STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225147	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saugus Center	266 Lincoln Avenue Saugus, MA 01906

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to notify one Resident's (#172) physician and legal guardian of a change in condition out of a total sample of 27 residents. Specifically, the facility failed to notify the physician of Resident #172's refusing medication, exit seeking behavior, an elopement from the facility and multiple other attempts of elopements from the facility, including through a second story window, resulting in Resident #172 from falling out of a second-floor window and requiring acute hospitalization with a fracture of the fourth lumbar vertebrae with mild retropulsion into the spinal canal (bone fragments in spinal cord), fractures of the second and third lumbar vertebrae, hematoma of the psoas muscle (lower back muscle), and fractures of the ninth through 12 ribs. Findings include: Review of the facility policy titled, Notification of Changes, dated 2024, indicated the following: -The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. -The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. -Circumstances requiring notification include: 1. Accidents a. resulting in injury b. potential to require physician intervention 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. 3. A change of room or roommate assignment. 4. Notice of Rome changes. Resident #172 was admitted to the facility in June 2025 with diagnoses including dementia with behavioral disturbances and unsteadiness on feet. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Brief Interview for Mental Status (BIMS) assessment completed on 6/6/25 indicated Resident #172 scored a 6 out of a possible 15, which indicated he/she had severe cognitive impairment. Review of the initial nursing assessment completed on 6/4/25 indicated the Resident required supervision for all mobility tasks. On 6/8/25 at 6:47 A.M., the surveyors observed Resident #172 lying on the ground on the outside of the building below a second-floor open window. A window screen was observed hanging from the side of the building. Resident #172 had significant lacerations to his/her left arm and face, and blood was visible on the Resident's bilateral arms, face and chest. The Resident was screaming and when approached by the surveyor the Resident said he/she went out the window because he/she was trying to get out of the building. The facility nursing staff called 911 and the Resident was taken to the hospital. During an interview on 6/8/25 at 6:52 A.M., Certified Nursing Assistant (CNA) #1 said she worked the overnight shift and Resident #172 was wandering up and down the hallways since 5:00 A.M., and at one point was attempting to go near the dining room window. CNA #1 said she had been told by other staff that the Resident had attempted to jump out of the dining room window previously and the staff had to barricade the window with tables and chairs to prevent access to the window. CNA #1 said at approximately 6:30 a.m., she left the Resident alone so she could go into the hallway and complete her paperwork. CNA #1 said it was at this point the Resident must have walked down to his/her bedroom and jumped out the window. On 6/8/25 at 6:56 A.M., the surveyor observed Resident #172's bedroom window. The window was open, with the opening measuring 24.5 inches wide and 4 feet 2 inches high. The surveyor observed nothing in the window to secure the opening of the window to prevent it from opening to that distance. Review of Resident #172's admission paperwork included the following: -A hospital psychiatric consultation dated 4/22/25, that indicated History of present illness. This is a (male/female) who was referred for admission because of increased agitation. Patient does have a history of dementia as well as depression and is a long-term nursing home resident. While there, (he/she) apparently was trying to get out a window on the third floor. (He/she has no recollection of this event and denies that it was a suicide attempt. (He/she) was subsequently referred for inpatient psychiatric treatment. -A Discharge summary, dated the day of admission to the facility, that indicated admitted (from another facility) for agitation and elopement behaviors. While admitted pt (patient) initially was exit seeking but redirectable, with medication adjustment improvement in exit seeking behaviors. Pt wanders at times but is easily redirectable and pleasant with redirection. -From (another facility), BIBA (brought in by ambulance), patient trying to get out 3rd floor window. Baseline confusion, alert to name only, secondary to dementia. Review of the elopement assessment dated [DATE] indicated Resident #172 was wandering and that his/her wandering was both goal-directed and aimless and not goal-oriented. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing note dated 6/5/25 and written by the Director of Nursing indicated the following: -At 0845 writer and the Administrator were called to the second floor. The resident was observed using a very loud tone of voice and swearing at staff members. The Director of Nursing (writer) was able to escalate (sic) the resident's behavior and redirect the resident. The resident responded very well to the Director of Nursing, with a calm, soft voice, and apologized for yelling. While the writer was assessing the resident, it was noted that the resident was very confused, did not know where they were, and was using word salad when speaking. The writer was able to calm the resident to the point that they were able to leave the resident safely with the nursing staff. Nursing staff will continue to monitor the resident for the remainder of the shift. The medical record failed to indicate the medical provider or guardian was notified of these escalating behaviors. Review of the social services note dated 6/5/25 indicated the following: -Resident was transferred from (first-floor room) to (second-floor room) for safety reasons with prior authorization from Guardian and the agreement of roommate. Social worker will continue to monitor for changes in mood and behavior. Social services continues to remain available as needed for ongoing psychological support and reassurance. The medical record failed to indicate the medical provider was notified of the room change. Review of the nursing note dated 6/7/25 and time stamped 7:11 A.M., indicated the following: -Resident attempt (sic) to elope twice by opening the window in the dinner room. Cont. (continue) to monitor for safety. The medical record failed to indicate the medical provider or guardian was notified of the attempts of elopement. Review of the nursing note dated 6/7/25 and time stamped 12:53 P.M., indicated the following: -Pt. (patient) is alert, oriented and confused at baseline. Refused all am (morning) scheduled medications, ate 50% of breakfast and 100% of lunch. The medical record failed to indicate the medical provider or guardian was notified of the Resident's refusal of medications. Review of Resident #172's mood care plan created on 6/4/25, indicated the following intervention: -Monitor/document/report any risk for harm to self: suicidal plan, past attempted suicide, risky actions (stocking pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med (medications) or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 6/8/25 at 6:56 A.M., and 6/10/25 at 6:52 A.M., Nurse #1 said he was aware Resident #172 had a history of attempting to jump out windows and while at this facility, the Resident had attempted to open and exit the second-floor dining room window on 6/6/25 and 6/7/25. Nurse #1 said the Resident had also opened the balcony door off the dining room on 6/6/25 and had gone over to the edge of the balcony and needed to be pulled from the edge. Nurse #1 said he did not notify the provider or management of these behaviors and incidents. During an interview on 6/8/25 at 6:59 A.M., CNA #1 said the staff were aware that Resident #172 had been attempting to exit seek through windows and was unaware if anyone contacted administration or the medical providers to report this. During an interview on 6/11/25 at 8:38 A.M., Nurse #6 said she worked the 3:00 P.M. to 11:00 P.M. shift on the second floor on the day of Resident #172's admission. Nurse #6 said the Resident was opening windows and looking outside. Nurse #6 said prior to the Resident moving to the second floor, he/she had been admitted to the first floor and had eloped out of the building, and as a result he/she was moved to the second floor. Nurse #6 said once the Resident was on the second floor, he/she was constantly trying to elope from the building by pushing on doors, elevators and windows. Nurse #6 said she did not bother to call down to tell the management that Resident #172 was exit seeking because they already knew and that is why he/she was transferred to the second floor. Nurse #6 said she did not notify the physician or nurse practitioner of the wandering and exit seeking behavior. During an interview on 6/9/25 at 10:12 A.M., CNA #5 said Resident #172 eloped from the building when he/she was first admitted and made it two miles down the road. CNA #5 said on the second day at the facility, Resident #172 attempted to jump off the second-floor balcony. CNA #5 said the administration blamed the nurse for agitating the Resident and said the nurse was overreacting to the situation. CNA #5 was unaware if the physician was notified after these two events. On 6/8/25 at 9:09 A.M., the surveyor interviewed the Administrator and Director of Nursing. During the interview, the Administrator said he received a call at 7:00 A.M. that Resident #172 had fallen out of his/her bedroom window. The Administrator said Resident #172 was a new admit to the facility and had dementia and was confused with a history of behaviors. The Administrator said the Resident recently displayed behaviors of yelling, swinging arms and banging on the walls and said the Resident wanted out and was assessed as being high risk for elopement. The Administrator said he was unaware of Resident #172's previous elopement history, including his/her attempt to elope from a third-floor window at a previous facility as he did not read the Resident's pre-admission paperwork. The Administrator said that the Resident did elope from the first floor on 6/4/25 and made it around the building to the back parking lot and was then moved to the second floor. He said he was also aware that on 6/6/25, Resident #172 was able to exit the second-floor dining room onto the balcony through a door that is supposed to be always locked. The Administrator said he had not received any calls over the weekend regarding Resident #172's increased behavior and attempt to elope from the second-floor dining room windows twice on 6/7/25. The Administrator said he was unaware if the physician was notified regarding Resident #172's elopement, elopement attempts, increased behaviors or history of elopement. During an interview on 6/9/25 at 2:03 P.M., the Director of Nursing said he read the nursing note dated 6/4/24 indicating Resident #172 was attempting to open windows, was aware he/she eloped out the front door on 6/4/25, and attempted to go out a window on 6/6/25 but was unaware the Resident had refused medications and did not notify the physician of any of these incidents. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/9/25 at 9:54 A.M., Resident #172's Guardian said she was never notified of the Resident's escalating behaviors, elopement, refusal of medications and attempted elopements out a window. The Guardian said she would have expected to be notified of all of these. During an interview on 6/9/25 at 8:44 A.M., Physician #1 said he had not yet assessed Resident #172 since his/her admission into the facility. Physician #1 said he was unaware of Resident #172's elopement history and the facility did not notify him or his nurse practitioner of Resident #172's behaviors, refusal of medications, room change, elopement and elopement attempts and that all of those examples are indicative of a call to the provider. Physician #1 said he is also the medical director of the facility and would have expected the facility to have a plan to ensure safety for residents admitted with a high risk and history of elopement. During an interview on 6/9/25 at 8:49 A.M., Nurse Practitioner (NP) #1 said she completed Resident #172's admission assessment. NP #1 said Resident #1 was wandering when she met him/her and was incoherent. NP #1 said she was unaware of Resident #172's elopement history and the facility did not make her aware of this on the day she was in the building. NP #1 said she expects the facility to notify her if a resident refuses medication, has escalating behaviors, attempts to elope and actually elopes from the facility. NP#1 said she was never notified with any of these when they occurred with Resident #172. NP#1 then checked the call log for the medical office and said no phone calls were made over the weekend on 6/7/25 to notify the physician's group that Resident #172 had attempted to elope out the window twice.

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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** 2. During an observation on 6/8/25 at 10:29 A.M., the surveyor observed a pink sticky substance on the floor between the beds in room [ROOM NUMBER]. There was a significant amount of napkins, food particles and food wrappers on the floor next to the bed. While walking in the area the surveyors shoes would stick to the floor. On 6/10/25 at approximately 8:20 A.M., the surveyor observed the floor in room [ROOM NUMBER] still had the pink sticky substance on the floor. A resident in the room said he/she would like the room clean and for the mess on the floor to be cleaned up. During observations on 6/10/25 at 1:58 P.M. and 6/11/25 at 6:42 A.M., the surveyor observed the floor of room [ROOM NUMBER] to continued to be sticky and the pink substance was still visible. During an interview on 6/11/25 at 7:35 A.M., the Director of Housekeeping said that resident rooms are cleaned and mopped daily. The Director of Housekeeping then joined the surveyor and observed the floor in room [ROOM NUMBER]. The Director of Housekeeping said that the pink substance was a stain that would require the floor to be waxed. The Director of Housekeeping said that it had been a month since the floor in room [ROOM NUMBER] was waxed. Based on observation and interview the facility failed to maintain a clean and comfortable home like environment. Specifically, 1. The facility failed to ensure the floors on the first floor unit were free of stains and baseboards were clean. 2. The facility failed to ensure the floors of a resident room on the 2nd floor were cleaned and free of stains. Findings include: Review of the facility policy titled, Homelike Environment, dated February 2021, indicated the following: -Residents are provided with a safe, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment. Throughout all days of survey, the surveyor observed that on the first floor unit, the tile floors in the hallway, nurses station and into resident rooms had dark patches of ingrained dirt on the floor tiles. The baseboards throughout the hallway of the first floor were coated in a thick, dark dirt. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/25 at 7:38 A.M., Certified Nurse Aide (CNA) #4 said the floors are very dirty, the baseboards have never looked this bad and that he wishes the first floor was cleaner. CNA #4 said the facility had a machine that would scrub the floors but it has been broken for awhile. CNA #4 said it is not a home-like environment for the residents or staff. During an interview on 6/11/25 at 7:42 A.M., Housekeeper #1 said she does not have anything but a mop to clean the floors and said the stains have been on the first floor for awhile. Housekeeper #1 said she does not clean the baseboards. The Housekeeper said the floor scrubbing machine has been broken for awhile. During an interview on 6/11/25 at 7:43 A.M., Nurse #3 said she has noticed that the first floor unit is dirty with multiple dirt stains on a lot of the tile floor in the hallway, dirt stains going into resident rooms and the baseboards are coated in dirt. During an interview on 6/11/25 at 7:48 A.M., a non sampled Resident said this whole place is dirty look at the dirt on my floor who would want to live here, I feel bad for the people who have to live here. During an interview on 6/11/25 at 7:51 A.M., the Housekeeping Manager said the floors and baseboards throughout the first floor have been dirty for awhile but once the machine is fixed he is going to be scrubbing the floors and walls. During an interview on 6/12/25 at 7:56 A.M., the Administrator said he has worked at this facility since October 2024 and the baseboards and the floors on the first floor have had dirt stains since that time but he had ordered a machine to clean the floors in May 2025. The Administrator said the facility has to do better with housekeeping services and is not aware of the floor cleaning machine is broken.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview the facility failed to accurately complete the Minimum Data Set (MDS) assessments for three Resident (#26, #33 and #2) out of a total sample of 27 residents. Specifically: 1. for Resident #26, the facility failed to code his/her vision status accurately. 2. for Resident #33, the facility failed to code assistance provided for transfers accurately. 3. for Resident #2, the facility failed to code assistance provided for transfers accurately. Findings include: 1. Resident #26 was admitted to the facility in August 2024 with diagnoses that include Hyperglycemia (high blood sugar level, with common symptoms that include blurred vision) and repeated falls. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/14/25, indicated that on the Brief Interview for Mental Status exam Resident #26 scored a 9 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated Resident #26's vision is adequate and that he/she does not wear corrective lenses. Review of the clinical record indicated the following: -A Nurse Practitioner (NP) progress note, dated 1/21/25, that indicated: Pt. (patient) would like referral for cataract surgery as he/she has missed recent surgical dates d/t (due to) acute illnesses. - An NP note, dated 2/4/2025 that indicated: Patient seen today at his/her request. He/she is wondering about his/her referral to the eye surgeon for his/her cataracts. Review of the Eye Care Evaluation note, dated 5/14/25 indicated: -Assessment: 1. Cataract, mixed; Both eyes 2. Macular degeneration, dry; Both eyes; stage unspecified -Plan: 1. Patient wants to proceed with surgery; Follow-Up: 5-6 Months; Referral: cataract ophthalmology; Note to nurses: please call (Hospital name and # redacted) and schedule appointment for cataract evaluation and removal. Please arrange transportation to and from appointments. Review of Resident #26's Activities Participation note, dated 6/2/25, indicated: Commission for the Blind was contacted waiting for confirmation for evaluation. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 8:38 A.M., Resident #26 said that he/she has cataracts in both eyes which was affecting his/her ability to see clearly and that he/she has been asking to get surgery for 8 months but no one is helping him/her. During an interview on 6/11/25 at 12:54 P.M., the MDS Coordinator said that the MDS should be coded accurately. She said that if Resident #26 does not wear glasses then the MDS is coded inaccurately for Resident #26's vision. During a follow-up interview on 6/11/25 at 1:19 P.M., with the MDS coordinator she said that Resident #26 sees fine as evidenced by Resident #26's ability to feeds him/herself, puts on his/her shoes by him/herself and wheels his/her wheelchair in the building. During an interview on 6/11/25 at 1:45 P.M., the Director of Nursing (DON) said that it is his expectation that the MDS be completed accurately. The DON said that Resident #26 has reported vision issues to him and that he is aware that Resident #26 needs cataract surgery.2. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1, dated October 2024, indicated the following: -For Mobility and transfers: Code 09, Not applicable: if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury Resident #33 was admitted to the facility in December 2017 with diagnoses that included morbid obesity, major depressive disorder and adult failure to thrive. Review of Resident #33's most recent MDS Assessment, dated 5/21/25, indicated that the Resident was assessed by staff to have severe cognitive impairment. Further, the MDS indicated that the resident was dependent for transfers and utilized a manual wheelchair with dependent assistance provided. During an interview and observation on 6/11/25 at 10:18 A.M., Resident #33 was awake in bed. Resident #33 said that he/she has not gotten out of bed in many months. He/she said they are comfortable in bed. Resident #33 said it is a preference to remain in bed. Review of progress notes during the look back period of the MDS failed to indicate a transfer out of bed to a chair or wheelchair. Review of Certified Nurse Aide (CNA) charting indicated dependent assistance for transfers out of bed to wheelchair during the look back period. During an interview on 6/11/25 at 10:11 A.M., CNA #8 said that Resident #33 does not get out of bed. She said that it has been at least 3 months since the Resident has gotten out of bed. During an interview on 6/11/25 at 10:14 A.M., CNA #5 said that Resident #33 does not get out of bed. She said that the CNA charting is inaccurate to say that the Resident was transferred with dependent assist provided. She said that the Director of Nurses told the staff that they were documenting wrong, because they should be documenting actual assistance provided, not what would need to be provided if the resident got out of bed. She said transfers should be documented as Not Applicable. