at 1:45 P.M., the Administrator said the Therapy Consultant Company is responsible for insurance billing. He said the DOR should discuss with the Administrator any residents with insurance issues or non-coverage who would benefit from therapy services as the facility would pay for therapy services. The Administrator said he had approved payment for therapy services in the past for other residents. The Administrator said he was unaware of Resident #33's therapy recommendations, but if Resident #33 was evaluated as benefiting from therapy services, then he/she should have received the appropriate services. During an interview on 1/5/26 at 2:13 P.M., the Director of Nursing (DON) reviewed Resident #33's medical record and said the Resident was at higher risk for pain or wounds without therapy services. The DON said Resident #33 should have been followed by and provided therapy services even if the facility had to pay for it.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure staff maintained accurate medical records for three Residents (#2, #87, #91), out of a total sample of 19 residents. Specifically, the facility failed:1. For Resident #2, to ensure the Resident's active Physician's Orders accurately reflected the Resident's advance directives as indicated on the Resident's Massachusetts Orders for Life Sustaining Treatment (MOLST);2. For Resident #87, to ensure information regarding a potential resident-to-resident altercation and follow up assessment and intervention were documented; and3. For Resident #91, to document information of an assessment on a potential cause for hospitalization or change in condition for Resident #91 prior to their transportation to the emergency room (ER). Findings include:1. Resident #2 was admitted to the facility in September 2025 with diagnoses including atrial fibrillation. Review of Resident #2's MOLST indicated the following: Do not resuscitate, use non-invasive ventilation, transfer to hospital, no dialysis, use artificial nutrition short term only signed by Resident #2's invoked Activated Health Care Proxy. Review of Resident #2's orders indicated the following: -Do not resuscitate, Honor the MOLST, use non-invasive ventilation, transfer to hospital, no dialysis, use artificial nutrition short term only, use artificial hydration short term only, dated 9/8/25 -Full Code, dated 9/5/25 During an interview on 12/31/25 at 10:45 A.M., Nurse #2 said Resident #2's code status was not accurately listed in the electronic health record. She said it is important for the advance directives to be accurate in the event of an emergency. She said the Resident's code status was unclear. During an interview on 12/31/25 at 10:58 A.M., the Director of Nurses (DON) said the medical record should reflect the accurate code status for the Resident. She said the orders should have been updated according to what the Resident's advanced directives were. She said she expects the order reflecting the Resident's full code to be discontinued when a MOLST was executed. 2. Resident #87 was admitted to the facility in July 2025 with diagnoses including: Metabolic encephalopathy, Cryptococcosis, Immune reconstitution syndrome, and altered mental status. Review of the medical record indicated the brief interview for mental status on the most reason minimum data set in October 2025 was not completed related to the Resident being rarely or never understood. Further review of the record indicated Resident #87 had a court ordered guardian. During an interview on 12/30/25 at 9:11 A.M., the guardian for Resident #87 said he was notified by the facility on Christmas night (12/25/25) of Resident #87 being molested by another resident who lives in the facility. He said he came to the facility and spoke with the police who came to the facility when the crime had been reported to them on that night by a nurse at the facility. He said he spoke with the police and decided not to press charges against the other resident to preserve Resident #87 from having to be involved in a legal situation related to their inability to communicate well. Review of the progress notes, evaluations and care plans for Resident #87 from 12/23/25 through (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/30/25 failed to indicate there were any potential incidents that may have occurred or any assessments or follow up conversations to ensure the Resident received any necessary emotional support following his alleged involvement in a resident-to-resident altercation with potential sexual contact. During an interview on 12/30/25 at 4:27 P.M., the Director of Nurses (DON) said she was aware that there was an alleged incident that had occurred on 12/25/25 and the staff had reported it to her. She said she would expect that there was some type of documentation of the event in the medical record to show that the incident had occurred, the police were called, and the family was notified, but on review of the medical record said there was no documentation of the alleged incident. During an interview on 12/30/25 at 4:55 P.M., the Administrator said he was informed on 12/25/25 at approximately 7:45 P.M., that Resident #87 may have been involved in an alleged incident with another resident. He said he didn't know the specifics but would suspect the information on the potential resident-to-resident contact and anything nursing did to intervene and assess the situation would be documented in the medical record. On review of the medical record, he said he was surprised there was no information in the record and there should be. During an interview on 12/31/25 at 3:15 P.M., the DON and Regional Nurse reviewed the medical record and said there is no documentation regarding the incident, follow up assessment, or any information at all that Resident #87 was involved in a potential resident-to-resident incident. The Regional nurse said there should have been a basic note indicating the Resident may have been involved in an incident and what steps the facility took to assess and then protect the Resident, but that information is not in the medical record. They said the medical record for Resident #87 is inaccurate and incomplete since it does not indicate that the Resident was involved in a potential incident on 12/25/25. 3. Resident #91 was admitted to the facility in October of 2025 with diagnoses including: Hepatic encephalopathy, disorder of the Urea cycle, Diabetes mellitus type 2 and mood disorder. Review of the medical record indicated Resident #91 suffered from severe cognitive impairment with a brief interview for mental status score of 2 out of 15 on the most recent Minimum Data Set, dated in October 2025. Review of the medical record indicated, but was not limited to the following: -10/20/25 labs were monitored -10/24/25 reddened sclera of the left eye was identified -10/27/25 a discharge/transfer evaluation was completed by the social worker on duty indicating the Resident was transferred to the hospital for a change in mental status The record failed to indicate through progress notes or assessments a reason for the Resident's transfer or attempted interventions by the clinical team. During an interview on 1/2/26 at 10:23 A.M., the Unit manager reviewed the medical record and said although she found the discharge/transfer evaluation completed by the social worker, she could not locate any documentation by nursing that would indicate why Resident #91 was transferred to the hospital or any possible change in condition. She said it is possible the Resident's wife/HCP had (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requested a transfer to the hospital, but that was not documented anywhere. She said regardless of the reason for Resident #91's transfer to the hospital there should be some documentation in the medical record to explain what had occurred and there was not. During an interview on 1/2/26 at 10:27 A.M., the DON said there is no documentation in Resident #91's medical record from 10/24/25 to the date of transfer to the hospital on [DATE] and the missing information made the record incomplete and inaccurate.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed for one Resident (#7), out of a total sample of 19 residents, to notify the physician of a significant weight loss of 11 percent over 90 days, that was unplanned and unexpected. Findings include:Review of the facility's policy titled Nutrition, dated as revised 6/2018, indicated but was not limited to the following: - the Physician is notified and consulted when there is a significant change in the resident's nutritional status Review of the facility's policy titled Change in a Resident's condition or status, dated as revised 7/2024, indicated but was not limited to the following: - the facility professional staff will communicate with physician's regarding changes in condition as warranted- the Nurse will notify the resident's provider or on call provider when there has been a change in resident condition (not limited to)-significant change in the resident's physical condition Resident #7 was admitted to the facility in August 2025 and had diagnoses including: Enterocolitis due to clostridium difficile (C. diff), obesity class 3, noninfective gastroenteritis, and gastro-esophageal reflux disease without esophagitis. Review of the Minimum Data Set (MDS) completed in November 2025 indicated the Resident had a significant weight loss but was not on a prescribed weight loss regimen. Review of the Nutritional Assessment, dated 11/19/25, indicated but was not limited to the following: - Diet: Consistent carbohydrate (CCHO); consistency is regular with thin liquids; with standard portion sizes- Weight: 225.7 pounds (lbs.) on 11/18/25; weight 90 days ago 254.4 lbs.; percent of weight change in 90 days is minus (-) 11% Review of progress notes, Physician notes, and Nurse Practitioner (NP) notes failed to indicate the Physician or NP was notified of the significant weight loss. During an interview on 12/31/25 at 10:28 A.M., Nurse #1 said she was aware of the Resident's weight loss, and she is Resident #7's primary nurse. She said she did not notify the physician or NP of the Resident's significant weight loss and that is why there are no documents in the medical record that indicate the physician or NP are aware of the change in the Resident's condition. During an interview on 12/31/25 at 10:36 A.M., the Physician said he was not made aware that Resident #7 had a significant weight loss and that is why he had not addressed the weight loss in the medical record. During an interview on 12/31/25 at 2:49 P.M. with the Director of Nurses (DON) and Regional Nurse, the DON said she would expect that the Physician or NP would be notified of a significant weight loss so they could evaluate the Resident or implement some type of intervention. The DON and Regional Nurse reviewed Resident #7's medical record and said there was no documentation that the Physician or NP was notified of Resident #7's significant weight loss. The DON said the facility should have notified either the Physician or NP and did not.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interviews, the facility failed to ensure for one Resident (#2), out of a total sample of 19 residents, that the Resident was free from chemical restraints. Specifically, the facility failed to address a recommended gradual dose reduction (GDR) of his/her physician's ordered Risperidone (antipsychotic medication). Findings include:Review of the facility's policy titled Psychotropic Medication, last revised 7/23, indicated but was not limited to the following:-psychoactive medications will be prescribed at the lowest possible dosage and are subject to gradual dose reduction and re-review as needed.