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 12:54 P.M., the MDS Nurse said that the MDS Assessments should be coded as per the RAI manual and should be coded correctly, reflecting the current status of the resident and the amount of assist actually provided to the resident. The MDS Nurse said that completing an MDS includes record review, talking to staff, rounding on section GG and going to the resident room to do assessments. She said that the MDS should be coded with actual assistance provided to a resident and not the assistance they would require if the transfer or event occurred. She said the CNA documentation was coded incorrectly, leading to the MDS being coded incorrectly. During an interview on 6/12/25 at 10:24 A.M., the Director of Nursing said that CNA documentation should be based on actual assistance provided. He said that during completion of an MDS conversations should be had among staff about the resident and their status, as well as actual provided assistance. The Director of Nursing would expect the MDS to accurately reflect the status of the Resident. He said that incorrect CNA documentation led to incorrect coding on the MDS. 3. Resident #2 was admitted to the facility in March 2021 with diagnoses that included rheumatoid arthritis and muscle weakness. Review of the most recent Minimum Data Set Assessment, dated 5/21/25, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the Resident was cognitively intact. The MDS further indicates that the Resident was provided dependent assist for transfers and wheelchair assistance with a manual wheelchair. During an interview and observation on 6/11/25 at 8:27 A.M., Resident #2 was observed awake in bed. Resident #22 said that it is his/her preference to remain in bed. Resident #2 said that he/she cannot recall the last time they got out of bed. There was no wheelchair observed in the Resident's room. During an interview on 6/11/25 at 9:42 A.M., the Director of Rehab said that Resident #2 has a tendency to refuse all care and refuses to get out of bed. She said that as long as she has known the Resident, he/she has never had a wheelchair to get up into due to refusals to get out of bed. Review of progress notes during the look back period of the MDS failed to indicate that the Resident was transferred out of bed. Review of Certified Nurse Aide (CNA) charting indicated dependent assistance for transfers out of bed to wheelchair during the look back period. During an interview on 6/11/25 at 10:11 A.M., CNA #8 said that Resident #2 does not get out of bed. She said that it has been months since the Resident has gotten out of bed. During an interview on 6/11/25 at 10:14 A.M., CNA #5 said that Resident #2 does not get out of bed. She said with the exception of one day last week (which was not in the MDS look back period) when the Resident got up because it was room of the day for housekeeping to clean, that he/she has not gotten out of bed that she can remember. She said that the CNA charting is inaccurate to say that the Resident was transferred with dependent assist provided. She said that the Director of Nurses told the staff that they were documenting wrong, because they should be documenting actual assistance provided, not what would need to be provided if the resident got out of bed. She said transfers should be documented as Not Applicable. (continued on next page)

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	225147	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saugus Center	266 Lincoln Avenue Saugus, MA 01906

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 12:54 P.M., the MDS Nurse said that the MDS Assessments should be coded as per the RAI manual and should be coded correctly, reflecting the current status of the resident and the amount of assist actually provided to the resident. The MDS Nurse said that completing an MDS includes record review, talking to staff, rounding on section GG and going to the resident room to do assessments. She said that the MDS should be coded with actual assistance provided to a resident and not the assistance they would require if the transfer or event occurred. She said the CNA documentation was coded incorrectly, leading to the MDS being coded incorrectly. During an interview on 6/12/25 at 10:24 A.M., the Director of Nursing said that CNA documentation should be based on actual assistance provided. He said that during completion of an MDS conversations should be had among staff about the resident and their status, as well as actual provided assistance. The Director of Nursing would expect the MDS to accurately reflect the status of the Resident. He said that incorrect CNA documentation led to incorrect coding on the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement care plans for two Residents, (#40 and #17), out of a total of 27 sampled residents. Specifically: 1. For Resident #40, the facility failed to develop and implement a care plan related to elopement. 2. For Resident #17, the facility failed to develop and implement a care plan related to smoking. Findings include: 1. Review of the facility's policy titled, Elopement Prevention, dated 12/27/24, indicated the following: -The facility maintains a process to assess all residents for risk of elopement, implement prevention strategies for those identified as elopement risk, institute measures for resident identification at the time of admission. Resident #40 was admitted to the facility in March 2025 with diagnoses including myopathy and dementia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #40 is severely cognitively impaired, as evidenced by a score of 6 out of a possible 15 on the Brief Interview for Mental Status exam. Review of Resident #40's hospital discharge paperwork dated 3/2/25 indicated: [patient] with a history of dementia who presented .from his/her nursing home facility with increased agitation also tried to elope from his/her nursing facility where he/she has been residing for 5 mo (months). Review of Resident #40's Elopement Risk Evaluation dated 3/31/25 indicated he/she did not have a history of elopement or attempted elopement, which contradicted the hospital discharge summary. Review of the nursing progress notes indicated: 4/3/25: The resident is alert and oriented X 3 .(He/She) said (he/she) would like to go out with his/her walker. (He/she) was discouraged and redirected from leaving the facility. (He/she) was assisted with dressing and (he/she) is presently sitting in the common lounge of the facility with other residents. Safety measures are in place. 4/4/25: Resident went outside for a smoke and refused to return inside the facility. 911 was called. Upon arrival, the resident told the responding police officer that (he/she) feels comfortable staying outside and will return inside when (he/she) feels ready. The officer stated that he/she could not force the resident to re-enter the facility. DON has been aware of the situation. Attempted to contact the conservator by phone. The call will (sic) no answer, and a voicemail message was left. Monitoring will continue. Review of Resident's #40's care plans failed to indicate a care plan related to elopement was developed or implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/25 1:39 P.M., the Administrator said if a resident is admitted with a history of elopement he/she should reside on the secure unit and have a wander guard and a care plan related to elopement. 2. Review of the facility's Smoking Policy, dated 2025 indicated the following: -The facility shall conduct an assessment to determine whether the resident requires any safety devices such as a smoking apron and shall document this in the resident's care plan. Resident #17 was admitted to the facility in March 2025 with diagnoses including chronic obstructive pulmonary disease and dysphagia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she is cognitively intact, as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status exam. During an interview on 6/8/25 at 9:23 A.M., Resident #17 said that he/she is a smoker and smokes during the facility's scheduled supervised smoking times. Review of Resident #17's clinical record failed to indicate a smoking care plan was developed until 6/10/25; approximately two months after his/her admission. During an interview on 6/12/25 at 8:48 A.M., the Administrator said that smoking care plans should be implemented immediately.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for three Residents (#16, #35 and #56) out of a total of 27 residents. Specifically, the facility failed: 1. For Resident #16, who was assessed as being at risk for developing pressure ulcers, the facility failed to ensure an air mattress was at the setting prescribed by the physician as well as ensure weekly skin checks were completed as ordered. 2. For Resident #35, the facility failed to ensure weekly skin checks were completed as ordered. 3. For Resident #56, who was assessed as being at high risk for developing pressure ulcers, the facility failed to ensure weekly skin checks were completed as ordered. Findings include: 1. Resident #16 was admitted to the facility in January 2016 with diagnoses including dementia. Review of Resident #16's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status of 6 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #16 is dependent on staff for all bed mobility tasks. On 6/8/25 at 10:14 A.M. Resident #16 was observed lying in bed on an air mattress set to 400 pounds. On 6/9/25 at 7:35 A.M. and 8:08 A.M., Resident #16 was observed sleeping in bed on an air mattress set to 400 pounds. On 6/10/25 at 6:48 A.M., Resident #16 was observed lying in bed on an air mattress that was set to 400 pounds. The Resident was unable to say if his/her mattress was comfortable. Review of Resident #16's physician orders indicated the following orders: -Air mattress MDT24A20 normal pressure; comfort number from 100 to 120 lbs. static. Check functioning and settings every shift, initiated 5/8/25 -Weekly skin checks 3-11 shift and document findings (in the electronic medical record) under the assessment tab, every evening shift, every Tue (Tuesday) for skin risk assessment. Review of the last [NAME] Pressure assessment dated [DATE], indicated Resident #16 was assessed to be at moderate risk for pressure ulcer development with a score of 5. The Norton Scale also indicated that for a score of 10 or less weekly skin checks are recommended. Review of Resident #16's hospice care plan, last revised 12/14/23, indicated the following intervention: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Air mattress MDT24A20 normal pressure; comfort number from 80 lbs. (pounds) to 160 lbs., initiated on 7/9/24. During interviews on 6/10/25 at 8:17 A.M., and on 6/11/25 at 8:04 A.M., Nurse #5 said skin checks are done weekly for all residents and there is typically a physician's order for weekly skin checks for all residents. Nurse#5 said a refusal note would be written by the nurse if a resident were to refuse their skin check. Nurse #5 said he was unaware Resident #16 had skin checks that were not completed as ordered. Nurse #5 said air mattresses should be set to the level prescribed by the physician in the physician's order. Nurse #5 said he was unaware Resident #16's air mattress was set to 400 pounds, and it should be set lower according to the order. During an interview on 6/10/25 at 10:18 A.M., the Director of Nursing said skin checks should be completed weekly for all residents and was unaware Resident #16 had missing skin checks. The Director of Nursing said air mattresses are typically set to weight, but the setting is specified in the physician order and these orders should be followed as written. The Director of Nursing said he was unaware Resident #16's air mattress was set to 400 pounds, and not the weight prescribed by the physician.2. Resident #56 was admitted to the facility in April 2024 with diagnoses that included dysphagia, Huntington's Disease, adult failure to thrive, and severe protein-calorie malnutrition. Review of Resident #56's Minimum Data Set (MDS) assessment, dated 4/2/25, indicated he/she scored an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam, indicating moderate cognitive deficits. Further review of the MDS indicated he/she is at risk for pressure ulcers and is frequently incontinent of both bowel and bladder. Review of Resident #56's physician order, dated 9/20/24, indicated Weekly Skin Check Fri (Friday) 7-3 (7:00 A.M. to 3:00 P.M.). Review of Resident #56's most recent Norton Scale (Scale Predicting Risk of Pressure Ulcer), dated 4/19/24, indicated he/she scored a 10 indicating the Resident is at high risk for developing pressure ulcers. Review of Resident #56's medical record indicated the only skin checks that were completed were on 10/17/24, 10/25/24, 1/3/25, 4/17/25, and 6/6/25. Review of Resident #56's progress notes from 10/1/24 through 6/11/25 failed to indicate that the Resident refused the missing skin checks. Review of Resident #56's Treatment Administration Record from October 2024 through June 2025 indicated that nursing staff signed off the weekly skin check order as administered on every Friday, except 4/4/25 which was left blank. Review of Resident #56's active Certified Nurse Aide (CNA) Kardex (form indicating the needs of the Resident), indicated The Resident requires SKIN inspection weekly Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. Review of Resident #56's Activity of Daily Living (ADL), dated 4/19/24, indicated The Resident requires SKIN inspection weekly Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/25 at 8:36 A.M., Nurse #5 said skin checks should be performed weekly as indicated by the physician's orders. Nurse #5 said skin checks are done to look for any abnormalities of the skin and if a resident refuses skin checks then staff need to be documenting it. During an interview on 6/10/25 at 10:26 A.M., the Director of Nursing (DON) said he would expect skin checks to be done weekly and he was not aware that Resident #35 has not had any since 5/9/25. The DON said physician's orders should be followed and if a resident refuses then it needs to be documented. During an interview on 6/11/25 at 10:11 A.M., Nurse Practitioner (NP) #1 said she expects the nurses to follow doctors orders and complete weekly skin checks as ordered. The NP said Resident #56 is at high risk for skin break down and was not aware that the skin checks were not being completed as ordered.3. Resident #35 was admitted to the facility in May 2025 with diagnoses including muscle wasting and heart disease. Review of the Resident's most recent Minimum Data Set assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 11 out of 15 indicating moderate cognitive impairment. Further review of the MDS indicated the Resident requires partial/moderate assistance from staff with activities of daily living. During an interview on 6/9/25 at 9:40 A.M., Resident #35 said no one from the facility has checked his/her skin since he/she got here. Review of Resident #35's physician's order dated 5/14/25 indicated the following: Weekly Skin Check to be done Wednesday. Review of Resident #35's Kardex (a form listing the type of care a resident needs) under the Resident Care section indicated the following: Follow facility policies/protocols for the prevention/treatment of skin breakdown. Review of Resident #35's skin assessment history in the medical record indicated that the Resident's last documented skin check was on 5/9/25. Review of Resident #35's skin assessment dated [DATE] indicated that the assessment was in progress and was incomplete. Review of Resident #35's medical record failed to indicate any documentation that Resident #35 refused to have any skin checks performed. During an interview on 6/10/25 at 8:36 A.M., Nurse #5 said skin checks should be performed weekly as indicated by the physician's orders. Nurse #5 said skin checks are done to look for any abnormalities of the skin and if a resident refuses skin checks then staff need to be documented. During an interview on 6/10/25 at 10:26 A.M., the Director of Nursing (DON) said he would expect skin checks to be done weekly and he was not aware that Resident #35 has not had any since 5/9/25. The DON said physician's orders should be followed and if a resident refuses then it needs to be documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 10:11 A.M., Nurse Practitioner (NP) #1 said she expects the nurses to follow doctor's orders and complete weekly skin checks as ordered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for two Residents (#24 and #44) out of a total sample of 27 residents. Specifically, 1. For Residents #24, who has a history of choking, the facility failed to provide supervision during meals. 2. For Resident #44, the facility failed to provide incontinence care. Findings include: 1. Resident #24 was admitted to the facility in January 2015 with diagnoses including muscle weakness. Review of Resident #24's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated he/she is cognitively intact. Review of the nursing note date 3/6/25, indicated the following: -At 12:15pm, resident started choking while being followed by speech therapist. I was alerted to the dinning (sic) room with my coworker to assist resident. I encouraged resident to deep breath while my coworker performed the Heimlich maneuver which was effect (sic). Review of the nursing note dated 3/6/25, indicated the following: -I was at the nurse station writing a note and the speech therapist who was with the resident during lunch called out that someone is choking. I and another nurse rushed and performed Heimlich maneuver. Patient was able to spit out the food that was stuck in (his/her) throat. Vs (vital signs) was taken- BP (blood pressure) 132/70, Temp 97.7, Pul 74, Res (respirations) 18, 02 96 RA (room air). No sign of sob (shortness of breath), no discomfort, and denied pain. Resident was helped to bed to rest and being closely monitored, call light within reach. On 6/9/25 at 8:11 A.M., Resident #24 was observed eating breakfast alone in his/her room while lying in bed. The privacy curtain was drawn, and the Resident was not visible from the hallway. On 6/10/25 at 8:05 A.M., Resident #24 was observed eating breakfast alone in his/her room while lying in bed. The privacy curtain was drawn, and the Resident was not visible from the hallway. On 6/11/25 at 7:55 A.M., Resident #24 was observed eating breakfast alone in his/her room while lying in bed. The privacy curtain was drawn, and the Resident was not visible from the hallway. Review of Resident #24's ADL (Activity of Daily Living) care plan, last revised 7/19/2023, indicated the following intervention: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Eating: continual supervision with tray set up and please assist (him/her) as needed when fatigued or behavioral. Review of Resident #24's Kardex (a form indicating the level of ADL care each resident requires), indicated the following: - Eating: continual supervision with tray set up and please assist (him/her) as needed when fatigued or behavioral. Review of the speech therapy discharge summary date 4/29/25 indicated Resident #24 required supervision at mealtimes and out of bed for meals when possible. During an interview on 6/11/25 at 7:56 A.M., Certified Nursing Assistant (CNA) #5 said Resident #24 had a previous episode of choking while at the facility. CNA #5 said she was unaware if the facility had Kardex forms or written care plans and she receives a verbal report from the nurses if a resident has a change in status. CNA #5 said she provided Resident #24 with his/her breakfast today and that she left the meal with the Resident to eat independently in his/her room. During an interview on 6/11/25 at 8:03 A.M., Nurse #5 said each resident has a care plan which explains the level of care the residents would need to be provided with. Nurse #5 was unaware Resident #24 had a previous choking episode at the building, and he/she can eat independently in his/her room. During an interview on 6/12/25 at 10:25 A.M., the Director of Nursing (DON) said he would expect staff to follow a resident's Kardex and provide the level of assistance identified on the Kardex and care plans. The DON said if Resident #24 is documented to need continual supervision, he/she should not be eating in his/her room independently or behind a privacy curtain while eating.2. Review of the facility policy titled Urinary Incontinence - Clinical Protocol, dated and revised April 2018, indicated the following: - Treatment/Management: As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status. The facility failed to provide a policy on Activities of Daily Living when requested by the surveyor. Resident #44 was admitted to the facility in May 2024 with diagnoses including metabolic encephalopathy, type 2 diabetes, altered mental status and neuropathy. Review of Resident #44's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 9 out of 15 indicating moderate cognitive impairment and is always incontinent of bladder. Review of Resident #44's ADL self-care performance deficit care plan indicated the following intervention: -Dated 6/12/24: Toilet Use: Resident #44 requires supervision assist for toileting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's Kardex (a form indicating the type of a care a resident needs) indicated the following: -Resident Care: Assess and anticipate Resident #44's needs: food, thirst, toileting needs, comfort level -Toileting: Toilet use: Resident #44 requires supervision/assist for toileting. Review of Resident #44's Quarterly Bowel and Bladder Assessment dated 4/28/25, indicated the following: -Continence Evaluation: Are you incontinent of bladder? - Yes. -On average, how long can you hold on after feeling the first urge? - Not at all Review of Resident #44's CNA documentation for the months of May and June 2025, under the section Toilet use, indicated that for every day, Resident #44 either required continual supervision, limited assist, extensive assist or total dependence for toilet use. The surveyor made the following continuous observations on 6/9/25: -At 7:53 A.M., Resident #44 was in his/her wheelchair in the dining room, The Resident had just finished eating his/her breakfast. At 9:49 A.M., Resident #44 was still in the dining room, no staff member had asked him/her if he/she needs to use the bathroom. -At 9:49 A.M., Resident #44 was wheeling up and down the hallway in his/her wheelchair and interacted with two nurses. The nurses did not ask if he/she had to use the bathroom. Resident #44 then proceeded to the dining room using his/her wheelchair. As Resident #44 wheeled by the surveyor he/she said to him/herself I need to pee. -From 10:01 A.M., to 12:37 P.M., Resident #44 was in the dining room, no staff member asked the Resident if he/she needed to use the bathroom. -At 12:41 P.M., Resident #44 had just finished his/her lunch in the dining room. Resident #44 told the surveyor that no one had asked him/her if he/she needed to use the bathroom and he/she said he/she needs to pee. -At 1:30 P.M., Resident #44 was ambulating down the hallway using his/her wheelchair. Resident #44 said to him/herself I need to pee. Resident #44 proceeded into a different resident's room, got out of his/her wheelchair and sat on a resident's bed with another resident present. Resident #44 told the surveyor that he/she was looking for a bathroom and he/she needs help because he/she needs to pee. -At 1:37 P.M., the surveyor informed Nurse #8 that Resident #44 was in a different Resident's room looking for a bathroom. Nurse #8 assisted Resident #44 to the bathroom, Nurse #8 informed the surveyor that Resident #44 urinated in the bathroom, 5 hours and 44 minutes after the initial observation from the surveyor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saugus Center	266 Lincoln Avenue Saugus, MA 01906