-A physician's order and an appropriate diagnosis is required for psychotropic medicationResident #2 was admitted to the facility in September 2025 with diagnoses including dementia. Review of the current Physician's Orders indicated Resident #2 had an order for Risperidone oral tablet 1 milligram (MG) with instructions to give 1 MG by mouth twice daily.Review of the Minimum Data Set assessment, dated 9/5/25, indicated Resident #2 was taking an antipsychotic medication and no GDR had been attempted. Review of the psychiatric Nurse Practitioners (NP) note, dated 9/26/25, indicated the Resident was seen for an initial assessment for medication management. Review of the note indicated previous med trials or GDRs: unknown why on risperidone.Review of the psychiatric NP note, dated 10/20/25, indicated the following: psychiatric medications reviewed with unclear reason for antipsychotic use. Given significant risks in the elderly and mood and behavior stability since admission we will recommend slight GDR of Risperidone. Plans/Recommendations: recommend Risperdal GDR decrease to 0.5 MG in AM 1 MG at night. Review of the psychiatric NP's note, dated 11/25/25, indicated the practitioner would still recommend a trial of Risperidone GDR. During an interview on 12/31/25 at 10:42 A.M., Nurse #2 said there is a log where staff will write down names of residents who need to be seen by psychiatric services. She said after the visits the Director of Nurses (DON) receives the recommendations electronically to review with the physician. She said she was unaware of any recommended GDR for this Resident; she said the Resident has not had any delusions or hallucinations that she is aware of. She said she was not sure what diagnosis the antipsychotic was treating. Review of the NP visit summary, dated 10/30/25, failed to indicate acknowledgement of the recommendations and that they were addressed. Review of NP visit summary, dated 11/25/25, failed to indicate acknowledgement of the recommendations and that they were addressed. During an interview on 12/31/25 at 2:28 P.M., the Psychiatric NP said there are communication books on the unit with whom the facility puts names of residents in for her to visit and see. She said she initials them when they have been seen. She said her recommendations have gone to previous DONs and she just recently was asked by the facility to add the current DON. She said she was not sure if the recommendations she made were discussed with the physician after the second visit so that is why she recommended the GDR again. At this time the Resident has not had a decrease in his Risperidone as previously recommended. She said Resident #2 does not have a diagnosis that Risperidone would be appropriate for, and her notes reflect the Resident has been stable, and no hallucinations or delusions are noted. During an interview on 12/31/25 at 2:45 P.M, the Physician said he was not made aware of these recommendations from behavior health services and said he typically follows the psychiatric nurse practitioner's recommendations and would have approved a GDR. He said he wanted to review his notes to see if there was any additional documentation he could provide.During an interview on 1/5/26 at 7:55 A.M., the Unit Manager said there was no additional documentation from the physician indicating the physician was made aware of the recommendations. During an interview on 1/5/26 at 3:31 P.M., the DON said she can't speak to what was being done prior to her employment, but she said she has just received the recommendations and sees that there were two recommendations for Resident #2 that were not followed up on. She said she expects a process where the recommendations are made by the psychiatric NP and then the physician is made aware of them. She said the goal of GDRs is to be on the least amount of medication as possible while still treating any symptoms.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, record review, and policy review, the facility failed for one Resident (#87), out of a total sample of 19 residents, to implement their abuse policy and procedure when there was a report of potential sexual abuse on 12/25/25. Findings include: Review of the facility's policy titled Abuse Investigation and Reporting, dated as revised 2/2024, indicated but was not limited to the following:-each resident has the right to be free from verbal, sexual, physical, and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property-the facility administrator will be the abuse prevention coordinatorDefinitions:Sexual abuse: any nonconsensual sexual contact. Includes but is not limited to sexual harassment, sexual coercion, or sexual assault of a resident.Identification and reporting:-to proactively identify any event that may be potential abuse, neglect, involuntary seclusion, or misappropriation of resident property and properly report that event to the appropriate agencies-each facility shall report to the Department suspected resident abuse, neglect, mistreatment or misappropriation-alleged violations are reported to the administrator and to other officials in accordance with state law. Alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process. The result of the investigations must be reported in accordance with state/federal law within 5 business days of the incident and if the alleged violation is verified appropriate corrective action must be taken.Elder Justice Act:-report to DPH and local law enforcement any reasonable suspicion of a crime committed against an individual who is a resident of, or receiving care from, the facility. If the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately (but no later than two hours) after forming the suspicion. Otherwise, the report must not be made later than 24 hours after forming the suspicion. Crime is defined by local law jurisdiction.Abuse investigation Procedure:Upon receiving a report of an allegation of abuse the following actions will be taken:-staff witnessing a potentially inappropriate treatment, or receiving an allegation verbally will immediately report the event to the nursing supervisor/management-the nursing supervisor, or if directed to do so, nurse assigned to the resident will physically examine the resident for injuries-the nursing supervisor or designee will take appropriate steps to protect the resident, if applicable, from further mistreatment, and ensure appropriate care is provided- separate accused/suspected employee or resident from alleged victim and other residents-provide emotional support to the alleged victim-in the case of abuse (suspected, witnessed or alleged) the nursing supervisor/nurse will notify the provider, health care proxy (HCP), responsible party, Administrator and Director of nurses (DON)-interviews of appropriate individuals; any individuals who may have knowledge of the event should be interviewed. This may include the alleged victim, employees, visitors and other residents; the social worker may interview other potential victims. During an interview on 12/30/25 at 9:11 A.M., the guardian/responsible party for Resident #87 said he was notified by the facility on Christmas night (12/25/25) of Resident #87 being molested by another resident who lives in the facility. He said he came to the facility and spoke with the police who came to the facility when the crime had been reported to them on that night by a nurse at the facility. He said he spoke with the police and decided not to press charges against the other resident to preserve Resident #87 from having to be involved in a legal situation related to their inability to communicate well. Review of the medical record for Resident #87 failed to indicate the Resident was involved in an alleged resident-to-resident sexual abuse situation or that any events had occurred on 12/25/25 that resulted in the police coming to the facility to see the Resident or his/her guardian. A telephone call was placed to the Certified Nursing Assistant (CNA) who witnessed the alleged inappropriate sexual contact, but a return call had not been received. During an interview on 12/30/25 at 4:27 P.M., the DON said it was reported to her that this Resident was found by a CNA with another resident leaving his/her room and their genitals were exposed by being pulled out the side of their undergarment. She said the CNA reported it to the nurse and the nurse reported it to her. She said she directed the staff to contact the police, write (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statements and place the accused on checks for safety. She said she does not have the statements written by the staff because after she had contacted the Administrator about the incident he told her nothing needed to be done because the residents involved were friends. During an interview on 12/30/25 at 4:55 P.M., the Administrator said he was informed on 12/25/25 at approximately 7:45 P.M., that Resident #87 may have been touched in a sexual manner by another resident. He said that since the residents were friends, he didn't think it was necessary to do anything about the alleged contact. He said Resident #87 is not capable of making their own decisions and had a court appointed guardian, who was also a family member and therefore would not be capable to consenting to any potential sexual relationship and that the alleged aggressor was cognitively intact. He said in retrospect the facility should have implemented their abuse policy and reported and investigated the alleged incident of sexual abuse and did not. During an interview on 12/31/25 at 3:19 P.M., the Regional Nurse said that upon reviewing the available information, the facility should have identified that Resident #87 was involved in a potentially sexually inappropriate resident-to-resident altercation and implemented their full abuse policy but did not. He and the DON said the abuse policy was not followed in the manner it should have been and it was the management team that dropped the ball.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and review of the Healthcare Facility Reporting System (HCFRS), the facility failed for one Resident (#87), out of a total sample of 19 residents, to report an alleged violation of potential sexual abuse within 24 hours as required under the Elder Justice Act. Findings include: Review of the facility's policy titled Abuse Investigation and Reporting, dated as revised 2/2024, indicated but was not limited to the following:-each resident has the right to be free from verbal, sexual, physical, and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property-the facility administrator will be the abuse prevention coordinatorDefinitions:Sexual abuse: any nonconsensual sexual contact. Includes but is not limited to sexual harassment, sexual coercion, or sexual assault of a resident.Identification and reporting:-to proactively identify any event that may be potential abuse, neglect, involuntary seclusion, or misappropriation of resident property and properly report that event to the appropriate agencies-each facility shall report to the Department suspected resident abuse, neglect, mistreatment or misappropriation-alleged violations are reported to the administrator and to other officials in accordance with state law. Alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process. The result of the investigations must be reported in accordance with state/federal law within 5 business days of the incident and if the alleged violation is verified appropriate