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/25 at 1:37 P.M., Nurse #8 said staff need to be asking residents if they need to use the bathroom before and after meals and every couple of hours. Nurse #8 said if she knew Resident #44 had to use the bathroom she would have taken him/her sooner. At 1:42 P.M., Resident #44 told the surveyor that he/she feels a lot better after going to the bathroom. At 1:47 P.M., Certified Nursing Assistant (CNA) #7 finished changing Resident #44, CNA #7 said staff should be asking residents every few hours as well as before and after meals if they need to use the bathroom. During an interview on 6/10/25 at 8:45 A.M., Nurse #5 said if a resident signals that they need to use the bathroom then staff should take them. Nurse #5 said staff normally do bathroom rounds before and after meals. During an interview on 6/10/25 at 9:30 A.M., Nurse #7 said staff should approach the resident and ask if they need to use the bathroom every few hours. Nurse #7 said when a resident wanders around the unit then staff should ask them when passing. During an interview on 6/10/25 at 10:47 A.M., the Director of Nursing (DON) said his expectations are that staff should be doing bathroom rounds before and after breakfast and lunch time as well as three times during their shift. The DON said staff should be following his expectations for incontinence care and asked Resident #44 if he/she needed to use the bathroom more frequently.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide quality activity programming for one Resident (#15) out of a total of 27 sampled Residents. Findings include: Review of the facility policy titled, Activities, undated, indicated the following: -It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan and preferences. Facility sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental and psychosocial well-being. Activities will encourage both independence and interaction within the community. Resident #15 was admitted to the facility in November 2020 with diagnoses including cognitive communication deficit and psychosis. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #15 is severely cognitively impaired as evidenced by his/her inability to complete the Brief Interview for Mental Status Exam. On 6/8/25 at 8:55 A.M., Resident #15 was observed laying in bed without his/her TV on. Resident #15 was unable to participate in the interview process. During observations on 6/8/25, 6/9/25, and 6/10/25, Resident #15 was observed multiple times throughout the 7:00-3:00 P.M. shift in his/her room laying in bed without his/her TV or music playing or any activity engagement. Review of Resident #15's care plans indicated: Focus: Resident exhibits or is at risk for limited and/or meaningful activity functions related to: cognitive loss/dementia, 2/5/21 Interventions: Consider the impact of medical problems. Provide a calendar and talk to family about Resident's interests and preferences. Staff to talk with Resident when visiting his/her room. Focus: Resident has little or no activity involvement r/t (related to) physical limitations, 4/30/25. Interventions: Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers and family on admission and as necessary. Focus: Resident has a mood problem r/t (related to) diagnosis of unspecified psychosis, 9/27/23. Interventions: Provide the resident with a program of activities that is meaningful and of interest. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2025 and June 2025 Activity participation sheets indicated Resident #15 had received individual visits from activities staff for a total of 9 days from 5/1/25 through 5/9/25. There was no evidence or documentation that Resident #15 had participated in any other activities or received any in-room visits. During an interview on 6/16/25 at 7:56 A.M., Certified Nursing Assistant (CNA) #1 said Resident #15 has not been out of his/her bed in 2-3 months and activities staff come in and provide visits. During an interview on 6/11/25 at 11:10 A.M., the Activity Director said that for Residents who are bedbound, in-room visits are provided and he would obtain a social history from family to ascertain resident preferences including TV and music choices. The Activity Director and the surveyor reviewed the resident activity participation sheets and he said he understood that there was no evidence Resident #15 had received any in-room visits or participated in any activities since 5/9/2025.

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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 provide oral mouth care to one Resident (#7) who does not receive food or drink by mouth resulting in oral thrush (a fungal infection of the mouth) developing out of a total sample of 27 residents. Findings include: Resident #7 was admitted to the facility in January 2018 with diagnoses including muscle wasting, depression and dysphagia. Review of Resident #7's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 13 out of 15 indicating no cognitive impairment. Further review of the MDS indicated that the Resident requires substantial/maximal assistance with oral hygiene and is currently receiving tube feeding therapy. During an observation on 6/8/25 at approximately 10:00 A.M., Resident #7 was lying in his/her bed, he/she has a percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted into the stomach through a small incision in the abdomen to provide artificial nutrition) in his/her stomach. The surveyor asked Resident#7 to stick out his/her tongue, the tongue was covered with a caked on, white substance. Resident #7 said he/she does not remember staff cleaning his/her mouth. Review of Resident #7's physician's orders indicated the following: - Dated 5/2/25: NPO (nothing by mouth) every shift - Dated 3/11/25: Enteral Feed every 4 hours, provide Jevity 1.5 (a tube feeding formula) at 237 mL (milliliters) q 4 hours (every 4 hours) via bolus per PEG tube at 0000, 0400, 0800, 1200, 1600, 2000. Review of Resident #7's physician's orders failed to indicate any interventions relating to performing daily mouth care. Review of Resident #7's care plan indicated the following: - Focus: Resident #7 requires bolus feeding via JG-tube r/t esophageal dysmotility, dysphagia (Dated 9/20/23) - Interventions: Resident #7 is dependent with tube feeding. See MD (medical doctor) orders for current feeding orders (Dated 9/20/23), Enhanced Barrier Precaution (dated 6/15/24) Review of Resident #7's care plans failed to indicate any interventions relating to performing daily mouth care. Review of Resident #7's Kardex (a form indicating the type of a care a resident needs) failed to indicate any interventions relating to daily mouth care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's Certified Nursing Assistant (CNA) documentation for May 2025, indicated that on 24 out of the 31 days, Resident #7 either needed partial/moderate assistance, substantial/maximal assistance or was dependent on staff for performing oral hygiene. Review of Resident #7's Certified Nursing Assistant (CNA) documentation for June 2025, indicated that on 9 of the 11 elapsed days of the month, Resident #7 either needed partial/moderate assistance, substantial/maximal assistance or was dependent on staff for performing oral hygiene. During an interview on 6/9/245 at 12:49 P.M., CNA #6 said she provides ADL care to Resident #7 and some days he/she needs it more than others. CNA #6 said she does not recall ever cleaning Resident #7's tongue or mouth. During an interview on 6/10/25 at 8:44 A.M., Nurse #5 said it is best practice to perform mouth care daily on a resident who is NPO. Nurse #5 said he is unsure if the expectation is to have a physician's order or if the CNA's just know to do it. During an interview on 6/10/25 at 9:30 A.M., Nurse #7 said staff need to remind Resident #7 to clean his/her mouth and supervise him/her cleaning it to ensure it is thoroughly done. At 9:38 A.M., Nurse #7 and the surveyor observed Resident #7's mouth, Nurse #7 said his/her tongue is covered in a caked on white substance. Nurse #7 said if a staff member notices his/her tongue like that they need to let a nurse or the nurse practitioner know. During an interview with the Assistant Director of Nursing (ADON) on 6/10/25 at 9:57 A.M., he and the surveyor observed Resident #7's tongue which was observed to have a white substance on it. The ADON said because Resident #7 has no teeth, he doesn't think he/she needs to clean his/her mouth. The ADON said Resident #7 is independent, so we do not have to ask him/her if he/she needs help or supervision with oral hygiene. The ADON said he is going to recommend a physician's order for oral care, so his/her tongue gets cleaned. The ADON then said even though Resident #7 does not drink water via his/her mouth, the tube feeding formula provided through the PEG tube will replenish the moisture in his/her mouth. During an interview on 6/10/25 at 10:42 A.M., the Director of Nursing (DON) said he is not familiar with Resident #7's case. The DON said Resident #7 needs to have full mouth care since he/she is NPO and he/she could develop oral thrush which is a fungal infection. The DON said general nursing practice is to have oral care done daily on each shift. During an interview on 6/11/25 at 9:56 A.M., the DON and ADON said the nurse practitioner assessed Resident #7 yesterday and put him/her on Nystatin (an antifungal medication) for oral thrush. We brushed his/her tongue yesterday and white residue was still present afterwards. During a telephone interview on 6/11/25 at 10:28 A.M., Nurse Practitioner (NP) #1 said she was contacted yesterday saying Resident #7 has oral thrush and requested an order for Nystatin. NP #1 said oral thrush can be uncomfortable and cause pain which is usually how it is diagnosed. NP #1 said if a resident is flagged as being a substantial/max assist for oral hygiene then staff should be ensuring oral hygiene is done daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 10:40 A.M., Nurse #9 reviewed Resident #7's MDS and said staff needs to be providing max assist when he/she cleans his mouth. Nurse #9 said she spoke with the Resident yesterday and he/she said he/she sometimes cleans it but she questioned if he/she does a thorough job and cleans his/her tongue. Nurse #9 said CNAs should be staying with him/her to make sure his/her tongue and mouth get cleaned thoroughly. Nurse #9 said she looked at his/her tongue yesterday and said it was covered in a white substance. Review of a progress note dated 6/11/25 at 7:15 A.M., written by the ADON, indicated the following: Resident observed with white coated tongue that remains after brushing with toothbrush, NP #1 informed. Ordered Nystatin mouth/throat suspension.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review and interview the facility failed to ensure that the necessary vision services were provided for one Resident (#26) out of a total sample of 27 residents. Findings include: Resident #26 was admitted to the facility in August 2024 with diagnoses that include Hyperglycemia (high blood sugar level, with common symptoms that include blurred vision) and repeated falls. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/14/25, indicated that on the Brief Interview for Mental Status exam, Resident #26 scored a 9 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated Resident #26's vision is adequate and that he/she does not wear corrective lenses. Review of the clinical record indicated the following: -A Nurse Practitioner (NP) progress note, dated 1/21/25,: Pt. (patient) would like referral for cataract surgery as he/she has missed recent surgical dates d/t (due to) acute illnesses. - An NP note, dated 2/4/2025,: Patient seen today at his/her request. He/she is wondering about his/her referral to the eye surgeon for his/her cataracts -A nurses notes dated 2/12/24 and timed stamped 8:14 A.M., that indicated: resident left the facility for appointment (at an eye and ear center-name redacted) *A nurses notes dated 2/12/24 and timed stamped 9:57 A.M., that indicated: resident return to the facility no new orders, appointment canceled by insurance. -A nurses note dated 5/1/25 that indicated: (Resident #26) had an appointment scheduled for an eye procedure on Wednesday February 12th, 2025, at 8:30 am. The appointment was canceled as they did not take his/her insurance. NP notified and will follow up. Review of the Eye Care evaluation note, dated 5/14/25 indicated: -Assessment: 1. Cataract, mixed; Both eyes 2. Macular degeneration, dry; Both eyes; stage unspecified -Plan: 1. Patient wants to proceed with surgery; Follow-Up: 5-6 Months; Referral: cataract ophthalmology; Note to nurses: please call (Hospital name and # redacted) and schedule appointment for cataract evaluation and removal. Please arrange transportation to and from appointments. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Activities Participation note dated 6/2/25 (written by Activity Director) indicated: Commission for the Blind was contacted waiting for confirmation for evaluation. During an interview on 6/11/25 at 8:38 A.M., Resident #26 said that he/she has cataracts in both eyes which was affecting his/her ability to see clearly and that he/she has been asking to get surgery for 8 months but no one is helping him/her. During an interview on 6/11/25 at 10:28 A.M., Nurse #5 said that he is Resident #26's nurse and that he is not sure if Resident #26 has any vision issues. Nurse #5 is unsure who coordinates eye doctor appointments or procedures when recommendations are made from the eye doctor. During an interview on 6/11/25 at 10:41 A.M., Social Worker (SW) #1 said that she is not involved in scheduling or coordinating services such as the eye doctor or eye procedures, that it is managed by the nursing department and that she does not know anything about the process. During an interview on 6/11/25 at 12:48 P.M., the Medical Records Coordinator (MRC) #1 said that she coordinates eye ancillary services for all residents in the facility. The MRC said that her role is to enroll all residents with the provider and that after each ancillary providers visit they send the visit notes, she prints them out and provides them to the Director of Nursing for follow-up. During an interview on 6/11/25 at 1:45 P.M., the Director of Nursing (DON) said that Resident #26 recently complained to him that he/she had been asking for 8 months to get his/her cataracts taken care of. The DON said that he spoke to the floor nurse who checked the computer and told him that Resident #26 had gone out to an eye MD appointment and returned but gave him no other information. The DON said that if he had known that there was a health insurance issue he would have called the eye MD service to get the issue resolved and ensure the Resident's cataracts were treated.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure nursing implemented a splinting device as ordered for contracture prevention for one Resident (#16) out of a total sample of 27 residents. Specifically, the facility failed to ensure Resident #16 was wearing a hand roll as ordered and recommended by the therapy department. Findings include: Resident #16 was admitted to the facility in January 2016 with diagnoses including muscle weakness, dementia and arthritis. Review of the Resident's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated the Resident has impairment on one side, is dependent on staff for activities of daily living. The surveyor made the following observations: -On 6/8/25 at 10:14 A.M., Resident #16 was lying in his/her bed, and he/she said his/her right hand was stuck and his/her last three fingers could not straighten and he/she said it was painful when he/she tried to straighten these three fingers. Resident #16 was not wearing a hand roll and there was no hand roll observed in the vicinity of the Resident's bed. -On 6/9/25 at 7:35 A.M., Resident #16 was sleeping in bed. The Resident's right hand was closed in a fist position and there was no hand roll in his/her right hand. The Resident did not receive morning ADL care yet. -On 6/10/25 at 6:48 A.M., Resident #16 was awake in bed. The Resident's right hand was closed in a fist position and there was no hand roll in his/her right hand. The Resident did not receive morning ADL care yet. -On 6/11/25 at 7:48 A.M., Resident #16 was sleeping in his/her bed. The Resident's right hand was closed in a fist position and there was no hand roll in his/her right hand, however, a hand roll was next to the Resident in the bed. The Resident did not receive morning ADL care yet. Next to Resident #16's bed, hanging on the wall, was a photo of Resident #16 holding a hand roll with the following directions: -Evening shift: please place blue hand roll on Resident's right hand prior to bedtime. -Morning shift: Please remove blue hand roll during morning ADLs. Review of Resident #16's physician's order dated 5/5/25 indicated the following: Occupational Therapy: Complete PROM (passive range of motion) to the right hand and then don (put on) right hand roll prior to bedtime and remove in the morning. Directions: No directions specified for this order. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's Kardex (a form indicating the type of care the resident needs) indicated the following: -Dressing/Splint Care section: OT eval (evaluation for contracture management 3/19/25, Passive range of motion to maintain WFL (within functional limits) in R (right) hand as tolerated. -Resident Care section: Patient to wear hand roll as per physician's order Review of Resident #16's care plan for right hand contractures dated 5/25/22 indicated the following interventions: -Dated 11/29/23: Patient to wear right hand roll as per physician's order. Review of Resident #16's Medication Administration Records and Treatment Administration Records failed to indicate the use of a hand roll due to the physician's order having incomplete directions for use. Review of Resident #16's OT Evaluation and Plan of Treatment dated 3/19/25 indicated the following: -History: Resident referred by hospice for OT services to assess new R hand orthotic (as previous one has gone missing), create wear schedule and educate staff on orthotic management/wear schedule/proper donning and doffing. -Impressions: After assessment of R hand, it was determined that pt (patient) would benefit from palm grip in order to provide maximum extension of digits without causing discomfort/pain. Pt in agreement to wear schedule of staff donning prior to bedtime and off in the morning. Nursing staff educated on wear schedule, donning and doffing. After education-nursing signing FMP (functional maintenance program), care plan and orders updated. Review of Resident #16's in-service sheet completed by the Therapy Director on 3/19/25, indicated the following: -Topic: Complete PROM to right hand, then donn palm grip to right hand prior to bedtime, remove in the morning. The in-service education had six nursing signatures. Review of Resident #16's progress notes from the hospice nurse dated 4/10/25, indicated the following: -Right hand contracture, please ensure palm roll applied. Review of Resident #16's document titled Quality Assurance Performance Improvement Action Plan dated 5/14/25, indicated the following: -Goal: To facilitate carry over with orthotic/device care + wear schedule. -Topic/Problem: Staff not consistent with orthotic + device wear schedules (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Action/Intervention: folders to be placed above all residents who have an orthotic, heel protectors and/or stockings which will include wear schedule + picture of device(s) on resident for proper donning. Educate all staff and intervention -By Whom: Rehab -Follow UO/Comments: intervention to be completed by 6/2/25 The action plan had 12 nursing signatures. During an interview on 6/11/25 at 8:05 A.M., Nurse #5 said Resident #16 should be wearing a hand roll, he thinks the resident should be wearing it during the day time and there should be a physician's order for it. Nurse #5 said he has not received any education on how or when Resident #16 should be wearing it. During an interview on 6/11/25 at 8:47 A.M., Certified Nursing Assistant (CNA) #7 said she was not sure if Resident #16 wore an orthotic on his/her right hand and she does not remember ever putting one on him/her. During an interview on 6/11/25 at 9:35 A.M., the Director of Rehab (DOR) said she is an OT. The DOR said Resident #16 is on hospice services and she got an evaluation from hospice to evaluate the resident for a new hand roll as he/she had lost the previous one. The DOR said the Resident agreed to wear it and she educated nursing staff and hung education on Resident #16's wall. The DOR said she would expect nursing staff to implement her education and make sure Resident #16 was wearing his/her hand splint as ordered. During an interview on 6/11/25 at 10:40 A.M., Nurse #9 said she has questioned why Resident #16's order had no directions. Nurse #9 said the Resident should be wearing the hand roll at bedtime and staff should be ensuring he/she is wearing it. During an interview on 6/12/25 at 10:27 A.M., the Director of Nursing said Resident #16 should be wearing the hand roll as ordered.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to keep three Residents (#172, #56 and #35 free from accidents while at the facility. Specifically, 1. For Resident #172, with a known history of elopement from a window, the facility failed to ensure it provided appropriate supervision and safety resulting in the Resident falling from his/her second-floor bedroom window during an elopement attempt, resulting in an acute hospitalization with a fracture of the fourth lumbar vertebrae with mild retropulsion into the spinal canal (bone fragments in spinal cord), fractures of the second and third lumbar vertebrae, hematoma of the psoas muscle (lower back muscle), and fractures of the ninth through 12 ribs; 2. For Resident #56, the facility failed to ensure supervision was provided during a trialing of an upgraded diet texture resulting in a choking episode requiring the Heimlich Maneuver; and 3. For Resident #35, the facility failed to ensure smoking materials were not left unsupervised in the Resident's room. Findings include: Review of the facility policy titled, Elopement Prevention, dated 12/27/24, indicated the following: -The facility maintains a process to assess all residents for risk of elopement, implement prevention strategies for those identified as elopement risk, institute measures for resident identification at the time of admission. -The physical plant is secured to minimize the risk of elopement, such as: c. safety locks or keypad entry that restrict access to dangerous areas, d. restricted window openings 1. Resident #172 was admitted to the facility in June 2025 with diagnoses including dementia with behavioral disturbances and unsteadiness on feet. Review of the Brief Interview for Mental Status (BIMS) completed on 6/6/25 indicated Resident #172 scored a 6 out of a possible 15, which indicated he/she had severe cognitive impairment. Review of the initial nursing admission assessment completed on 6/4/25 indicated the Resident required supervision for all mobility tasks. On 6/8/25 at 6:47 A.M., the surveyors observed Resident #172 lying on the ground on the outside of the building below a second-floor open window. A window screen was observed hanging from the side of the building. Resident #172 had significant lacerations to his/her left arm and face, and blood was visible on his/her bilateral arms, face and chest. The Resident was screaming and when approached by the surveyor he/she said he/she went out the window because he/she was trying to get out of the building. The facility nursing staff called 911 and the Resident was taken to the hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/8/25 at 6:52 A.M., Certified Nursing Assistant (CNA) #1 said she worked the overnight shift and Resident #172 was wandering up and down the hallways since 5:00 A.M., and at one point was attempting to go near the dining room window. CNA #1 said she had been told by other staff that the Resident had attempted to jump out of the dining room window previously and the staff had to barricade the window with tables and chairs to prevent access to the window. CNA #1 said at approximately 6:30 a.m., she left the Resident alone so she could go into the hallway and complete her paperwork. CNA #1 said it was at this point the Resident must have walked down to his/her bedroom and jumped out the window. On 6/8/25 at 6:56 A.M., the surveyor observed Resident #172's bedroom window. The window was open, with the opening measuring 24.5 inches wide and 4 feet 2 inches high. There was nothing in the window to secure the opening of the window to prevent it from opening to that distance. On 6/8/25 at approximately 7:00 A.M., the surveyor observed the second-floor dining room window that CNA #1 said Resident #172 had been repeatedly approaching. The window was able to open from the left side with an opening measuring 22.5 inches wide and 4 feet 7 inches high. There was nothing in the window to secure the opening of the window to prevent it from opening to that distance. The right side of the window was secured with a device in the window ledge to prevent it from opening. Review of Resident #172's admission paperwork included the following: -A hospital psychiatric consultation dated 4/22/25, that indicated History of present illness. This is a (male/female) who was referred for admission because of increased agitation. Patient does have a history of dementia as well as depression and is a long-term nursing home resident. While there, (he/she) apparently was trying to get a window on the third floor. (He/she has no recollection of this event and denies that it was a suicide attempt. (He/she) was subsequently referred for inpatient psychiatric treatment. -A Discharge summary, dated the day of admission to the facility, that indicated admitted (from another facility) for agitation and elopement behaviors. While admitted pt (patient) initially was exit seeking but redirectable, with medication adjustment improvement in exit seeking behaviors. Pt wanders at times but is easily redirectable and pleasant with redirection. -From (another facility), BIBA (brought in by ambulance), patient trying to get out 3rd floor window. Baseline confusion, alert to name only, secondary to dementia. Review of the elopement assessment dated [DATE] indicated Resident #172 was wandering and that his/her wandering was both goal-directed and aimless and not goal-oriented. Review of the nursing note dated 6/5/25 and written by the Director of Nursing indicated the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 0845 writer and the Administrator were called to the second floor. The resident was observed using a very loud tone of voice and swearing at staff members. The Director of Nursing (writer) was able to escalate (sic) the resident's behavior and redirect the resident. The resident responded very well to the Director of Nursing, with a calm, soft voice, and apologized for yelling. While the writer was assessing the resident, it was noted that the resident was very confused, did not know where they were, and was using word salad when speaking. The writer was able to calm the resident to the point that they were able to leave the resident safely with the nursing staff. Nursing staff will continue to monitor the resident for the remainder of the shift. Review of the social services note dated 6/5/25 indicated the following: -Resident was transferred from (first-floor room) to (second-floor room) for safety reasons with prior authorization from Guardian and the agreement of roommate. Social worker will continue to monitor for changes in mood and behavior. Social services continues to remain available as needed for ongoing psychological support and reassurance. Review of the nursing note dated 6/7/25 and time stamped 7:11 A.M., indicated the following: -Resident attempt to elope twice by opening the window in the dinner room. Cont. (continue) to monitor for safety. Review of the nursing note dated 6/7/25 and time stamped 12:53 P.M., indicated the following: -Pt. (patient) is alert, oriented and confused at baseline. Refused all am (morning) scheduled medications, at 50% of breakfast and 100% of lunch. Review of Resident #172's elopement and wandering care plan created on 6/4/25, failed to indicate an individualized care plan for Resident #172's history of elopement through windows. Interventions that were included on the care plan, all initiated on 6/4/25, were: -Clearly identify Resident's room and bathroom. -Engage Resident in purposeful activity. -Identify if there are triggers for wandering/eloping. -Identify if there is a certain time of day wandering/elopement attempts occur. -Identify if there is a pattern and purpose of wandering. -Provide care in a calm and reassuring manner. -Provide clear, simple instructions. -Provide reorientation to surroundings. -Wander guard (a bracelet worn to activate an alarm if exiting through the doors or elevator of the unit) placed to left ankle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan failed to include any interventions after actual elopement attempts by the Resident. Review of Resident #172's mood care plan created on 6/4/25, indicated the following intervention: -Monitor/document/report any risk for harm to self: suicidal plan, past attempted suicide, risky actions (stocking pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med (medications) or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. During interviews on 6/8/25 at 6:56 A.M., and 6/10/25 at 6:52 A.M., Nurse #1 said he was aware Resident #172 had a history of attempting to jump out windows and while at this facility, the Resident had attempted to open and exit the second-floor dining room window on 6/6/25 and 6/7/25. Nurse #1 said the Resident had also opened the balcony door off the dining room on 6/6/25 and had gone over to the edge of the balcony and needed to be pulled from the edge. Nurse #1 said he did not notify the provider or management of these behaviors and incidents. During an interview on 6/8/25 at 6:59 A.M., CNA #1 said the staff were aware that Resident #172 had been attempting to exit seek through windows and was unaware if anyone contacted administration or the medical providers to report this. During an interview on 6/11/25 at 8:38 A.M., Nurse #6 said she worked the 3:00 P.M. to 11:00 P.M. shift on the second floor on the day of Resident #172's admission. Nurse #6 said the Resident was opening windows and looking outside. Nurse #6 said prior to the Resident moving to the second floor, he/she had been admitted to the first floor and had eloped out of the building, and as a result he/she was moved to the second floor. Nurse #6 said once the Resident was on the second floor, he/she was constantly trying to elope from the building by pushing on doors, elevators and windows. Nurse #6 said she did not bother to call down to tell the management that Resident #172 was exit seeking because they already knew and that is why he/she was transferred to the second floor. Nurse #6 said she did not notify the physician or nurse practitioner of the wandering and exit seeking behavior. During an interview on 6/9/25 at 10:12 A.M., CNA #5 said Resident #172 eloped from the building when he/she was first admitted and made it two miles down the road. CNA #5 said on the second day at the facility, Resident #172 attempted to jump off the second-floor balcony. CNA #5 said the administration blamed the nurse for agitating the Resident and said the nurse was overreacting to the situation. CNA #5 was unaware if the physician was notified after these two events. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/8/25 at 9:09 A.M., the surveyor interviewed the Administrator and Director of Nursing. During the interview, the Administrator said he received a call at 7:00 A.M. that Resident #172 had fallen out of his/her bedroom window. The Administrator said Resident #172 was a new admit to the facility and had dementia and was confused with a history of behaviors. Both the Administrator and Director of Nursing said they had not read Resident #172's admission paperwork and were unaware of his/her behaviors, elopement risk and previous attempt to elope out a third-floor window. The Administrator said that the Resident did elope from the first floor on 6/4/25 and made it around the building to the back parking lot and was then moved to the second floor. He said he was also aware that on 6/6/25, Resident #172 was able to exit the second-floor dining room onto the balcony through a door that is supposed to be always locked. The Administrator and Director of Nursing said they were aware Resident #172 displayed behaviors of yelling, swinging arms and banging on the walls and said the Resident wanted out and was assessed as being high risk for elopement. The Director of Nursing said he needed to be called to Resident #172's floor when his/her behavior escalated and needed to provide support to the Resident in order to deescalate the behaviors. The Administrator said he had not received any calls over the weekend regarding Resident #172's increased behavior and attempt to elope from the second-floor dining room windows twice on 6/7/25. The Administrator said he was unaware if the physician was notified regarding Resident #172's elopement, elopement attempts, increased behaviors or history of elopement. During an interview on 6/9/25 at 2:03 P.M., the Director of Nursing said he read the nursing note dated 6/4/24 indicating Resident #172 was attempting to open windows, was aware he/she eloped out the front door on 6/4/25, and attempted to go out a window on 6/6/25 but was unaware the Resident had refused medications and did not notify the physician of any of these incidents. The Director of Nursing said he attempted to secure the second-floor dining room window, and was successful in doing so on the right side of the window, but because I am not a carpenter he was unable to secure the left side. The Director of Nursing said after not being able to secure the left side of the window, he did not come up with a plan to secure that window further. During an interview on 6/9/25 at 9:54 A.M., Resident #172's Guardian said she was never notified of the Resident's escalating behaviors, elopement, refusal of medications and attempted elopements out a window. The Guardian said she would have expected to be notified of all of these. During an interview on 6/9/25 at 8:44 A.M., Physician #1 said as the medical director of the facility and would have expected the facility to have a plan to ensure safety for residents admitted with a high risk and history of elopement. During an interview on 6/9/25 at 8:49 A.M., Nurse Practitioner (NP) #1 said she completed Resident #172's admission assessment. NP #1 said Resident #1 was wandering when she met him/her and was incoherent. NP #1 said she was unaware of Resident #172's elopement history and the facility did not make her aware of this on the day she was in the building. NP #1 said she was unaware of Resident #172's actual elopement and elopement attempts at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/9/25 at 1:33 P.M., the Administrator said the clinical liaison who interacts with the hospital does the initial admission screening, then speaks with the admission coordinator at the facility. The Administrator said this screening process is in place to ensure the facility can clinically and safely take care of the residents. The Administrator says he has little involvement in looking at the preadmission screens as he trusts the Director of Nursing to do this. The Administrator said elopements are not something he has had a great deal of experience with as it has been many years since he has had a building with a locked unit. He said he believed the facility would be able to clinically care for Resident #172 at the time of his/her admission, however, he was not aware of the Resident's prior elopement attempts. The Administrator said he was aware Resident #172 had eloped from the building, had gotten out onto the second-floor balcony and had banged on windows; however, he said he was unaware the Resident had attempted to open and climb out a second-floor window on two other occasions. The Administrator said he would have expected any elopement attempts or safety concerns to be reported to him as it is his responsibility for all residents' safety. When asked about his system for ensuring the windows of the facility are secure, the Administrator said he had asked his maintenance director to complete an audit in March 2025 to check all windows and ensure they could not open more than four inches. The Administrator said he did not receive a formal audit from the maintenance director and took his word that it had been completed. During an interview on 6/10/25 at 7:35 A.M., the Case Manager in charge of admissions from the hospital was interviewed. The Case Manager said she helps coordinate Resident #172's admission to the facility and was aware that the Resident was in the hospital for psychiatric concerns and had attempted to elope from a window at a previous facility. The Case Manager said she sent all of the preadmission paperwork and the Resident's clinical history/information to the facility to ensure the facility would be able to handle the patient. During an interview on 6/10/25 at 9:01 A.M., the Admissions Coordinator said she was aware of Resident #172's prior attempt to elope from a window prior to his/her admission to the facility and did not tell the Administrator and did not have a conversation with anyone in the building to ensure the windows were secure. During an interview on 6/11/25 at 8:17 A.M., the Maintenance Director said he was asked to complete a window audit in March 2025, and he delegated his task to his assistant, asking him to ensure the windows could not open more than 4 inches. The Maintenance Director said he was never given a formal audit showing that his assistant completed this task, but he took his word for it. The Maintenance Director said he was never told to check the second-floor dining room door to the outside balcony, and he had never been told to add that door to his daily safety check. During an interview on 6/11/25 at 8:29 A.M., the Maintenance Assistant said he was assigned the task to audit all windows in March 2025, and he did this task but did not write down the results on a formal audit form. The Maintenance Assistant said he was aware that the window in Resident #172's room could open all the way, and he did not go back to ensure that it was secure. The Maintenance Assistant said the door to the second-floor dining room is not on a daily safety check list and he was never told to check the door after the fact. During an interview on 6/11/25 at 11:18 A.M., the Administrator said he was unaware the window in Resident #172's bedroom was able to open all the way and that the maintenance assistant was aware of this. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Resident #56 was admitted to the facility in April 2024 with diagnoses that included dysphagia, Huntington's Disease, adult failure to thrive, and severe protein-calorie malnutrition. Review of Resident #56's Minimum Data Set (MDS) assessment, Dated 7/27/24, indicated require change in texture of food or liquids (e.g., pureed food, thickened liquids). Review of Resident #56's Minimum Data Set (MDS) assessment, dated 4/2/25, indicated he/she scored an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive deficits. Further review of the MDS indicated mechanically altered diet - require change in texture of food or liquids (e. g., pureed food, thickened liquids). Review of Resident #56's diet order from 8/4/24 to 1/14/25 indicated Regular diet, Liquid / No Texture texture, Nectar consistency. Review of Resident #56's Speech Evaluation, dated 8/2/24, indicated baseline mechanical soft nectar liquids. Swallowing abilities= Severe, Oral phase= Moderate. Diet Recs - Solids = Mechanical Soft Textures, Mechanical Soft/Ground Textures. Supervision for Oral Intake = Close supervision. Review of Resident #56's Speech Therapy note, dated 8/6/24, indicated Pt (patient) was trialed on soft meatballs during noon meal. Pt took an entire meatball and place in her mouth. SLP directed pt to take food out of her mouth. Review of Resident #56's Speech Therapy note, dated 8/29/24, indicated Pt presented with mechanical soft food. Review of Resident #56's nursing progress note, dated 9/3/24, indicated During the lunch service, the dietician provided a chicken sandwich to the patient. While eating, the patient began to choke. The nurse on duty quickly intervened by performing the Heimlich maneuver. It was successful, and patient expelled the pieces of the sandwich that were obstructing her airway. After the incident, the patient was assessed and found to be in stable condition. Review of Resident #56's Nurse Practitioner progress note, dated 9/5/24, indicated Patient seen today following an episode of choking on 9/3/2024. Patient was eating a sandwich and choked requiring the Heimlich maneuver, article fluid was expelled. Due to this episode patient continues to have nectar consistent, puréed texture. (sic) During an interview on 6/10/25 at 10:55 A.M., the Speech Therapist said she was working with Resident #56 on 9/3/25, gave the Resident a chicken salad sandwich and then left the Resident with the nurse to be supervised. The Speech Therapist said at that time there was not an order in place for the Resident to have mechanically altered foods with nursing staff but she was working with the Resident to try and upgrade his/her diet. The Speech Therapist said he/she was a puree diet at the time of the trial and was discharged to stay on a puree with thickened liquid diet. During an interview on 6/10/25 at 1:46 P.M., Nurse #3 said she is familiar with Resident #56 and the choking incident that happened on 9/3/24. Nurse # 3 said that speech should not have left the nurse alone with the Resident while trialing new food textures until a doctors order is in place for that food texture. Nurse #3 said the diet order at the time should have said puree texture and not no texture texture. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/12/25 at 10:24 A.M., the Director of Nursing (DON) said when a Resident is working with speech on trialing different foods the expectation is that the speech therapist stay for the whole duration of that meal. The DON said the speech therapist should have never left the nurse with the Resident with the chicken salad sandwich because there was not a doctors order in place for that texture of food and could be dangerous. The DON said he expects the Residents plan of care to be followed and the diet texture should have been clear in the order. During an interview on 6/12/25 at 10:28 A.M., Nurse Practitioner (NP) #1 said she knows Resident #56 well and he/she does have a history of choking at the facility. The NP said she would expect the speech therapist to have stayed until the Resident was done with that session of trialing the mechanically altered food as it is their job. The NP said the texture should have been clear in the doctors orders at that time as the Resident was on a puree diet and still is. 3. Review of the facility policy titled Smoking Policy, undated, indicated the following: - Each Resident should be individually assessed to determine whether he/she can safely smoke without supervision. The Facility shall conduct an assessment to determine whether the resident requires any safety devices such as a smoking apron and shall document this in the resident's care plan. - Supervised smokers are not permitted to have any smoking paraphernalia in their room or on their person. Resident #35 was admitted to the facility in May 2025 with diagnoses including muscle wasting, heart disease and nicotine dependence. Review of the Resident's most recent Minimum Data Set assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 11 out of 15 indicating moderate cognitive impairment. Further review of the MDS indicated the Resident requires partial/moderate assistance from staff with ADL care and currently uses tobacco. Review of the list of Residents who currently smoke in the facility provided by the facility failed to indicate that Resident #35 smokes. On 6/8/25 at 8:50 A.M., the surveyor observed Resident #35 lying in his/her bed. On Resident #35's bedside table next to his/her bed was one unlit cigarette and one cigarette that had been previously lit and stubbed out (burnt, black markings were on the end of it). Resident #35 told the surveyor that he/she smokes while living in the facility. Review of Resident #35's Nursing admission Evaluation dated 5/9/25, indicated the following under the smoking section: - Smoking: yes - Resident needs for adaptive equipment: supervision - Does the resident need facility to store lighter and cigarettes: yes - Decision: safe to smoke with supervision (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #35's active care plans failed to indicate that the facility developed a smoking care plan with individualized, resident-specific interventions. During an interview on 6/10/25 at 8:36 A.M., Nurse #5 said there is a lock box downstairs that contains all of the Residents' smoking materials after they finish smoking. Nurse #5 said Residents should not have any cigarettes or smoking material at the bedside. The surveyor showed Nurse #5 the photos of the cigarettes at Resident #35's bedside and he said they should not be there. During an interview on 6/10/25 at 9:19 A.M., Nurse #7 said cigarettes are kept in a lock box and staff who are in charge of supervising smoking ensure Residents put all smoking material back in the box after smoking. Nurse #7 said nursing has complained about this and residents are going outside without supervision and smoking. Nurse #7 said we have lost control of residents going out to smoke. During an observation on 6/10/25 at 9:41 A.M., as the surveyor was interviewing Nurse #7, Resident #35 was walking down the hallway coming from his/her room holding a cigarette in his/her right hand. Resident #35 told Nurse #7 that he/she had the cigarette with him/her and is trying to leave the building to smoke. During an interview on 6/10/25 at 10:33 A.M., the Director of Nursing (DON) said all residents who wish to smoke in the facility must have a smoking assessment and smoking care plan. The DON said if a resident is of sound mind and body then they can have smoking materials with them. During an interview on 6/10/25 at 12:30 P.M., the Administrator said residents who are alert and oriented and are safe smokers who do not need supervision are allowed to have smoking materials with them and he said he refers to the facility policy. The Surveyor reviewed the smoking policy with the Administrator, and he said Resident #35 should not have smoking materials with him/her and he/she should have a smoking care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure one Resident (#32) was receiving oxygen at the correct flow rate and failed to ensure there was water in the humidifier bottle while the Resident was receiving oxygen, out of a total sample of 27 residents. Findings include: Review of the facility policy titled Oxygen Administration per Nasal Cannula, dated September 2024, indicated the following: - Policy: A physician's order shall be required for administering oxygen, humidifier shall be changed every 72 hours and when needed. - Procedure: Verify order in the resident's medical record, attach pre-filled humidifier bottle to the concentrator (if indicated). Resident #32 was admitted to the facility in August 2019 with diagnoses including acute bronchitis, chronic respiratory failure and anxiety disorder. Review of Resident #32's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 13 out of 15 indicating intact cognition. Further review of the MDS indicated that the Resident is dependent on staff for all Activities of Daily Living. The surveyor made the following observations: -On 6/8/25 at 8:50 A.M., Resident #32 was awake lying in bed, not wearing his/her nasal cannula to receive oxygen. The Resident's oxygen concentrator was set to 1.5 liters; the humidifier bottle was empty and did not contain water. -On 6/9/25 at 7:07 A.M., Resident #32 was awake lying in his/her bed receiving oxygen via nasal cannula. The Resident's oxygen concentrator was set to 1.5 liters; the humidifier bottle was empty and did not contain water. -On 6/9/25 at 12:57 A.M., Resident #32 was awake lying in bed, not wearing his/her nasal cannula to receive oxygen. The Resident's oxygen concentrator was set to 1.5 liters; the humidifier bottle was empty and did not contain water. Resident #32 said his/her nostrils get dry from the oxygen and are uncomfortable at times. -On 6/10/25 at 7:57 A.M., Resident #32 was awake lying in bed, not wearing his/her nasal cannula to receive oxygen. The Resident's oxygen concentrator was set to 1.5 liters; the humidifier bottle was empty and did not contain water. Review of Resident #32's physician's order dated 7/2/24, indicated the following: Apply O2 (oxygen) @ 2-4 l (liters) via nasal cannula PRN (as needed). Directions: No directions specified for order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's care plan for shortness of breath dated 2/28/24, indicated the following intervention: Apply O2 at 2-4 liters as needed via nasal cannula. Review of Resident #32's Kardex (a form listing to the type of care a resident needs) under the monitoring section, indicated the following: Apply O2 at 2-4 liters as needed via nasal cannula. During an interview on 6/10/25 at 8:41 A.M., Nurse #5 said nursing staff should be checking the oxygen flow rate when residents are receiving supplemental oxygen. Nurse #5 said the humidifier bottle should be checked to ensure it has water in it. Nurse #5 said a Resident can get a dry nose and possibly nose bleeds if there is no water in the humidifier because the air would be too dry. Nurse #5 said Resident #32 should be receiving oxygen at 1.5 liters and have water in the concentrator bottle at all times while receiving supplemental oxygen. During an interview on 6/10/25 at 9:27 A.M., Nurse #7 said residents receiving oxygen therapy need to be followed by whatever the physician's order says. Nurse #7 said supplemental oxygen should be set to the specified flow rate and the humidifier bottle needs to have water in it to make sure the air is not too dry. The surveyor and Nurse #7 observed Resident #32 receiving supplemental oxygen and the concentrator was set to 1.5 liters and there was no water in the humidifier bottle. Nurse #7 said the flow rate was incorrect and there should be water in the humidifier bottle. During an interview on 6/10/25 at 10:37 A.M., the Director of Nursing (DON) said physician's orders should be followed when residents are receiving supplemental oxygen. The DON said the flow rate should be specified and there should always be water in the humidifier bottle if present. The DON said Resident #32 should be receiving oxygen at 1.5 liters and there should be water in his/her humidifier bottle while he/she is receiving oxygen.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a trauma care plan related to Post Traumatic Stress Disorder (PTSD) or identify triggers for one Resident (#48) out of a total of 27 sampled Residents. Findings include: Review of the facility's policy titled, Trauma Informed Care, dated 2025 indicated the following: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. 7. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected and hopeful regarding their own recovery. 8. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. 10. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. Resident #48 was admitted to the facility in May 2025 with diagnoses including PTSD and dementia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #48 is moderately cognitively impaired evidenced by a score of nine out of a possible 15 on the Brief Interview for Mental Status exam. Review of Resident #48's Trauma Informed Care assessment dated [DATE] indicated: Resident endorses trauma. He/she talks about life's challenges and the losses that she has endured throughout life. He/She presents with depressive and anxiety symptoms. Explains he/she has experienced personal losses in life, i.e. break-ups, deaths in family etc. Referred to psych for psychotherapy. Review of Resident #48's care plans failed to indicate a care plan related to Resident #48's diagnosis of PTSD or trauma history, inclusive of triggers, was developed since his/her admission to the facility. During an interview on 6/9/25 at 1:07 P.M., The Social Worker said she is responsible to complete trauma assessments and to develop and implement PTSD care plans, inclusive of triggers. The Social Worker said she had been out sick and knew she had some residents she needed to circle back to and that Resident #48 was one of them and that's why a care plan had not been developed. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 1:09 P.M., the Administrator said that he would expect residents with a diagnosis of PTSD to have care plans developed and implemented related to their trauma and triggers.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure licensed nursing staff were trained and competent in managing wandering behavior and elopement, subsequently, one Resident (#172) eloped and fell from a second-floor bedroom window and requiring acute hospitalization with a fracture of the fourth lumbar vertebrae with mild retropulsion into the spinal canal (bone fragments in spinal cord), fractures of the second and third lumbar vertebrae, hematoma of the psoas muscle (lower back muscle), and fractures of the ninth through 12 ribs. Findings include: Review of the Facility Assessment, most recently updated on 4/18/25, indicated the following: -The staff are provided with training/education which includes how to care for residents with a diagnosis of dementia. -The staff are provided with competency training on disaster planning and procedures, which includes competency on elopements. Review of the document titled, Round [NAME]: Annual Education, undated and provided by the Administrator indicated the following: -Round [NAME] Education (group education) is mandatory. -Stations for training included: elopement, dementia, how to deal with difficult behaviors, and safety training. Resident #172 was admitted to the facility in June 2025 with diagnoses including dementia with behavioral disturbances and unsteadiness on feet. Review of the Brief Interview for Mental Status (BIMS) completed on 6/6/25 indicated Resident #172 scored a 6 out of a possible 15, which indicated he/she had severe cognitive impairment. Review of the initial nursing admission assessment completed on 6/4/25 indicated the Resident required supervision for all mobility tasks. On 6/8/25 at 6:47 A.M., the surveyors observed Resident #172 lying on the ground on the outside of the building below a second-floor open window. A window screen was observed hanging from the side of the building. Resident #172 had significant lacerations to his/her left arm and face, and blood was visible on his/her bilateral arms, face and chest. The Resident was screaming and when approached by the surveyor he/she said he/she went out the window because he/she was trying to get out of the building. The Facility nursing staff called 911 and the Resident was taken to the hospital. Review of Resident #172's admission paperwork included the following: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A hospital psychiatric consultation dated 4/22/25, that indicated History of present illness. This is a (male/female) who was referred for admission because of increased agitation. Patient does have a history of dementia as well as depression and is a long-term nursing home resident. While there, (he/she) apparently was trying to get a window on the third floor. (He/she has no recollection of this event and denies that it was a suicide attempt. (He/she) was subsequently referred for inpatient psychiatric treatment. -A Discharge summary, dated [DATE], that indicated admitted (from another facility) for agitation and elopement behaviors. While admitted pt (patient) initially was exit seeking but redirectable, with medication adjustment improvement in exit seeking behaviors. Pt wanders at times but is easily redirectable and pleasant with redirection. -A referral sheet that indicated, From (another facility), BIBA (brought in by ambulance), patient trying to get out 3rd floor window. Baseline confusion, alert to name only, secondary to dementia. Review of Resident #172's medical record indicated the following: -A daily skilled nursing note dated 6/4/25 indicating Resident #172 was attempting to push on doors and open windows. -A nursing note dated 6/7/25 indicating Resident #172 attempted to elope from the facility by the window twice. -Resident #172 was documented as having wandering behaviors on 6/5/25 and 6/7/25. -A social service note dated 6/6/25 indicating Resident #172 was admitted to the facility after a psychiatric hospitalization for irritability and altered mental status. The note failed to include the Resident's history of attempting to elope out of a window. Review of Resident #172's elopement and wandering care plan created on 6/4/25, failed to indicate an individualized care plan for Resident #172's history of elopement through windows. Interventions that were included on the care plan, all initiated on 6/4/25, were: -Clearly identify Resident's room and bathroom. -Engage Resident in purposeful activity. -Identify if there are triggers for wandering/eloping. -Identify if there is a certain time of day wandering/elopement attempts occur. -Identify if there is a pattern and purpose of wandering. -Provide care in a calm and reassuring manner. -Provide clear, simple instructions. -Provide reorientation to surroundings. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Wander guard (a bracelet worn to activate an alarm if exiting through the doors or elevator of the unit) placed to left ankle. The care plan failed to include any revisions/updates to interventions after actual elopement attempts by the Resident. Observations of the facility indicated the wander guard system was only located on the elevators and doors and not any window. During an interview on 6/10/25 6:52 A.M., Nurse #1 said the facility had never given the staff guidance or education on handling residents with a high elopement risk. Nurse #1 said the staff felt stuck because they didn't have guidance on how to manage extreme behaviors, such as residents who are attempting to elope from windows. During an interview on 6/10/25 at 8:02 A.M., Certified Nursing Assistant (CNA) #3 said he works at another facility that does annual competencies and education, so he is not required to do them here. CNA #3 said he was not familiar with Resident #172. During an interview on 6/10/25 at 8:06 A.M., CNA #4 said the staff have not been provided with any in-services or annual education since the new company bought the building in September 2024. CNA #4 said he was not familiar with Resident #172. During an interview on 6/10/25 at 8:14 A.M., Nurse #4 said she has worked at the building for about two and a half months and she had some competencies since starting work but has not finished them. Nurse #4 said she does not remember learning about elopement during her hiring process/orientation. During an interview on 6/10/25 at 8:36 A.M., CNA #9 said he worked over the previous weekend and was aware of Resident #172's attempts to elope from the building, but no one educated him that the Resident was attempting to get out the window. CNA #9 said Resident #172 is not like the typical person the staff had to take care of and the staff had to give him/her special attention. CNA #9 said they were not given any specific education or guidance from management on how to properly take care of Resident #172. During an interview on 6/10/25 at 8:44 A.M., CNA #6 said when she worked over the weekend, Resident #172 was attempting to elope and that the Resident was always in the dining room attempting to go out the window. CNA #6 said no one from the facility talked to her before her shift about the Resident trying to wander and elope and how to manage those behaviors. CNA #6 said she received education from the previous staff educator but cannot remember if managing elopement was part of that education. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/11/25 at 8:38 A.M., Nurse #6 said she worked the 3:00 P.M. to 11:00 P.M. shift on the second floor on the day of Resident #172's admission. Nurse #6 said the Resident was opening windows and looking outside. Nurse #6 said prior to the Resident moving to the second floor, he/she had been admitted to the first floor and had eloped out of the building, and as a result he/she was moved to the second floor. Nurse #6 said once the Resident was on the second floor, he/she was constantly trying to elope from the building by pushing on doors, elevators and windows. Nurse #6 said she did not bother to call down to tell the management that Resident #172 was exit seeking because they already knew and that is why he/she was transferred to the second floor. Nurse #6 said no one from the administration came to the unit to offer her or the other staff guidance or education on how to manage these behaviors and that this would have been very helpful. She said the staff provided constant supervision to the Resident for the entirety of the shift as the intervention of the exit seeking behavior. Review of ten employee records indicated the following: -Eight out of ten employees had no dementia training. Five of these employees were newly hired and did not have the required 8 hours of dementia training. Three out of the five employees had been employed at the facility for over a year and did not have the required four-hour yearly dementia training. -Four out of five employees who had been employed at the facility for more than a year had not completed annual education or competencies for caring for residents with dementia and a risk of elopement. During an interview on 6/8/25 at 9:09 A.M., the Administrator said all staff should have direct knowledge on how to manage residents with dementia who have a risk of elopement. The Administrator said nursing staff are expected to complete education upon hire, annually and as needed. The Administrator said the Assistant Director of Nursing is responsible for staff education. During an interview on 06/09/25 02:03 P.M., the Director of Nursing (DON) said he expects the staff to have education regarding elopement annually and at orientation. The DON said when Resident #172 had escalating behaviors and attempts at elopement, he did not provide staff with on the spot education regarding techniques to prevent elopement. During an interview on 6/10/25 at 11:50 A.M., the Assistant Director of Nursing (ADON) said he was hired within the last 30 days and did not have a chance to meet with the prior staff educator to understand the level of education previously provided to the staff. The ADON said that he is responsible for all new hire education and dementia training. The ADON said he was unaware the staff reviewed did not have annual competencies/education or dementia training. During an interview on 6/12/25 at 10:02 A.M., the Administrator said he was unaware that there was no annual education provided to the nursing staff last year. The Administrator said he had asked the previous nursing leadership to complete education and he had observed some ad hoc education occurring on the floor and assumed all education was being provided.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to complete annual performance reviews for 10 of 10 sampled staff. Findings include: Review of 5 Certified Nursing Assistants (CNA) employee records and 5 Nursing employee records indicated that 10 out of 10 staff did not have annual reviews completed. During an interview on 6/12/25 at 10:02 A.M., the Administrator said annual reviews were not completed for 2024. The Administrator said the previous management had not completed reviews and he has only been at the building since October 2024 and did not feel he knew the staff well enough to complete reviews.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility staff failed to ensure a care plan was developed with individualized-person centered interventions for one Resident (#12), who has a diagnosis of dementia, out of a total sample of 27 residents. Findings include: Review of the facility policy titled Dementia Treatment Plan, dated September 2024, indicated the following: - For the individual with confirmed dementia, the IDT (interdisciplinary team) will identify a resident-centered care plan to maximize remaining function and quality of life. - The IDT will adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes etc. Resident #12 was admitted to the facility in October 2024 with diagnoses including unspecified dementia, major depressive disorder and psychotic disorder. Review of Resident #12's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident has a Brief Interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the resident has non-Alzheimer's dementia. The surveyor made the following observations: - On 6/8/25 at 12:07 P.M., 6/9/25 at 12:29 P.M., 6/10/25 at 8:01 A.M., Resident #12 was lying in his/her bed awake with no engagement. During an interview on 6/11/25 at 7:59 A.M., Resident #12's roommate said the facility never gives anything to Resident #12 to do and he/she just stays in bed all day. Review of Resident #12's care plans failed to indicate that the facility developed and implemented a person-centered care plan that includes and supports Resident #12's dementia care needs. During an interview on 6/10/25 at 8:44 A.M., Nurse #5 said resident care plans are how the staff know how to properly care for each resident. Nurse #5 said each resident should have resident-specific care plans to meet their needs. Nurse #5 said Resident #12 should have a specific care plan related to dementia care. During an interview on 6/10/25 at 9:28 A.M., Nurse #7 said every resident with a dementia diagnosis should have a resident-specific care plan related to dementia care including Resident #12. During an interview on 6/10/25 at 10:39 A.M., the Director of Nursing (DON) said Resident #12 should have a specific care plan with resident-specific interventions relating to his/her dementia care.

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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 observations and interviews the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, 1. The facility failed to ensure the high side medication cart was locked while a nurse was not present on the first floor unit. 2. The facility failed to ensure treatment carts were locked while a nurse was not present on the second floor unit. Findings include: Review of the facility policy titled, Medication Storage, dated 9/24, indicated the following: -The Facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. On 6/8/25 from 8:52 A.M. to 8:58 A.M., the surveyor observed the high side medication cart unlocked and unsupervised in the hallway. Multiple staff and residents were observed walking by the medication cart. On 6/8/25 at 10:07 A.M., the surveyor observed the high side medication cart on the first floor unlocked and unsupervised in the hallway. The nurse was not present at the cart. On 6/8/25 at 10:15 A.M., the surveyor observed the high side medication cart on the first floor unlocked and unsupervised in the hallway. The nurse was not present at the cart. During an interview on 6/10/25 at 8:36 A.M., Nurse #5 said all medication and treatment carts containing resident medications or treatments should be locked when unattended. During an interview on 6/10/25 at 9:24 A.M., the Director of Nursing said all medication and treatment carts containing resident medications and treatment supplies should be locked when unattended by a nurse. 2. The surveyor made the following observations on the second-floor unit, (a secured unit which houses residents with behaviors of wandering): - On 6/8/25 at 8:35 A.M., 6/8/25 at 10:14 A.M., and 6/9/25 at 7:05 A.M., treatment cart in the whirlpool/tub room on the second floor was unlocked and unattended. The surveyor was able to open the drawers which contained various resident-specific treatment supplies such as creams and ointments. The treatment cart was accessible to residents wandering the unit. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/25 at 8:36 A.M., Nurse #5 said all medication and treatment carts containing resident medications or treatments should be locked when unattended. Nurse #5 said the treatment cart in the shower/tub room should be locked. During an interview on 6/10/25 at 9:24 A.M., the Director of Nursing said all medication and treatment carts containing resident medications and treatment supplies should be locked when unattended by a nurse.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure laboratory services were obtained timely for three Residents (#60, #68, #40), out of a total 27 sampled Residents. Findings include: Review of the Specimen Collection policy, dated April 2007, indicated: 1. All specimens, sputum's, etc, order for testing shall be obtained in accordance with established nursing service procedures. 2. Specimen collections must be placed in their proper container, securely sealed and properly labeled for transfer to the laboratory. 1. Resident #60 was admitted to the facility April 2025 with diagnoses including metabolic encephalopathy and acute kidney failure. Review of his/her Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #60 is cognitively intact as evidenced by a score of 14 out of a possible 15 on the Brief Interview for Mental Status exam. Review of Resident #60's physician's orders indicated the following orders: -4/17/25: CMP, CBC next lab day -5/6/25: CMP and CBC never done 4/17, please ensure ordered -5/13/25: please make sure labs from 4/17 are done Review of the clinical record indicated that the labs initially ordered on 4/17/25 were not obtained until 5/13/25; 25 days after the initial orders were documented. During an interview on 6/9/25 at 9:54 A.M., Nurse Practitioner #1 said she would expect labs to be completed at the next lab draw day, (Tuesdays), or if stat, the same day. Nurse Practitioner #1 said that she was not aware of the delay in the lab draws for Resident #60 and that she had discussions with facility staff about obtaining labs timely. During an interview on 6/9/25 at 11:46 A.M., Nurse #4 said that nurses obtain lab orders from the physician and input the orders in the electronic health record. Nurse #4 said that labs should be drawn the next draw day (Tuesdays) or the same day if labs were ordered stat. During an interview on 6/9/25 at 12:55 P.M., the Director of Nursing (DON) said stat labs should be obtained the same day and 24-48 hours for standard lab orders. The DON could not speak to the delay in completing Resident #60's lab as he was not employed at the facility at that time. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #68 was admitted to the facility in May 2025 with diagnoses including vascular dementia and dysphagia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #68 is severely cognitively impaired as evidenced by a score of six out of a possible 15 on the Brief Interview for Mental Status Exam. Review of Resident #68's physician's orders indicated the following order: CBC, cmp, 5/20/25. Review of the clinical record indicated the ordered labs were not completed. During an interview on 6/9/25 at 9:54 A.M., Nurse Practitioner #1 said she would expect labs to be completed the next lab draw day, (Tuesdays), or if stat, the same day. Nurse Practitioner #1 said that she was not aware of the delay in the lab draws for Resident #48 and that she had discussions with facility staff about obtaining labs timely. During an interview on 6/9/25 at 11:46 A.M., Nurse #4 said that nurses obtain lab orders from the physician and input the orders in the electronic health record. Nurse #4 said that labs should be drawn the next draw day (Tuesdays) or the same day if labs were ordered stat. During an interview on 6/9/25 at 12:55 P.M., The Director of Nursing (DON) said stat labs should be obtained the same day and 24-48 hours for standard lab orders. The DON said he was aware that there had been issues with obtaining labs timely. 3. Resident #40 was admitted to the facility in March 2025 with diagnoses including myopathy and dementia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #40 is severely cognitively impaired as evidenced by a score of 6 out of a possible 15 on the Brief Interview for Mental Status exam. Review of Resident #40's physicians orders indicated the following order: CBC cmp, pending confirmation, 5/20/25 During an interview on 6/9/25 at 9:54 A.M., Nurse Practitioner #1 said she would expect labs to be completed at the next lab draw day, (Tuesdays), or if stat, the same day. Nurse Practitioner #1 said that she had spoken with staff at the facility about orders being put in as pending which results in labs not being obtained, but the issue was still occurring. During an interview on 6/9/25 at 11:46 A.M., Nurse #4 said that nurses obtain lab orders from the physician and input the orders in the electronic health record. Nurse #4 said that labs should be drawn the next draw day (Tuesdays) or the same day if labs were ordered stat. During an interview on 6/9/25 at 12:55 P.M., The Director of Nursing stat labs should be obtained the same day and 24-48 hours for standard lab orders. The DON said he had noticed at times orders had been put in under pending which has resulted in the delay in obtaining labs.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure follow-up dental services were provided for two Residents (#22 and #24) out of a total of 27 sampled residents. Specifically, the facility failed to ensure recommendations related to the fabrication of dentures for Resident #22 and Resident #24 were implemented. Findings include: Review of the facility policy titled, Dental Services, undated indicated the following: -Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. 1. Resident #22 was admitted to the facility in March 2024 with diagnoses including dysphagia and Alzheimer's. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #22 is severely cognitively impaired as evidenced by a score of seven out of a possible 15 on the Brief Interview for Mental Status Exam. During an interview on 6/8/25 at approximately 9:02 A.M., the surveyor observed Resident #22 was missing teeth. Review of the most recent dental note dated 6/19/24 indicated the following: -Denture has loose fit. Rec (recommend): add tooth #6 to denture to improve retention and prevent food impaction. Review of the clinical record failed to indicate any follow up was provided related to the additional fabrication to Resident #22's denture. During an interview on 6/10/25 at 9:32 A.M., Nurse #5 said that when dental services makes recommendations for dental fabrication the staff would place a referral to an outside dental agency. During an interview on 6/16/25 at 2:11 P.M., the Medical Record Coordinator said that it is her responsibility to arrange for follow up visits for dental services for Residents. She said she obtains the print outs from the contracted dental services and gives them to the Director of Nursing for review and to obtain follow up services. The Director of Nursing was not employed at the facility at the time of Resident #22's denture recommendations. During an interview on 6/10/25 at 11:54 A.M., the Corporate Nurse said that when dental services makes recommendations the nursing staff are expected to alert the physician and facilitate the process. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #24 was admitted to the facility in June 2018 with diagnoses including metabolic encephalopathy and muscle weakness. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #24 is cognitively intact as evidenced by a score of 13 out of a possible 15 on the Brief Interview for Mental Status Exam. During an interview on 6/8/25 at 10:37 A.M., Resident #24 said that he/she needs to see a dentist because he/she needs upper and lower dentures. Review Resident #24's most recent dental visit dated 1/22/25 indicated the following: -Pt (patient) states he/she has difficulty chewing food. Pt requested dentures. Upon exam- edentulous ridge- adequate at baseline, pt healed well after extractions. Pt will benefit from denture fabrication. Review of the clinical record failed to indicate any follow up was provided related to the additional fabrication to Resident #24's denture. During an interview on 6/10/25 at 9:32 A.M., Nurse #5 said that when dental services makes recommendations for dental fabrication the staff would place a referral to an outside dental agency. During an interview on 6/16/25 at 2:11 P.M., the Medical Record Coordinator said that it is her responsibility to arrange for follow up visits for dental services for Residents. She said she obtains the print outs from the contracted dental services and gives them to the Director of Nursing for review and to obtain follow up services. The Director of Nursing was not employed at the facility at the time of Resident #24's denture recommendations. During an interview on 6/10/25 at 11:54 A.M., the Corporate Nurse said that when dental services makes recommendations the nursing staff are expected to alert the physician and facilitate the process.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record review and interview, the facility failed to provide the appropriate diet texture for one Resident (#56) out of a total sample of 27 residents. Specifically, Resident #56, who has a known history of choking at the facility, was given a peanut butter and jelly sandwich while being prescribed a puree diet. Findings include: Resident #56 was admitted to the facility in April 2024 with diagnoses that included dysphagia, Huntington's Disease, adult failure to thrive, and severe protein-calorie malnutrition. Review of Resident #56's Minimum Data Set (MDS) assessment, dated 4/2/25, indicated he/she scored an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive deficits. Further review of the MDS indicated mechanically altered diet - require change in texture of food or liquids (e. g., pureed food, thickened liquids). Review of Resident #56's active physician order, dated 9/3/24, indicated Regular diet, Puree texture, Nectar consistency. On 6/10/25 at 8:45 A.M., the surveyor observed the Resident walk to the nurses station and ask for food. On 6/10/25 at 8:47 A.M., the surveyor observed the Assistant Director of Nursing (ADON) called down to the kitchen for a sandwich. The surveyor observed a kitchen diet aide bring up a peanut butter and jelly sandwich and said it was for Resident #56. The ADON then brought it to the Resident in his/her room and left it on his/her beside table. On 6/10/25 from 9:00 A.M. to 10:07 A.M., the surveyor observed Resident #56 in his/her room with the peanut butter and jelly sandwich on his/her beside table without staff present. During an interview and observation on 10:12 A.M., Nurse #5 said Resident #56 is on puree and thickened liquids diet. The surveyor and Nurse #5 then entered Resident #56's room and observed the sandwich. Nurse #5 said That's a PBJ, it should not be in here and removed it. Review of Resident #56's nutrition assessment, dated 4/3/25, indicated Residents #56's diet as: Diet: Regular/Puree/Nectar. Review of Resident #56's nutrition care plan, dated 4/8/25, indicated the following intervention: -Provide diet as ordered and honor food preferences. Review of Resident #56's aspiration risk care plan, dated 5/1/24, indicated the following intervention: -Diet to be followed as prescribed. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #56's active Certified Nurse Aide (CNA) Kardex (form indicating the needs of the Resident), indicated Diet to be followed as prescribed. During an interview on 6/10/25 at 10:55 A.M., the Speech Therapist said Resident #56 has choked twice in the facility. The Speech Therapist said Resident #56 was discharged from speech therapy services with recommendations for the Resident to have a puree diet and should not be given a peanut butter and jelly sandwich on a pureed diet. During an interview on 6/10/25 at 11:54 A.M., the Assistance Director of Nurses (ADON) said he did not review Resident #56's diet orders before calling down to the kitchen and requesting a sandwich for the Resident. The ADON said the kitchen should check the Resident's diet before sending up food for a resident and if the kitchen staff are not sure of their diet they would ask nursing. The ADON said Resident cannot have a peanut butter and jelly sandwich if on a puree diet. The ADON said he provided him/her with the peanut butter and jelly sandwich and left him/her alone with the sandwich in his/her room and he should not have. During an interview on 6/10/25 at 12:06 P.M., the Food Service Director said when staff call down for snacks or food the kitchen staff always check the residents' diets. The Food Service Director said the kitchen staff did send up a peanut butter and jelly sandwich for Resident #56 who is on a puree diet. During an interview on 6/10/25 at 1:46 P.M., Nurse #3 said that Resident #56 has choked while at the facility in the past. Nurse #3 said a resident who is on a pureed diet should never be given a peanut butter and jelly sandwich because they could choke. Nurse #3 said the nurses and the kitchen should be checking the residents' diet prior to giving a snack or meal. During an interview on 6/10/25 at 1:48 P.M., Certified Nursing Assistant #3 said if a resident is on a pureed diet then they should never receive a peanut butter and jelly sandwich. During an interview on 6/12/25 at 10:24 A.M., the Director of Nursing (DON) said a Resident who is on a puree diet should never be given a peanut butter and jelly sandwich. The DON said Resident #56 has choked at the facility and it puts the Resident at risk for choking by providing him/her with a peanut butter and jelly sandwich. The DON said he expects staff to follow the plan of care for every resident. On 6/12/25 at 10:28 A.M., Nurse Practitioner #1 said Resident #56 has choked at the facility and the Resident should not be given a peanut butter and jelly sandwich on a puree diet because it is a sticky sandwich and is dangerous.