corrective action must be taken.Elder Justice Act:-report to DPH and local law enforcement any reasonable suspicion of a crime committed against an individual who is a resident of, or receiving care from, the facility. If the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately (but no later than two hours) after forming the suspicion. Otherwise, the report must not be made later than 24 hours after forming the suspicion. Crime is defined by local law jurisdiction. During an interview on 12/30/25 at 9:11 A.M., the guardian/responsible party for Resident #87 said he was notified by the facility on Christmas night (12/25/25) of Resident #87 being molested by another resident who lives in the facility. He said he came to the facility and spoke with the police who came to the facility when the crime had been reported to them on that night by a nurse at the facility. He said he spoke with the police and decided not to press charges against the other resident to preserve Resident #87 from having to be involved in a legal situation related to their inability to communicate well. Review of the HCFRS for the facility on 12/30/25 at 9:36 A.M., failed to indicate the facility had reported any alleged incidents of potential abuse or any incidents at all regarding Resident #87 in the month of December 2025. During an interview on 12/30/25 at 4:27 P.M., the Director of Nurses (DON) said it was reported to her that this Resident was found by a certified nurse assistant (CNA) with another resident leaving his/her room and their genitals were exposed by being pulled out the side of their undergarment. She said the CNA reported it to the nurse and the nurse reported it to her. She said she directed the staff to contact the police, write statements and place the accused on checks for safety. She said she did not report the incident because when she spoke with the Administrator he had told her that there is no issue since the residents involved were known to be friends. She said she had a feeling and should have reported it but did not. During an interview on 12/30/25 at 4:55 P.M., the Administrator said he was informed on 12/25/25 at approximately 7:45 P.M., that Resident #87 may have been touched in a sexual manner by another resident. He said that since the residents were friends, he didn't think it was necessary to do anything about the alleged contact and did not report the incident in accordance with the abuse policy. He asked the surveyor if the facility should bother to report the incident at this time since it should have been reported in the two-hour timeframe on the day of the occurrence and was informed that the facility should follow their company approved abuse policy. He said looking back at the situation the incident should have been reported within the two-hour time frame by the facility and wasn't. During an interview on 12/31/25 at 3:19 P.M., the Regional Nurse said that upon reviewing the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available information, the facility should have identified that Resident #87 was involved in a potentially sexually inappropriate resident-to-resident altercation, and the event should have been reported in accordance with the abuse policy and Elder Justice Act and was not.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and document review, the facility failed to thoroughly investigate allegations of sexual abuse for one Resident (#87), out of a total sample of 19 residents. Findings include: Review of the facility's policy titled Abuse Investigation and Reporting, dated as revised 2/2024, indicated but was not limited to the following:-each resident has the right to be free from verbal, sexual, physical, and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property-the facility administrator will be the abuse prevention coordinatorDefinitions:Sexual abuse: any nonconsensual sexual contact. Includes but is not limited to sexual harassment, sexual coercion, or sexual assault of a resident.Identification and reporting:-to proactively identify any event that may be potential abuse, neglect, involuntary seclusion, or misappropriation of resident property . Alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process. The result of the investigations must be reported in accordance with state/federal law within 5 business days of the incident and if the alleged violation is verified appropriate corrective action must be taken.Abuse investigation Procedure:Upon receiving a report of an allegation of abuse the following actions will be taken:-staff witnessing a potentially inappropriate treatment, or receiving an allegation verbally will immediately report the event to the nursing supervisor/management-the nursing supervisor, or if directed to do so, nurse assigned to the resident will physically examine the resident for injuries-the nursing supervisor or designee will take appropriate steps to protect the resident, if applicable, from further mistreatment, and ensure appropriate care is provided- separate accused/suspected employee or resident from alleged victim and other residents-provide emotional support to the alleged victim-in the case of abuse (suspected, witnessed or alleged) the nursing supervisor/nurse will notify the provider, health care proxy (HCP), responsible party, Administrator and Director of nurses (DON)-interviews of appropriate individuals; any individuals who may have knowledge of the event should be interviewed. This may include the alleged victim, employees, visitors and other residents; the social worker may interview other potential victims. During an interview on 12/30/25 at 9:11 A.M., the guardian/responsible party for Resident #87 said he was notified by the facility on Christmas night (12/25/25) of Resident #87 being molested by another resident who lives in the facility. He said he came to the facility and spoke with the police who came to the facility when the crime had been reported to them on that night by a nurse at the facility. He said he spoke with the police and decided not to press charges against the other resident to preserve Resident #87 from having to be involved in a legal situation related to their inability to communicate well. A telephone call was placed to the Certified Nursing Assistant (CNA) who witnessed the alleged inappropriate sexual contact, but a return call had not been received. Review of the Healthcare Facility Reporting System (HCFRS) for the facility on 12/30/25 at 9:36 A.M., failed to indicate the facility had completed an investigation into the alleged incident on 12/25/25 for Resident #87. During an interview on 12/30/25 at 4:27 P.M., the Director of Nurses (DON) said it was reported to her that this Resident was found by a CNA with another resident leaving his/her room and their genitals were exposed by being pulled out the side of their undergarment. She said the CNA reported it to the nurse and the nurse reported it to her. She said she directed the staff to contact the police, write statements and place the accused on checks for safety. She said she does not have the statements written by the staff and had not read or reviewed the record, followed up on the situation, or completed an investigation regarding the allegation. She said after her conversation in which she reported the incident to the Administrator she didn't think it was necessary. During an interview on 12/30/25 at 4:55 P.M., the Administrator said he was informed on 12/25/25 at approximately 7:45 P.M., that Resident #87 may have been touched in a sexual manner by another resident. He said that since the residents were friends, he didn't think it was necessary to do anything about the alleged contact. He said Resident #87 is not capable of making their own decisions and had a court appointed guardian, who was also a family member and therefore would not be (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	capable to consenting to any potential sexual relationship and that the alleged aggressor was cognitively intact. He said in hindsight he can see how the facility should have investigated the situation prior to making a judgement or assumption of assumed consent and the incident should have been investigated since it does fall under the abuse statue for possible sexual abuse. He said the police were called and did come to the facility, but he is unaware of the outcome of that occurrence and did not request a copy of the police report. He said the incident hasn't been investigated by the facility so it's hard to say whether any wrongdoing potentially occurred. He said the incident should have been investigated in line with the facility policy. During an interview on 12/31/25 at 9:45 A.M., the DON said she found the original statements she asked the staff to write and was obtaining more investigation information at this time. She said once the investigation was completed it would be put in HCFRS. Review of the progress notes, evaluations and care plans for Resident #87 from 12/23/25 through 12/30/25 failed to indicate there were any potential incidents that may have occurred or any assessments or follow up conversations to ensure the Resident received any necessary emotional support. Review of the facility incident report for resident-to-resident altercation regarding Resident #87 on 12/25/25 indicated but was not limited to the following: -the incident report was started and completed on 12/25/25-the police, responsible party for Resident #87, physicians, and DON were all notified of the incident on 12/25/25-the alleged aggressor was placed on 15-minute checks During an interview on 12/31/25 at 3:19 P.M., the Regional Nurse said the process for incident reports is that they are reviewed by the team at morning meeting the day after they are completed. The Regional Nurse said that upon reviewing the available information, the facility should have identified that Resident #87 was involved in a potentially sexually inappropriate resident-to-resident altercation and fully investigated the incident. He said regardless of any friendship the residents may have had, the facility had an obligation to ensure no abuse occurred. He said the investigation was ongoing at this time.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interview, the facility failed to provide indwelling catheter (a flexible tube inserted into the bladder to drain urine outside of the body) care and management consistent with professional standards for one Resident (#65), out of a total sample of 19 residents. Specifically, the facility failed to ensure the Foley catheter was positioned below the bladder draining with the flow of gravity.Findings include:Resident #65 was admitted to the facility in October 2024 with diagnoses including benign prostatic hyperplasia and malignant neoplasm of right kidney.Review of Resident #65's most recent Minimum Data Set (MDS) assessment indicated the Resident had an indwelling catheter.Review of Resident #65's current Physician's Orders indicated but was not limited to the following:Foley Cath care every shift, dated 10/25/24, indefinite. Review of Resident #65's care plan indicated the following:-The Resident has an indwelling catheter, dated 11/7/24.-The Resident will not develop any complications associated with catheter usage through the next review, revision dated 11/13/25.-Keep drainage bag below level of bladder, date initiated on 10/25/24.The surveyor observed Resident #65's catheter drainage bag positioned on the side of his/her elevated head of bed as follows:-12/30/25 at 8:04 A.M.-12/30/25 11:47 A.M.-12/30/25 12:35 P.M.-12/30/25 3:51 P.M.