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure it provided appropriate administrative oversight, specific to clinical management and building safety, when one Resident (#172) fell from his/her second-floor bedroom window during an elopement attempt, resulting in an acute hospitalization with a fracture of the fourth lumbar vertebrae with mild retropulsion into the spinal canal (bone fragments in spinal cord), fractures of the second and third lumbar vertebrae, hematoma of the psoas muscle (lower back muscle), and fractures of the ninth through 12 ribs. Specifically, the facility administration failed to: 1. Ensure the facility's environment was safe for a Resident with a known risk of elopement from a window; 2. Ensure effective systems were in place for education and training for licensed staff to ensure competent, safe, and effective resident care related to residents with dementia and a risk of elopement; 3. Ensure the facility assessment indicated the facility cared for a population with the behaviors of elopement in order to use the facility's resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include: Review of the facility policy titled, Elopement Prevention, dated 12/27/24, indicated the following: -The facility maintains a process to assess all residents for risk of elopement, implement prevention strategies for those identified as elopement risk, institute measures for resident identification at the time of admission. -The physical plant is secured to minimize the risk of elopement, such as: c. safety locks or keypad entry that restrict access to dangerous areas, d. restricted window openings Review of the facility policy titled, Dementia Treatment Plan, dated 9/2024, indicated the following: -For the individual with confirmed dementia, the IDT (interdisciplinary team) will identify a resident-centered care plan to maximize remaining function and quality of life. -Nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually thereafter. Additionally, performance reviews will be conducted annually and in-service education will be based on results of the reviews. -Progressive or persistent worsening of symptoms and increased need for staff support will be reported to the IDT. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The IDT will review the past and current physical, functional, and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related complication, and functional impairments. -The IDT will adjust interventions and the overall plan depending on he individual's response to those interventions, progression of dementia, development on new acute medical conditions or complications, changes in resident or family wishes, etc. 1. Resident #172 was admitted to the facility in June 2025 with diagnoses including dementia with behavioral disturbances and unsteadiness on feet. Review of the Brief Interview for Mental Status (BIMS) completed on 6/6/25 indicated Resident #172 scored a 6 out of a possible 15, which indicated he/she had severe cognitive impairment. Review of the initial nursing admission assessment completed on 6/4/25 indicated the Resident required supervision for all mobility tasks. On 6/8/25 at 6:47 A.M., the surveyors observed Resident #172 lying on the ground on the outside of the building below a second-floor open window. A window screen was observed hanging from the side of the building. Resident #172 had significant lacerations to his/her left arm and face, and blood was visible on his/her bilateral arms, face and chest. The Resident was screaming and when approached by the surveyor he/she said he/she went out the window because he/she was trying to get out of the building. The facility nursing called 911 and the Resident was taken to the hospital. During an interview on 6/8/25 at 6:52 A.M., Certified Nursing Assistant (CNA) #1 said she worked the overnight shift and Resident #172 was wandering up and down the hallways since 5:00 A.M., and at one point was attempting to go near the dining room window. CNA #1 said she had been told by other staff that the Resident had attempted to jump out of the dining room window previously and the staff had to barricade the window with tables and chairs to prevent access to the window. CNA #1 said at approximately 6:30 a.m., she left the Resident alone so she could go into the hallway and complete her paperwork. CNA #1 said it was at this point the Resident must have walked down to his/her bedroom and jumped out the window. On 6/8/25 at 6:56 A.M., the surveyor observed Resident #172's bedroom window. The window was open, with the opening measuring 24.5 inches wide and 4 feet 2 inches high. There was nothing in the window to secure the opening of the window to prevent it from opening to that distance. Review of Resident #172's admission paperwork included the following: -A hospital psychiatric consultation dated 4/22/25, that indicated History of present illness. This is a (male/female) who was referred for admission because of increased agitation. Patient does have a history of dementia as well as depression and is a long-term nursing home resident. While there, (he/she) apparently was trying to get a window on the third floor. (He/she has no recollection of this event and denies that it was a suicide attempt. (He/she) was subsequently referred for inpatient psychiatric treatment. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A Discharge summary, dated [DATE], that indicated admitted (from another facility) for agitation and elopement behaviors. While admitted pt (patient) initially was exit seeking but redirectable, with medication adjustment improvement in exit seeking behaviors. Pt wanders at times but is easily redirectable and pleasant with redirection. -A referral form that indicated: From (another facility), BIBA (brought in by ambulance), patient trying to get out 3rd floor window. Baseline confusion, alert to name only, secondary to dementia. Review of Resident #172's medical record indicated the following: -A daily skilled nursing note dated 6/4/25 indicating Resident #172 was attempting to push on doors and open windows. -Resident #172 was documented as having wandering behaviors on 6/5/25 and 6/7/25. -A nursing note dated 6/7/25 indicating Resident #172 attempted to elope from the facility by the window twice. -A social service note dated 6/6/25 indicating Resident #172 was admitted to the facility after a psychiatric hospitalization for irritability and altered mental status. The note failed to include the Resident's history of attempting to elope out of a window. Review of Resident #172's elopement and wandering care plan created on 6/4/25, failed to indicate an individualized care plan for Resident #172's history of elopement through windows. Interventions that were included on the care plan, all initiated on 6/4/25, were: -Clearly identify Resident's room and bathroom. -Engage Resident in purposeful activity. -Identify if there are triggers for wandering/eloping. -Identify if there is a certain time of day wandering/elopement attempts occur. -Identify if there is a pattern and purpose of wandering. -Provide care in a calm and reassuring manner. -Provide clear, simple instructions. -Provide reorientation to surroundings. -Wander guard (a bracelet worn to activate an alarm if exiting through the doors or elevator of the unit) placed to left ankle. The care plan failed to include any revisions/updates for interventions after actual elopement attempts by the Resident. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations of the facility indicated the wander guard system was only placed on doors and elevators and was not on any of the windows in the facility. During interviews on 6/8/25 at 6:56 A.M., and 6/10/25 at 6:52 A.M., Nurse #1 said he was aware Resident #172 had a history of attempting to jump out windows and while at this facility, the Resident had attempted to open and exit the second-floor dining room window on 6/6/25 and 6/7/25. Nurse #1 said the Resident had also opened the balcony door off the dining room on 6/6/25 and had gone over to the edge of the balcony and needed to be pulled from the edge. Nurse #1 said he did not notify the provider or management of these incidents. On 6/8/25 an observation of the second-floor dining room window at 7:50 A.M., the window was observed to be able to open 22.5 inches wide and 4 feet 7 inches high. During an interview on 6/8/25 at 6:59 A.M., CNA #1 said she had noticed that the second-floor dining room window was open from the left side so she barricaded the window with tables and chairs so Resident #172 could not have access to the window. CNA #1 said she did not know how else to secure the window from being able to open to the width a person would be able to get out of. During an interview on 6/8/25 at 7:17 A.M., a resident who was sitting in the second-floor hallway said he/she had witnessed Resident #172 exit the dining room and go onto the outside balcony on 6/6/25 and saw the nurse have to run out onto the balcony to grab the Resident. During an interview on 6/8/25 at 7:35 A.M., Nurse #1 said he was aware the Director of Nursing secured the second-floor window on the right side but failed to secure the left side of the window and that no one assessed Resident #172's window to see if it was secure and unable to open. During an interview on 6/8/25 at 7:32 A.M., when asked about the windows being secure on the second floor, Nurse #2 said there was a dining room window that could open all the way on the left side of the window. Nurse #2 said he was unsure why the full window was not secured. Nurse #2 also said he was unsure why Resident #172's bedroom window was not secured given his/her elopement history. Nurse #2 said he felt the facility was not prepared for this patient due to the high risk of elopement. During an interview on 6/11/25 at 8:38 A.M., Nurse #6 said she worked the 3:00 P.M. to 11:00 P.M. shift on the second floor on the day of Resident #172's admission. Nurse #6 said the Resident was opening windows and looking outside. Nurse #6 said prior to the Resident moving to the second floor, he/she had been admitted to the first floor and had eloped out of the building, and as a result he/she was moved to the second floor. Nurse #6 said once the Resident was on the second floor, he/she was constantly trying to elope from the building by pushing on doors, elevators and windows. Nurse #6 said she did not bother to call down to tell the management that Resident #172 was exit seeking because they already knew and that is why he/she was transferred to the second floor. Nurse #6 said no one from the administration came to the unit to offer her or the other staff guidance or education on how to manage these behaviors and that this would have been very helpful. She said the staff provided constant supervision to the Resident for the entirety of the shift as the intervention of the exit seeking behavior. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/8/25 at 9:09 A.M., the Administrator said he received a call at 7:00 A.M. that Resident #172 had fallen out of his/her bedroom window. The Administrator said Resident #172 was a new admit to the facility and had dementia and was confused with a history of behaviors. The Administrator said the Resident recently displayed behaviors of yelling, swinging arms and banging on the walls and said the Resident wanted out and was assessed as being high risk for elopement. The Administrator said he was unaware of Resident #172's previous elopement history, including his/her attempt to elope from a third-floor window at a previous facility as he did not read the Resident's pre-admission paperwork. The Administrator said that the Resident did elope from the first floor on 6/4/25 and made it around the building to the back parking lot and was then moved to the second floor. He said he was also aware that on 6/6/25, Resident #172 was able to exit the second-floor dining room onto the balcony through a door that is supposed to be always locked. The Administrator said he was unsure how the door was unlocked as that is a safety risk and asked maintenance to immediately lock it. The Administrator said he had not received any calls over the weekend regarding Resident #172's increased behavior and attempt to elope from the second-floor dining room windows twice on 6/7/25. The Administrator said maintenance should check all the windows and doors for safety and he believes there was a specific audit for window safety that had been completed, and he would look for that audit. During an interview on 6/9/25 at 1:33 P.M., the Administrator said the clinical liaison who interacts with the hospital does the initial admission screening, then speaks with the admission coordinator at the facility. The Administrator said this screening process is in place to ensure the facility can clinically and safely take care of the residents. The Administrator says he has little involvement in looking at the preadmission screens as he trusts the Director of Nursing to do this. The Administrator said elopements are not something he has had a great deal of experience with as it has been many years since he has had a building with a locked unit. He said he believed the facility would be able to clinically care for Resident #172 at the time of his/her admission; however, he was not aware of the Resident's prior elopement attempts. The Administrator said he was aware Resident #172 had eloped from the building, had gotten out onto the second-floor balcony and had banged on windows, however, he said he was unaware the Resident had attempted to open and climb out a second floor window on other occasions. The Administrator said he would have expected any elopement attempts or safety concerns to be reported to him as it is his responsibility for all residents' safety. When asked about his system for ensuring the windows of the facility are secure, the Administrator said he had asked his maintenance director to complete an audit in March 2025 to check all windows and ensure they could not open more than four inches. The Administrator said he did not receive a formal audit from the maintenance director and took his word that it had been completed. During an interview on 6/10/25 at 7:35 A.M., the Case Manager in charge of admissions from the hospital was interviewed. The Case Manager said she helps coordinate Resident #172's admission to the facility and was aware that the Resident was in the hospital for psychiatric concerns and had attempted to elope from a window at a previous facility. The Case Manager said she sent all of the preadmission paperwork and the Resident's clinical history/information to the facility to ensure the facility would be able to handle the patient. During an interview on 6/10/25 at 9:01 A.M., the Admissions Coordinator said she was aware of Resident #172's prior attempt to elope from a window prior to his/her admission to the facility and did not tell the Administrator and did not have a conversation with anyone in the building to ensure the windows were secure. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/11/25 at 8:17 A.M., the Maintenance Director said he was asked to complete a window audit in March 2025, and he delegated his task to his assistant, asking him to ensure the windows could not open more than 4 inches. The Maintenance Director said he was never given a formal audit showing that his assistant completed this task, but he took his word for it. The Maintenance Director said he was never told to check the second-floor dining room door to the outside balcony, and he had never been told to add that door to his daily safety check. During an interview on 6/11/25 at 8:29 A.M., the Maintenance Assistant said he was assigned the task to audit all windows in March 2025, and he did this task but did not write down the results on a formal audit form. The Maintenance Assistant said he was aware that the window in Resident #172's room could open all the way, and he did not go back to ensure that it was secure. The Maintenance Assistant said the door to second-floor dining room is not on a daily safety check list and he was never told to check the door after the fact. During an interview on 6/11/25 at 11:18 A.M., the Administrator said he was unaware the window in Resident #172's bedroom was able to open all the way and that the maintenance assistant was aware of this. During an interview on 6/9/25 at 8:44 A.M., Physician #1 said he is the medical director of the facility and would have expected the facility to have a plan to ensure safety for residents admitted with a high risk and history of elopement. 2. Review of ten employee records indicated the following: -Eight out of ten employees had no dementia training. Five of these employees were newly hired and did not have the required 8 hours of dementia training. Three out of the five employees had been employed at the facility for over a year and did not have the required four hour yearly dementia training. -Four out of five employees who had been employed at the facility for more than a year had not completed annual education or competencies for caring for residents with dementia and a risk of elopement. During an interview on 6/10/25 6:52 A.M., Nurse #1 said the facility had never given the staff guidance or education on handling residents with a high elopement risk. Nurse #1 said the staff felt stuck because they didn't have guidance on how to manage extreme behaviors, such as residents who are attempting to elope from windows. During an interview on 6/11/25 at 8:38 A.M., Nurse #6 said she worked the 3:00 P.M. to 11:00 P.M. shift on the day of Resident #172's admission and that the Resident was constantly trying to elope from the building by pushing on door, elevators and windows. Nurse #6 said the Resident was opening windows and looking outside. Nurse #6 said no one from administration came to the unit to offer her or the other staff guidance of education on how to manage these behaviors and that this would have been very helpful. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/8/25 at 9:09 A.M., the Administrator said all staff should have direct knowledge on how to manage residents with dementia who have a risk of elopement. The Administrator said nursing staff are expected to complete education upon hire, annually and as needed. The Administrator said the Assistant Director of Nursing is responsible for staff education. During an interview on 6/10/25 at 11:50 A.M., the Assistant Director of Nursing (ADON) said he was hired within the last 30 days and did not have a chance to meet with the prior staff educator to understand the level of education previously provided to the staff. The ADON said that he is responsible for all new hire education and dementia training. The ADON said he was unaware the staff reviewed did not have annual competencies/education or dementia training. During an interview on 6/12/25 at 10:02 A.M., the Administrator said he was unaware that there was no annual education provided to the nursing staff last year. The Administrator said he had asked the previous nursing leadership to complete education and he had observed some ad hoc education occurring on the floor and assumed all education was being provided. 3. Review of the Facility Assessment, most recently updated on 4/18/25, indicated the following: -The purpose of the assessment is to evaluate the resident population and determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Use this assessment to make decisions about your direct staff needs (including those who provide services under contract and volunteers), as well as your capabilities to provide services to the residents in your facility, at least annually and as necessary, per the above requirement. Using evidence-based, data driven methods focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. - If the facility is less familiar with or has not previously provided care for diagnosis of potential admission, the IDT team will review the details of the referral's requirements for care prior to admission. The review will consist of matching the care needs of the residents to the current skill set of the staff. Any shortfalls in skill and knowledge sets will be identified. Educational opportunities for staff education and training to overcome the skill set lack will be identified and taken advantage of. Training will be provided by nursing management or by vendors of specific medical products the staff are not familiar with. -The facility created a grid of common diagnoses residents are admitted with. The list of diagnoses under the Mental and Behavioral Health sections listed behavior that needs interventions as a diagnosis the facility is able to admit. -The facility created a grid of resident care needs. Under the Mental Health and Behavior care area, the facility lists the following as areas of resident care provided by the facility: manage the medical conditions and medication-relates issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (post traumatic stress disorder), other psychiatric diagnoses, intellectual or developmental disabilities. -The staff are provided with training/education which includes how to care for residents with a diagnosis of dementia. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The staff are provided with competency training on disaster planning and procedures, which includes competency on elopements. The facility assessment failed to indicate the facility cared for a resident population with an increased risk of elopement. The assessment also failed to indicate caring for residents who are at risk for elopement was part of their staff training. During an interview on 6/10/25 at 12:37 P.M., the Administrator said he has written a lot of facility assessments over the years and did not think the elopement risk of the population was something that needed to be included in the assessment. The Administrator said every resident with dementia is at risk for elopement and the facility has a lot of residents with wander guards (a bracelet worn by the resident that triggers an alarm if a resident were to open a door or elevator) so that would indicate there is a risk for elopement. The Administrator said it was his responsibility to ensure the residents of the building were safe, including ensuring the windows are secure as listed in the facility assessment.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to develop, implement, and maintain a Quality Assurance and Performance Improvement (QAPI) program which addressed the full range of care and services, was comprehensive and data-driven, and focused on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility developed QAPI plans related to staff education and infection control once these concerns were identified by the Administrator. Findings include: Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Policy and Procedure, dated 2025, indicated the following: -Purpose: To ensure that (the facility) implements a comprehensive QAPI program which addresses all the care and unique services that the facility provides. -To ensure continuous evaluation of the facility's systems with the objectives of: ensuring that care delivery systems function consistently, accurately, and incorporate current and evidence-based practice standards where available; Preventing deviation from care processes, to the extent possible; Identifying issues and concerns with the facility's systems, as well as identifying opportunities for improvement; And developing and implementing plans to correct and/or improve identified areas. -To ensure that the facility implements a quality management program which takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality. An interdisciplinary approach encompasses all managerial and clinical services, which include care and services provided by outside providers and suppliers. -Policy: it is the policy of the facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The program will: -it is the policy of the facility to develop and implement systems that ensure the care and services it delivers meet acceptable standards of quality in accordance with recognized standards of practice period this shall be accomplished, in part, by identifying, collecting, analyzing, and monitoring data which reflects the functions of each department and outcomes to residents. a. During an interview on 6/11/25 at 12:02 P.M., the Director of Nurses said that he had been at the facility for only three weeks. He said that the previous Director of Nurses was responsible for the Infection Control and Prevention Program before his arrival at the facility and was in the process of training the Assistant Director of Nurses to manage the program. The Director of Nurses said that in the time he has been at the facility he has not maintained any line listings and was unable to locate any previous line listings used to track infection in the facility. The Director of Nurses also said cannot provide any documentation on the facilities Antibiotic Stewardship Program. b. Review of ten employee records indicated the following: (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Eight out of ten employees had no dementia training. Five of these employees were newly hired and did not have the required 8 hours of dementia training. Three out of the five employees had been employed at the facility for over a year and did not have the required four-hour yearly dementia training. -Four out of five employees who had been employed at the facility for more than a year had not completed annual education or competencies for caring for residents with dementia and a risk of elopement. -Ten out of ten employees did not have an annual review completed by the facility to assess areas of improvement/educational opportunities. During a follow up interview on 6/11/25 at 12:13 P.M., the Director of Nurse said that the expectation is that an Antibiotic Stewardship Program is maintained and followed in the facility. He does not know how the facility was following antibiotic use prior to his arrival at the facility but said that currently no one is overseeing the program. During an interview on 6/12/25 at 8:07 A.M., the Administrator said that it is his expectation that the facility follows an infection prevention and control program that includes a system for appropriate infection surveillance. The Administrator also said that he would expect that the facility is implementing an Antibiotic Stewardship Program. During an interview on 6/12/25 at 8:32 A.M., the Medical Director said that he would expect that the facility tracks and trends infections in the facility with line listings. During a follow-up interview on 6/12/25 at 10:02 A.M., the Administrator said the facility meets monthly for QAPI meetings and projects are created based on what he and the staff have identified as issues needing improvement in the facility. The Administrator listed projects worked on in the past six months and neither infection control nor staff education were listed. The Administrator said he did meet with the previous Director of Nursing and discussed the lack of line listing/infection control program in the facility, and he assumed it was being improved but he never followed up. The Administrator said this was never made into a QAPI program. In addition, the Administrator said he was also aware that staff education was lacking in the facility and did question making this into a QAPI program. The Administrator said because he thought more was being done about it than actually was, he did not make it into a QAPI project.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of the facility policy titled Enhanced Barrier Precautions, undated, indicated the following: - It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. - Implementation of Enhanced Barrier Precautions: - a. Make gowns and gloves available immediately near or outside of the resident's room. - b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. - High-contact resident care activities include: Device care or use: feeding tubes Resident #7 was admitted to the facility in January 2018 with diagnoses including muscle wasting, depression and dysphagia. Review of Resident #7's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 13 out of 15 which indicated the Resident is cognitively intact. Further review of the MDS indicated that the Resident requires substantial/maximal assistance with oral hygiene and is currently receiving tube feeding therapy. On 6/8/25 at 7:45 A.M., the surveyor observed Resident #7 laying in his/her bed. Resident #7 said he/she has a feeding tube connected to his/her stomach. The surveyor observed a percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted into the stomach through a small incision in the abdomen to provide artificial nutrition) in his/her stomach. There was no precaution sign observed at the entrance of Resident #7's room, there were no gowns in the Personal Protective Equipment (PPE) cart. During the entire survey period from 6/8/25 through 6/12/25, the surveyor did not observe an enhanced barrier precaution sign on Resident #7's doorway or any accessible PPE gowns outside of the room. Review of Resident #7's physician's order dated 3/11/25, indicated the following: Enteral Feed every 4 hours, provide Jevity 1.5 (a tube feeding formula) at 237 mL (milliliters) q 4 hours (every 4 hours) via bolus per PEG tube at 0000, 0400, 0800, 1200, 1600, 2000. Review of Resident #7's care plan indicated the following: - Focus: Resident #7 requires bolus feeding via JG-tube r/t esophageal dysmotility, dysphagia (Dated 9/20/23) - Interventions: Resident #7 is dependent with tube feeding. See MD (medical doctor) orders for current feeding orders (Dated 9/20/23), Enhanced Barrier Precaution (dated 6/15/24) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/9/25 at 11:55 A.M., the surveyor and Nurse #8 entered Resident #7's room, there was no enhanced barrier precaution sign on the doorway. The surveyor observed Nurse #8 provide tube feeding care to Resident #7. Nurse #8 performed hand hygiene and donned gloves, Nurse #8 did not put on a gown. Nurse #8 proceeded to touch Resident #7's PEG feeding tube and provide tube feeding formula. Nurse #8 did not wear a gown during the entire tube feeding procedure. During an interview on 6/9/25 at 12:26 P.M., Nurse #8 said if she sees any infection control signage on a Resident's doorway she would follow those recommendations. She continued to say she did not wear a gown because there was no sign on Resident #7's doorway. During an interview on 6/10/25 at 10:42 A.M., the Director of Nursing (DON) said he is not familiar with Resident #7's case. The DON said he would expect enhanced barrier precautions to be followed when staff provide tube feeding care and staff should be wearing a gown. Based on observation, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, 1. The facility failed to establish an infection prevention and control program that includes a system for appropriate infection surveillance. 2. The facility failed to ensure a program was in place to monitor for water-borne contaminants, including Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program. 3. The facility failed to implement Enhanced Barrier Precautions for a gastrostomy tube for one Resident (#7) out of a total sample of 27 residents. Findings include: Review of the facility assessment, undated, indicated the following: -General Care: Infection Prevention and Control -Specific care or Practices: Identification and containment of infections, prevention of infections 1. During an interview on 6/11/25 at 12:02 P.M., the Director of Nurses said that he had been at the facility for only three weeks. He said that the previous Director of Nurses was responsible for the Infection Control and Prevention Program before his arrival at the facility and was in the process of training the Assistant Director of Nurses to manage the program. The Director of Nurses said that in the time he has been at the facility he has not maintained any line listings and was unable to locate any previous line listings used to track infection in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/25 at 12:12 P.M., the Assistant Director of Nurses said that he has not received any training on the infection control program or how to maintain line listings to track infections in the facility. He said that he is not keeping any logs at this time and did not previously either. He said that he found out three weeks ago when the new Director of Nurses arrived that he would be the new Infection Preventionist. During a follow up interview on 6/11/25 at 12:13 A.M., the Director of Nurses said that he would expect that infections in the facility are being tracked on line lists including trends and symptoms of resident infections. He said at this time no one is overseeing the program and was not sure what was happening before he came to the facility. The Director of Nurses said he had no documentation to show to the surveyor. The Director of Nurses said that he can run a report in the Electronic Medical Record to show residents who have utilized antibiotics, but at this time no one is monitoring that report tracking or trending it. He said the program is just getting off the ground at this time. During an interview on 6/12/25 at 8:07 A.M., the Administrator said that it is his expectation that that the facility follows an infection prevention and control program that includes a system for appropriate infection surveillance. During an interview on 6/12/25 at 8:32 A.M., the Medical Director said that he would expect that the facility tracks and trends infections in the facility with line listings. 2. Review of the Water Management binder submitted during survey, failed to indicate an assessment or water system mapping to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility. During an interview on 6/11/24 at 10:48 A.M., the Administrator said that he is currently working on a water management program, but it is not complete and is in process. He said that he reviewed the current water management program and said it wasn't up to par.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to establish an infection prevention and control program (IPCP) that included an Antibiotic Stewardship Program that includes antibiotic use protocols and a system to monitor antibiotic use. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following: - The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance. - Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. - The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. - Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting. Review of facility policy titled, Antibiotic Stewardship, dated as revised December 2016, indicated the following: -Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. -The purpose of out Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. -When antibiotics are prescribed over the phone, the primary care practitioner will assess the resident within 72 hours of the telephone order. Review of the facility policy titled, Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, dated as revised December 2016, indicated the following: -Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. -As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP), or designee. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. -At the conclusion of the review, the provider will be notified of the review findings. -all resident antibiotic regimens will be documented on the facility- approved antibiotic surveillance tracking form. Resident #28 was admitted to the facility in June 2018 with diagnoses that included septic pulmonary embolism and acute hepatitis. Review of Resident #28's Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the Resident was cognitively intact. Review of discontinued physician orders indicated the following: -Levaquin 500 mg, give 1 tablet by mouth one time a day for + (positive) wound cx (culture) for 14 days, in place from 5/14/25 through 5/28/25. Review of the medical record dated 5/14/25 through 5/28/25 failed to indicate review of antibiotic use or documented signs or symptoms of infection in the wound requiring treatment with antibiotics. The facility was unable to provide a line listing indicating signs or symptoms of infection and culture results for Resident #28. The facility was unable to provide evidence of an Antibiotic Stewardship Program. During an interview on 6/11/25 at 12:02 P.M., the Director of Nurses said that he has only been at the facility for three weeks and cannot provide any documentation on the facilities Antibiotic Stewardship Program. During a follow up interview on 6/11/25 at 12:13 P.M., the Director of Nurses said that the expectation is that an Antibiotic Stewardship Program is maintained and followed in the facility. He does not know how the facility was following antibiotic use prior to his arrival at the facility but said that currently no one is overseeing the program. During an interview on 6/12/25 at 8:07 A.M., the Administrator said that he would expect that the facility is implementing an Antibiotic Stewardship Program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225147	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saugus Center	266 Lincoln Avenue Saugus, MA 01906

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interviews, the facility failed to offer the COVID-19 (Coronavirus disease) vaccine to five out of five sampled Residents, (#35. #17, #68, #60, and #28) Specifically, the facility failed to offer COVID-19 vaccinations upon admission or seasonally for residents. Findings include: Review of the CDC guidance titled Stay Up to Date with COVID-19 Vaccines, revised 1/7/25, indicated but was not limited to the following: - Getting the 2024-2025 COVID-19 vaccine is important because: protection from the COVID-19 vaccine decreases with time; immunity after COVID-19 infection decreases with time; COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. - Everyone ages 6 months and older should get the 2024-2025 COVID-19 vaccine. This includes people who have received a COVID-19 vaccine, people who have had COVID-19, and people with long COVID. People ages 12-64 years; You are up to date when you have received: - 1 dose of the 2024-2025 Moderna COVID-19 vaccine OR - 1 dose of the 2024-2025 Pfizer-BioNTech COVID-19 vaccine OR - 1 dose of the 2024-2025 Novavax vaccine unless you are receiving a COVID-19 vaccine for the very first time. If you have never received any COVID-19 vaccine and get Novavax, you need 2 doses of 2024-2025 Novavax COVID-19 vaccine to be up to date. Review of the facility assessment, undated, indicated the following: -General Care: Infection Prevention and Control -Specific care or Practices: Identification and containment of infections, prevention of infections 1a. Resident #35 was admitted to the facility in May 2025 with diagnoses that included muscle wasting and hypothyroidism Review of the most recent Minimum Data Set (MDS) Assessment, dated 5/14/25, indicated that the Resident was not up to date with his/her covid vaccine. Review of the medical record failed to indicate that the current covid vaccine had been offered or that education regarding the vaccine had been completed 1b. Resident #17 was admitted to the facility in March 2025 with diagnoses that included muscle wasting and dysphagia. (continued on next page)

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	225147	A. Building B. Wing	06/16/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17's most recent MDS Assessment, dated 5/28/25, indicated that the Resident was not up to date with his/her covid vaccine. Review of the medical record failed to indicate that the current covid vaccine had been offered or that education regarding the vaccine had been completed. 1c. Resident #60 was admitted to the facility in April 2025 with diagnoses that included metabolic encephalopathy and hypertension Review of Resident #60's most recent MDS Assessment, dated 5/28/25 indicated that the Resident was not up to date with his/her covid vaccine. Review of the medical record failed to indicate that the current covid vaccine had been offered or that education regarding the vaccine had been completed. 1d. Resident #68 was admitted to the facility in May 2025 with diagnoses that included muscle wasting and hypertension Review of Resident #68's most recent MDS Assessment, dated 5/9/25 indicated that the Resident was not up to date with his/her covid vaccine. Review of the medical record failed to indicate that the current covid vaccine had been offered or that education regarding the vaccine had been completed. 1e. Resident #28 was admitted to the facility in June 2024 with diagnoses that included septic pulmonary embolism Review of Resident #28's most recent MDS Assessment, dated 3/19/25, indicated that the Resident was not up to date with his/her covid vaccine. Review of the medical record failed to indicate that the current covid vaccine had been offered or that education regarding the vaccine had been completed. During an interview on 6/8/25 at 9:09 A.M., the Administrator and Director of Nursing said the Assistant Director of Nursing is the infection preventionist at the facility. During an interview on 6/11/25 at 12:12 P.M., the Assistant Director of Nurses said that he has not yet been trained on the infection control program and is not currently tracking anything for the program. During an interview on 6/11/25 at 12:21 P.M., the Director of Nurses said that he would expect that vaccines are offered to all residents as appropriate and if consented to that they receive them. During an interview on 6/12/25 at 8:07 A.M., the Administrator said that residents in a facility are a high-risk population and his expectation is that the facility if offering the covid vaccine on admission and seasonally as well as providing education to residents about the benefits of vaccination. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/25 at 8:32 A.M., the Medical Director said that residents who live in a facility are a high-risk population. He said his expectation is that all residents are offered vaccines, including the covid vaccine on admission and seasonally. The Medical Director further said he would expect education be provided regarding the vaccine and the benefits of it.