-12/31/25 7:13 A.M., and-12/31/25 8:21 A.M. On 12/31/25 at 7:34 A.M., the surveyor observed two staff members in Resident #65's room delivering the breakfast tray and offering to reposition the Resident for their meal; the catheter drainage bag was positioned at the level of the Resident's head. There was a staff member on each side of the bed near the Resident's head of bed. Neither staff member moved the catheter drainage bag to standard positioning, below the bladder level. During an interview on 12/31/25 at 8:21 A.M., Nurse #2 said the drainage bag should be positioned below the bladder. She said the drainage bag is too high. She said she didn't see it positioned incorrectly when she was in the room. She said the tubing should be flowing down with gravity to avoid any urine flowing back into the bladder.During an interview on 12/31/25 at 12:49 P.M., the Director of Nurses (DON) said the bag was positioned incorrectly and should have been placed in the correct position by nursing staff. She said the flow appears sedentary because it has to drain upwards and said the standard of care is for the drainage bag to flow with gravity and be below the bladder.

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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 and interview, the facility failed to ensure medications with a shortened expiration date were properly labeled once opened, in one medication cart out of three medication carts observed.Findings include: Review of the facility's policy titled Storage Medications, dated as revised 8/2024, indicated but was not limited to the following:-Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations.-Certain medications or package types, ophthalmic (eye drops) require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency.-When the manufacturer has specified a usable duration after opening (i.e. beyond use date), the nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration.On 12/31/25 at 3:33 P.M., the surveyor observed the medication cart with Nurse #4 on Unit C Side 1 and made the following observations:Three bottles of Cosopt (used to treat increased pressure inside the eye) eye drops, for two different residents, opened and in use with no opened date.One bottle of Latanoprost (used to treat increased pressure inside the eye) drops, opened and in use with no open date.During an interview on 12/31/25 at 3:38 P.M., Nurse #4 said eye drops are only good for 28 days after opening and require the open date to be written on the bottle. Nurse #4 said if they are not dated upon opening, she has no way of knowing when they expire. During an interview on 1/5/26 at 2:57 P.M., the Director of Nursing (DON) said medications such as eye drops have a shortened expiration date and should be labeled with the open and discard date upon opening to ensure they are not used after the shortened expiration date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225145	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhill Healthcare	76 North Street Middleboro, MA 02346

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure:1. The main kitchen floor and walk-in refrigerator shelving were maintained in a sanitary and safe condition; and2. Labeling and dating of refrigerated items in two of four kitchenettes. Findings include: 1. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. 4-602.13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 6-101.11 Surface Characteristics. (A) Except as specified in (B) of this section, materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: (1) SMOOTH, durable, and EASILY CLEANABLE for areas where FOOD ESTABLISHMENT operations are conducted Review of the facility's policy titled Cleaning and Sanitizing Stationary Foodservice Equipment and Work Surface, revised June 2018, indicated but was not limited to the following:POLICY: Stationary foodservice equipment and surfaces are cleaned, and food contact surfaces of stationary foodservice equipment and work surfaces are cleaned and sanitized to minimize the risk of pathogen and chemical food contamination. GUIDELINES:-The frequency of cleaning foodservice equipment and surfaces that are nonfood-contact surfaces is dependent on the type of equipment and is outlined on the cleaning schedule.-Cleaning and sanitizing other foodservice surfaces (such as shelving):>Scrape or remove food bits from the surface. Use a nylon brush or pad, or a cloth towel if needed;>Wash the surface with the cleaning solution using the correct cleaning tool, such as a cloth towel;>Rinse the surface;>Allow surface to air dry. On 12/30/25 at 7:30 A.M., the surveyor observed the following:-several missing floor tiles in the walk-in refrigerator with debris accumulation-receding and crumbling grout in areas of the dishwashing room containing accumulated water-black splotches throughout shelving used to store food in the walk-in refrigerator During an interview on 12/30/25 at 7:30 A.M., Dietary Aide #1 said floor cleaning consisted of sweeping and mopping the floor with no special method to clean the recessed grouting in the dish room. Dietary Aide #1 said it can be a challenge to get all the debris out of the grout. During an interview on 1/5/26 at 11:15 A.M., the Corporate Food Service Director (FSD) said the kitchen floors should be easily cleanable. She said the floor grout in the dish room was receding and should be replaced and the missing floor tiles in the walk-in refrigerator should also be replaced. During an observation and interview on 1/5/26 at 11:50 A.M., the Corporate FSD and surveyor observed the walk-in refrigerator shelving (in use with stored food) to have black splotches throughout. The Corporate FSD said the shelves should be cleaned regularly to prevent accumulation of debris. 2. Review of the facility's policy titled Food and Supply Storage, revised 06/2018, indicated but was not limited to the following:-Food, non-food items, and supplies used in food preparation and service shall be stored in such a manner as to maintain safety and sanitation of the food or supply for human consumption as outlined in the Federal Drug Administration Food Code, state regulations, and city/county health codes.-Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by 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: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 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 or 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: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; 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 12/30/25 at 4:16 P.M., the surveyor observed in the A-Wing kitchenette:-One container of thickened liquid, opened, with no date indicating when it was opened or when to use it by.-One homemade smoothie-type drink with no label or date. During an interview on 12/30/25 at 4:16 P.M., Nurse #8 said all items in kitchenette refrigerators should be labeled and dated and opened items should be labeled with the date they were opened. On 1/5/26 at 10:32 A.M., the surveyor observed in the B-Wing kitchenette:-Two thickened liquids, opened, with no date indicating when they were opened or when to use them by.-One single serve nutritional supplement container, opened, with no label or use by date. On 1/5/26 at 2:15 P.M., the surveyor observed in the B-Wing kitchenette:-Two thickened liquids, opened, with no date indicating when they were opened or when to use them by.-One single serve nutritional supplement container, opened, with no label or date indicating when it was opened or when to use it by. During an interview on 1/5/26 at 3:01 P.M., the FSD said items in the kitchenette refrigerators should be labeled and dated and any opened items should be labeled with the date it was opened. The FSD said the thickened liquids and opened nutritional supplement should have been labeled and dated.

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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 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, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to ensure proper hand hygiene after handling contaminated equipment and follow infection control standards while administering medications for two Residents (#15 and #44), out of five residents observed during medication administration.Findings include:Review of the facility's policy titled Administering Oral Medications, dated as revised 11/2025, indicated but was not limited to the following:-Perform hand hygiene-Select the drug from the medication cart-Perform hand hygieneReview of the facility's policy titled Handwashing/Hand Hygiene, dated as last revised 7/2024, indicated but was not limited to the following:-This facility considers hand hygiene the primary means to prevent the spread of infections.-All staff shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.-Use an alcohol-based hand rub containing at least 62% alcohol or alternatively, soap and water for the following:-Before and after direct contact with residents-Before preparing or handling medications-After handling contaminated equipment-To protect residents from health care associated infectionsOn 12/31/25 at 8:53 A.M., the surveyor observed Nurse #4 standing next to her medication cart that was in the hallway. Resident #15 was seated in a wheelchair positioned on the side of the medication cart. Nurse #4 lifted the Resident's left shirt sleeve and placed a blood pressure cuff on his/her left arm. Nurse #4 did not clean the cuff prior to applying it to the Resident's arm and did not perform hand hygiene. Nurse #4 then recorded the blood pressure, removed the cuff and placed it back into the medication cart. Nurse #4 did not clean the blood pressure cuff or perform hand hygiene. Nurse #4 then reached back into her medication cart and started preparing medications and administered the medications to the Resident.On 12/31/25 at 9:10 A.M., the surveyor observed Nurse #4 prepare Resident #44's morning medications which included the following:-Advair 21 micrograms (mcg) inhaler (treats asthma) two puffs by mouth twice a day.-Nurse #4 entered Resident #44's room with the Advair in her hand and handed it to the Resident; the Resident self-administered two puffs by mouth.-Nurse #4 took the used inhaler from the Resident with her bare hands and exited the room.-Nurse #4 placed the used inhaler directly on top of her medication cart, without a clean barrier.-Nurse #4 then opened her medication cart drawer without performing hand hygiene.-Nurse #4 then picked up the used inhaler, put it in a bag and stored it in the medication cart and performed hand hygiene.-Nurse #4 did not clean the top of the medication cart and started preparing other medications.During an interview on 12/31/25 at 11:05 A.M., Nurse #4 said she should have cleaned her hands before and after taking the Resident's blood pressure. She said her normal practice is to clean her blood pressure cuff before and after each use; she just forgot. Nurse #4 said she should have completed hand hygiene after administering medications and cleaned the top of the medication cart because the used inhaler was placed on top of the cart.During an interview on 1/5/26 at 2:52 P.M., the Director of Nursing (DON) said her expectations were for any shared equipment to be cleaned before and after use. She said hand hygiene must be performed prior to and after medication administration. The DON said if any dirty items are placed on the medication cart during a medication pass, it must be cleaned prior to preparing any more medications due to the risk of cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect).