STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225154	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M I Nursing & Restorative Center	172 Lawrence Street Lawrence, MA 01841

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to 1. provide a dignified dining experience on the 4A nursing unit and 2. ensure staff did not speak in a foreign language while providing care on the nursing units. Findings include: 1. Review of the policy titled the person centered dining approach undated, indicated: Person centered care and hospitality services, including dining, will be a vital part of everyday living. The person-centered dining approach will focus on each individual's needs related to food, nutrition and dining. 1. Each person will be treated like a special individual with a focus on personalizing all interactions and interventions, including nutrition care, food, beverages and dining. 13. Individuals at the same table will be served and assisted at the same time. The following was observed on the 4A unit, (a certified dementia unit): On 1/28/26 at 8:07 A.M., on the 4A unit, the surveyor observed 15 residents seated in the dining area. Three tables had residents who had not been served their meals and were watching their tablemates eat. At 8:10 A.M., a staff member entered and delivered a meal to a resident who was waiting, and four residents continued to wait and watching their tablemates eat. At 8:14 A.M., a total of three residents continued to wait and watch the rest of the dining room eat. One resident was observed eating his/her cornflakes with milk by scooping out the cereal with his/her finger. Staff did not observe or intervene. At 8:17 A.M., another resident arrived in the dining and room and was seated by staff. The resident was immediately served his/her meal while two other residents continued to wait. At 8:20 A.M., one waiting resident was served his/her meal while the last resident continued to wait. Another resident continued to eat his/her cereal with his/her finger. At 8:26 A.M., One resident continued to wait for his/her meal. A staff member arrived and sat to assist the resident who had been eating his/her cereal with his/her finger. Another resident arrived and sat in the dining room and was immediately served his/her meal. At 8:30 A.M., a Certified Nursing Assistant (CNA) inquired with another staff member if the waiting resident had been fed his/her meal and staff confirmed he/she had not been served yet. At 8:32 A.M the last resident was served his/her meal; 25 minutes after the observations began. On 1/29/26 at 7:48 A.M., 12 residents were observed seated in the dining room waiting for their breakfast meals. At 7:49 A.M., staff began serving the breakfast meals. At 8:04 A.M., a CNA delivered a meal to a resident who was sitting alone, while two residents at a table of three observed their tablemate eat their meal. At 8:06 A.M., a CNA delivered a meal to another resident at a different table while the two residents at the table of three continued to wait and watch their tablemate eat. At 8:09 A.M., A CNA delivered a meal to the table of three, leaving one resident waiting for his/her meal. At 8:11 A.M., a resident was observed holding a plastic cup in his/her mouth and not eating his/her meal. Another resident saw this and said, that's weird, that's not pretty. Staff did not observe this or intervene. At 8:13 A.M., a total of 17 total residents were in the dining area. The resident at the table of three was still waiting for his/her meal while his/her two tablemates were eating. A CNA observed this and said oh! Him/her too! and went to obtain his/her breakfast. At 8:14 A.M., the resident was given his/her breakfast meal after watching his/her tablemates eat. During an interview on 1/29/26 at 9:15 A.M., Unit Manager #3 said that staff promote dining with dignity by taking items off the trays and placing them directly on the table and being at eye level while assisting residents with meals. Unit Manager #3 said that do (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their best to serve residents at the same time, but it can be challenging. During an interview on 1/29/26 at 11:35 A.M., the Director of Nursing (DON) said that staff make an effort to serve residents at the same time, and they are planning on implementing a steam table in the next month on the unit to help with the dining program. 2. The surveyor made the following observations on the 4th floor nursing unit: On 1/27/26 at 8:01 A.M., on the 4a side of the unit, the surveyor observed a resident room with the door ajar. Two Certified Nursing Assistants (CNA's) were in the room providing care. The curtain was pulled and the staff were conversing with one another in Spanish; the residents in the room primary language was English. At 8:04 A.M., another CNA entered the room and the staff continued to speak in Spanish while providing morning care. On 1/28/26 at 11:01 A.M., the surveyor observed staff speaking Spanish in the hallway of the 4b side of the unit. On 1/28/26 at 11:04 A.M., a CNA was observed walking a resident down the hallway of the 4a side of the unit. Another staff member called to the CNA in Spanish the CNA stopped walking with the resident and the other staff wiped the Resident's face. The Resident's primary language was English. On 1/28/26 at 11:07 A.M., in the 4b side dining area, the surveyor observed the Residents seated with a sensory activity occurring and a CNA on his/her phone scrolling through videos on Tiktok. At 11:09 A.M., another staff person exited the dining area and spoke to the CNA on her phone in Spanish. On 1/28/26 at 12:06 P.M., in the 4b side dining area two CNA's were speaking in Spanish to each other across dining room in front of residents. On 1/29/26 at 8:17 A.M., the surveyor observed a resident room door ajar and water running in the bathroom on the 4b side. Two staff members were in the room providing care and speaking to each other in Spanish. The primary language for the residents in the room was English. On 1/29/2026 at 8:20 A.M., in the 4b side dining room, two staff members were speaking to one another in Spanish in front of the residents. The following was observed on the 3A side nursing unit: On 1/29/26 at 7:32 A.M., house keepers and CNA staff were speaking to each other in the unit hallway in Spanish. The following was observed on the 2nd floor nursing unit: On 1/28/26 at 11:32 A.M., a staff member was pushing a resident in his/her wheelchair down the hallway and speaking with another staff member at the other side of the hallway in Spanish. The resident's primary language was not Spanish. On 1/28/26 at 9:29 A.M., staff at the 2B nursing station were speaking to each other in Spanish. During an interview on 1/29/2026 at 9:18 A.M., Unit Manager #3 said that she didn't know what the expectations were for staff regarding speaking in foreign languages in front of residents or during care but would look into it. During an interview on 1/29/26 at 11:36 A.M., the Director of Nursing (DON) said that the expectation is for staff to not speak to each other in foreign languages on the units or while providing resident care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to develop and implement a comprehensive person-centered plan of care for five Residents (#171, #4, #11, #3 and #14) out of a total sample of 38 Residents. Specifically,1. For Resident #171 the facility failed to implement heel booties (specialty booties utilized to relieve pressure on the heels). 2. For Resident #4 the facility failed to implement bilateral lower extremity ace wraps.3. For Resident #11 the facility failed to implement bilateral lower extremity compression stockings.4. For resident #3 the facility failed to implement bilateral fall mats while the Resident was in bed.5. For Resident #14 the facility failed to develop a comprehensive plan of care for a pacemaker. Findings include: Review of the facility policy titled Baseline Care Plan, not dated, indicated that the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 1. Resident #171 was admitted to the facility in August 2022 with diagnoses including Alzheimer's disease, anxiety and depression. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #171 is severely cognitively impaired and totally dependent on staff for all activities of daily living. On 1/27/26 at 8:53 A.M., 12:51 P.M., and 4:35 P.M., the surveyor observed Resident #171 lying in bed with both feet directly on the mattress and a pair of blue heel protector booties on top of the Resident's dresser. Review of the care plan indicated a focus for skin integrity with an intervention for protective heel booties on both feet at all times when in bed. Further review failed to indicate that Resident #171 refuses to wear the protective heel booties. Review of the progress notes failed to indicate that Resident #171 refuses to wear the heel protector booties. During an interview on 1/28/26 at 9:48 A.M., Nurse #1 said that the Resident should have the heel protectors on at all times when in bed. Nurse #1 then said that the care plan should be followed. Nurse #1 also said that she didn't check whether the heel protectors were on because there is no physician's order that she has to sign off to trigger her to look for the application of the heel protectors. During an interview on 1/29/26 at 11:53 A.M., the Director of Nursing (DON) said that the care plan should be followed. The DON also said that any refusals of care should be documented in the medical record. 2. Resident #4 was admitted to the facility in June 2023 with diagnoses that included atrial fibrillation, heart failure, edema, and venous insufficiency chronic, peripheral. Review of Resident #4's most recent Minimum Data Set (MDS) assessment, dated 12/12/25, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident #4 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she is cognitively intact. Further review of the MDs indicated Resident #4 requires set-up to supervision for self-care activities. Review of physician orders on 1/27/26 at 1:06 P.M., indicated the following: Apply two ace bandages per leg to bilateral legs, first thing in the morning prior to resident getting out of bed. One time a day for edema and remove per schedule, dated initiated 2/7/25. Review of Resident #4's care plan dated 8/4/25 indicated the following: Focus: Resident #4 is at risk for pain D/T (due to) generalized discomfort, related to lymphedema (swelling) and decreased mobility. Interventions: Wrap bilateral legs daily q (every) AM with ace wraps. On 1/27/26 at 8:37 A.M., and 1:01 P.M., and 1/28/26 at 8:16 A.M., the surveyor observed Resident #4 washed and dressed and seated in his/her wheelchair. Resident #4 bilateral legs were not ace wrapped. Review of #4's medical record failed to indicate the Resident refused to have his/her legs ace wrapped. During an interview on 1/29/26 at 7:45 A.M., Resident #4 said he/she is unable to ace wrap his/her legs and needs assistance from the nurses who will normally ace wrap them first thing in the morning. During an interview on 1/29/26 at 9:01 A.M., Nurse #5 said Resident #4's legs should be ace wrapped in the early morning by the overnight staff. Nurse #5 said she was not aware if the Resident refused his/her legs to be wrapped, but if there was a refusal it should be documented in the medical record. During an interview on 1/29/26 at 9:15 A.M., Certified Nursing Aide (CNA) #5 said the overnight nurses wrap Resident #4's legs. CNA #5 said she does not ace wrap the Resident's legs the nurses do and she was not aware if Resident #4 refuses his/her legs to be wrapped. During an interview on 1/29/26 at 10:54 A.M., Unit Manager #4 said the nurses on the 11:00 P.M. to 7:00 A.M. shift put the ace wraps on Resident #4's legs in the morning as he/she is an early riser. Unit Manager #4 said she was not aware Resident #4 had refused his/her legs to be wrapped but all refusals should be documented in the medical record. 3. Resident #11 was admitted to the facility in February 2023 with diagnoses that included end stage renal disease, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, chronic pulmonary edema, and dependence on renal dialysis, and edema. Review of Resident #11's most recent Minimum Data Set (MDS) assessment, dated 10/27/25, indicated Resident #11 was assessed by staff to have severe cognitive deficits. Further review of the MDS indicated Resident #11 requires set-up or clean up assistance to supervision or touching assistance with self-care activities. Review of Resident #11's care plan dated 8/19/24 indicated the following: Focus: Resident #11 has ESRD (End Stage Renal Disease) and frequently refuses to go to dialysis. Complicated by refusal to adhere to dietary restrictions. Intervention: Apply TED stockings (compression stockings) daily at 6 A.M. for edema to bilateral lower extremities-off HS (hours sleeping). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/26 at 9:50 A.M., 1/28/26 at 9:43 A.M., and 10:43 A.M., and 1/29/26 at 8:29 A.M., Resident #11 was observed sitting on the edge of his/her bed and he/she did not have compression stockings on his/her legs. Review of Resident #11's nursing notes failed to indicate the Resident refused to wear his/her compression stockings. During an interview on 1/29/26 at 9:01 A.M., Nurse #5 said she was not aware if Resident #11 should be wearing TED stockings, but she would check. Nurse #5 said if Resident #11 had any refusal of care it should be documented in the medical record. During an interview on 1/29/26 at 9:24 A.M., Certified Nursing Aide (CNA) #4 said she did not think Resident #11 should be wearing TED stockings as she has never seen them on the Resident. During an interview on 1/29/26 at 10:54 A.M., Unit Manager #4 said she did not think Resident #4 was wearing TED stocking any longer but said if the Resident is care planned for compression stocking, she would expect the care plan to be followed. Unit Manager #4 said all refusals of care should be documented in the medical record. 4. Resident #3 was admitted to the facility in June 2024 with diagnoses that included vascular dementia, blindness in one eye, adult failure to thrive, and depression. Review of Resident #3's most recent Minimum Data Set (MDS) assessment, dated 12/28/25, indicated he/she scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Further review of the MDS indicated the Resident is dependent on staff for activities of daily living. Review of Resident #3's fall care plan, dated 1/26/26, indicated Floor mats on bilateral sides of bed when resident is in bed. Review of Resident #3's Nurse Practitioner (NP) progress note, dated 1/27/26, indicated Continue fall precautions. Patient had a fall on 1/26/26. On 1/27/26 at 8:34 A.M., the surveyor observed the Resident in bed with his/her fall mats folded next to the head of his/her bed. On 1/28/26 at 8:11 A.M., the surveyor observed the Resident in bed with his/her fall mats folded next to the head of his/her bed. On 1/29/26 at 8:21 A.M., Nurse #3 said the Resident has fallen recently and should have the fall mats down on the floor right next to each side of the bed. Nurse #3 said fall mats are a fall intervention. On 1/29/26 at 8:23 A.M., Certified Nurse Aide (CNA) #3 said she does take care of the Resident sometimes and he/she is a fall risk. CNA #3 said she was not sure if the Resident has fall mats in his/her room. On 1/29/26 at 8:24 A.M., Unit Manager #1 said the Resident had a fall on 1/26/26 which was more of a behavior but the intervention that was put into place for that fall was the fall mats, and they should be down on the floor as ordered when he/she is in bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/26 at 8:44 A.M., the Director of Nurses was unable to tell the surveyor what interventions should be in place from his/her fall that occurred on 1/26/26. 5. Resident #14 was admitted to the facility in November 2025 with diagnoses that included paroxysmal atrial fibrillation and presence of cardiac pacemaker. Review of Resident #14's most recent Minimum Data Set (MDS) Assessment, dated 11/16/25, indicated a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. Review of physician's orders indicated the following: -Please change reason for Jardiance to CHF (congestive heart failure), not afib (atrial fibrillation). Please schedule pacemaker checks per cardiology recommendations- [with cardiologist], dated 11/12/25. Further review of physician's orders failed to indicate orders regarding the pacemaker. Review of progress notes since admission failed to indicate pacemaker type, serial number or paced rate of the Resident's pacemaker. Review of Resident #14's active care plan failed to indicate a plan of care around a pacemaker. During an interview on 1/29/26 at 9:48 A.M., Unit Manager #2 said that she is aware that the Resident has a pacemaker. She said when a Resident has a pacemaker the staff need to know the model of the pacemaker, the serial number, the paced rate and who the cardiologist is. She said there should be a comprehensive plan of care for a pacemaker to include serial number, the paced rate and when the next appointment is for a pacemaker check. During an interview on 1/29/26 at 11:46 A.M., the Director of Nurses said that there should be a comprehensive plan of care for the pacemaker.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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,For one Resident (#23) the facility failed to ensure medications were not unsecured and stored at the bedside, out of a total sample of 38 residents.The facility failed to ensure that treatment and medication carts were locked when unattended on two units (2B and 3A) out of six units.The facility failed to ensure medications were not left unattended at the nurse's station.Findings include:Review of facility policy titled Medication Storage, undated, indicated the following: -It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control segregation and security. -All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, draws, refrigerators, medication rooms) under proper temperature controls. 1. Resident #23 was admitted to the facility in May 2022 with diagnoses that included Chronic Obstructive Pulmonary Disease and asthma. Review of Resident #23's most recent Minimum Data Set (MDS) assessment, dated 1/14/26, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Review of the medical record failed to indicate an assessment for the self-administration of and self-storage of medications. Review of Resident #23's active care plan failed to indicate a plan of care around medication self-administration or storage of medications in resident room. On 1/27/26 at 8:55 A.M., the surveyor observed Resident #23 sleeping in bed. Observed in the Resident's room was a tube of diclofenac topical gel (a topical non-steroidal anti-inflammatory drug) and a Trelegy inhaler with 10 doses remaining in it. On 1/27/26 at 12:40 P.M., the surveyor observed the resident sitting up in bed, eating lunch, there was a tube of diclofenac topical gel at the Resident's bedside. On 1/28/26 at 7:31 A.M., the surveyor observed the Resident sleeping in bed. There was a tube of diclofenac gel on the over bed table. On 1/29/26 at 8:24 A.M., the surveyor observed Resident #23 sitting up on the side of the bed eating breakfast. A tube of diclofenac gel was on the bedside table. Review of Physician's orders indicated the following: -Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25 MCG/ACT (micrograms per actuation) (Fluticasone-Umeclidinium-Vilanterol), 1 inhalation orally in the morning, rinse mouth with (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water and spit back into cup after use, dated 10/25/24. -Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)), apply to neck three time a day for joint pain, dated 10/25/24. -Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)), apply to shoulders three times a day, dated 10/25/24. -Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)), apply to bilateral knees three times a day, dated 10/25/24. -Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)), apply to affected areas every 12 hours as needed, apply 2 grams to neck, shoulders, elbows, hands and knees, dated 1/18/24. During an interview on 1/29/26 at 8:27 A.M., Unit Manager #2 said that there are no residents on the unit who store medications at the bedside or self-administer medications. She said that the Resident should not have medications stored at the bedside which could be accessible to other residents on the unit. During an interview on 1/29/26 at 11:42 A.M., the Director of Nurses said that medications should not be kept at the bed side and should be secured in a medication or treatment cart. 2. On 1/27/26 at 8:17 A.M., the surveyor observed an unlocked and unattended treatment cart in the hallway in the 2B unit. The surveyor was able to gain access to the cart which contained treatment supplies and medicated ointments. On 1/28/26 at 7:26 A.M., the surveyor observed an unlocked and unattended treatment cart in the hallway in the 2B unit. The surveyor was able to gain access to the cart which contained treatment supplies and medicated ointments. During an interview on 1/28/26 at 12:46 P.M., Unit Manager #2 said that medication and treatment carts should be locked when unattended. During an interview on 1/29/26 at 11:42 A.M., the Director of Nurses said that medication and treatment carts should be locked when they are unattended. On 1/27/26 at 8:23 A.M., the surveyor observed a medication cart unlocked and unsupervised on the 3A Unit. On 1/27/26 from 12:40 P.M. to 12:43 P.M., the surveyor observed a treatment cart unlocked and unsupervised on the 3A Unit. During an interview on 1/28/26 at 12:46 P.M., Unit Manager #2 said that medication and treatment carts should be locked when unattended. During an interview on 1/29/26 at 11:42 A.M., the Director of Nurses said that medication and treatment carts should be locked when they are unattended. 3. On 1/27/26 at 8:39 A.M., the surveyor observed a clear plastic container on top of the 4B Unit (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses' station that was closed with a red tag. Inside the container the surveyor observed two vials of a liquid and packaging. There was a slip inside the container which indicated the following contents: Levetiracetam (keppra) 250 tab and Lidocaine 5% vial. There were no staff in the area, and the medications were accessible to anyone who arrived on the unit or walked through. On 1/27/2026 at 10:06 A.M., the surveyor observed the medications were still unattended on top of the 4B unit nursing station. There were no staff in the area, and the medications were accessible to anyone who arrived on the unit or walked through. Nurse #6 was observed at the end of the hallway near the dining room. The surveyor called her over and Nurse #6 said that the medications were dropped off by the pharmacy and should be locked in the medication room. During an interview on 1/28/26 at 8:49 A.M., Unit Manager #3 said that medications were left at the nursing station to be picked up by the pharmacy. Unit Manager #3 said that the nursing staff is usually in the area but moving forward, staff will keep the medications secured while waiting for a pharmacy pick up. During an interview on 1/28/2026 at 10:54 A.M., the Director of Nursing (DON) said that staff leave the medications at the nursing station for the pharmacy to pick up out of necessity as the pharmacy techs historically will not wait or find a nurse to obtain the medications scheduled for pick up, resulting in the medications being left behind.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instruct health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were able to be located in the medical record for one Resident (#28) out of a total sample of 38 residents. Findings include:Resident #28 was admitted to the facility in May 2023 with diagnoses that included encounter for palliative care, congestion heart failure, Alzheimer's disease, dysphagia, and chronic kidney disease. Review of Resident #28's most recent Minimum Data Set (MDS) assessment, dated 1/13/26, indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Further review of the MDS indicated he/she is a DNR, DNI, DNH (Do not hospitalize). Review of Resident #28's physician order, dated 5/23/23, indicated Advance Directive: DO NOT RESUSCITATE (DNR) DO NOT INTUBATE (DNI) Transfer to Hospital. Review of Resident #28's Advanced Directives care plan, dated 1/27/26, indicated Review Advanced Directives on file, if applicable. During an interview and record review on 1/28/26 at 8:24 A.M., Unit Manager #1 was unable to locate Resident #28's MOLST (Medical Orders for Life-Sustaining Treatment) in both the paper record and the electronic medical record. Unit Manager #1 said this is a document that needs to always be in the chart because if the Resident coded at this very moment the staff would have to provide life saving measures as the MOLST is the order. Unit Manager #1 said the Resident is on hospice and maybe their staff have it. During an interview on 1/28/26 at 8:35 A.M., the Infection control nurse said if the MOLST is unable to be located then the staff have to assume he/she is a full code as the MOLST is the order. During an interview on 1/28/26 at 8:44 A.M., Nurse #2 and Nurse #3 said if a resident codes the nurse goes to the record to see if the Resident has a MOLST (Medical Orders for Life-Sustaining Treatment) on file and they would go by what that MOLST says. Nurse #2 and Nurse #3 said if there is not a MOLST in the resident record then they are assumed to be a full code.

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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 observation, record review and interview, the facility failed to ensure staff implemented physician orders for on Resident (#87) out of a total of 38 sampled residents. Specifically, for Resident #87, the facility failed to implement physical therapy and occupational therapy services per the physician orders. Findings include: Review of [NAME], Manual of Nursing Practice 11ed, dated 2019 indicated the following: The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Resident #87 was admitted to the facility in November 2025 with diagnoses including periprosthetic fracture around internal prosthetic right hip joint, Parkinsons and conversion disorder with seizures. Review of the Minimum Data Set assessment (MDS) dated [DATE] indicated Resident #87 was severely cognitively impaired evidenced by a score of seven out of a possible 15 on the Brief Interview for Mental Status exam. During an observation on 1/27/26 at 10:08 A.M., the surveyor observed Resident #87 in bed and a Certified Nursing Assistant (CNA) was observed preparing to assist Resident #87 out of bed with the use of a hoyer lift. Review of the Resident #87's neurology consult form dated 1/15/26 indicated: Needs aggressive rehab to help him/her walk PT (physical therapy) OT, (occupational therapy) and ST (speech therapy.) Review of Nurse Practitioner #1's progress notes indicated: 1/21/26: Patient was seen by neurologist on 1/15/26: Per visit notes/summary: No changes to PD meds at this time. Needs aggressive rehab to help him/her walk --> PT/OT and ST. F/u appt 5/18/26 3:30pm. Nurse is unsure if patient has been receiving PT/OT; will place order in PCC. Patient tells this NP he/she wants to walk again. He/She was walking before hospital admission. 1/27/26 This NP placed order for PT/OT last week on 1/21/26, however, patient is still saying she has not worked with PT/OT. Will follow-up with nurse/nurse manager. Patient is seen sitting up in wheelchair in her room. He/She is alert and in no acute distress. Review of the physician orders indicated: PT/OT. Per neurologist recommendations on 1/15/26: Patient needs aggressive rehab to help her walk, PT/OT, initiated 1/22/26. During an interview on 1/28/2026 at 8:42 A.M., Resident #87 was observed in bed. Resident #87 said that he/she had not been working with rehab doing exercises and that the surveyor was the 3rd person who had come in and asked him/her about that. During interviews on 1/27/26 at 10:09 A.M., and 1/28/26 at 8:44 A.M. Unit Manager #3 said that requests for screens or evaluations for the rehab department are filled out on forms and placed in an interoffice box for their review. Unit Manager #3 said that a request was completed for Resident #87 to be seen by the rehab department after his/her appointment on 1/15/26 and they try to get someone out as soon as possible to do a screen and treatment order. Unit Manager #3 said that Resident #87 is on service with rehab for mobility. During interviews on 1/27/26 at 10:38 A.M., and 1/28/26 at 10:00 A.M., the Director of Rehab (DOR) said that screens and evaluations for therapy services are completed based on MD orders or screen forms. The DOR said she was aware of the need for an evaluation for Resident #87 based on the physician order. The DOR said that Resident #87 was supposed to be screened this past Sunday (1/25/26; ten days after his/her neurology appointment) but due to staffing issues Resident #87 had not yet been seen by PT or OT. During an interview on 1/28/26 at 1:00 P.M., Nurse Practitioner #1 said that rehab evals are usually completed within the week and she believed that there had been a delay in obtaining an evaluation or screen for Resident #87 due to staffing issues.

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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 observation, record review and interview the facility failed to provide one Resident (#7), who is unable to carry out activities of daily living, nail care out of a total sample of 38 residents. Findings include:Resident #7 was admitted to the facility in February 2024 with diagnoses including dementia, schizoaffective disorder and adult failure to thrive. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #7 is moderately cognitively impaired evidenced by a score of 12 out of a possible 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #7 is dependent on staff for all activities of daily living. Review of the current care plan indicated a focus for self-care deficit with interventions including: 1. The resident prefers dressing/grooming routine in early morning. 2. Is dependent of 1-2 (staff) with his/her grooming needs. Further review failed to indicate that Resident #7 refused care. Review of the progress notes failed to indicate that Resident #7 refuses care. Review of the Certified Nurse's Aide (CNA) documentation dated 1/27/26, failed to indicate Resident #7 refused care. On 1/27/26 at 9:59 A.M., and 12:50 P.M. the surveyor observed Resident #7 to be eating in the dining room. The surveyor also observed Resident #7's fingernails to be long and dirty. On 1/28/26 at 12:30 P.M., the surveyor observed Resident #7 to be eating in the dining room. The surveyor also observed Resident #7's fingernails to be long and dirty. During an interview on 1/28/26 at 12:39 P.M., Resident #7 said that he/she would like his/her nails cleaned and trimmed. During an interview on 1/28/26 at 12:50 P.M., CNA #1 said that she was responsible for Resident #7's care today. CNA #1 said that she did not clean or trim Resident #7's nails today because she didn't think the Resident wanted it done. CNA #1 said that the Resident did not specifically refuse to have his/her nails cleaned. During an interview on 1/28/26 at 12:53 P.M., Nurse #1 said that if the Resident refuses nail care the CNA should document in the medical record and notify nursing. She then said that she has been able to clean and trim Resident #7's nails in the past. During an interview on 1/29/26 at 11:43 A.M., the Director of Nursing said that if a resident refuses care, it should be documented in the medical record.

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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, interviews and records reviewed, the facility failed to ensure treatment and care in accordance with professional standards for one Resident (#74) out of a total sample of 38 residents. Specifically, the facility failed to ensure Resident #74 received appropriate assessment, monitoring, treatment, and care planning for multiple skin integrity issues, in accordance with the resident's assessed needs and hospice status. Findings include: Review of the facility policy titled Skin Program dated as revised 7/2024, indicated but was not limited to the following:-All residents will have daily skin inspection done by the Nursing Assistant (CNA) skin issues will be referred to the team leaders immediately for further assessment.-All residents will have a weekly skin inspection done by the team leader and documented in PCC (electronic medical record) in weekly wound notes.-Inspect skin for changes/concerns daily by CNA and notify Team Leader.Resident #74 was admitted to the facility in May 2022 with diagnoses including congestive heart failure, anemia (low red blood cells, dorsalgia (pain in the back), protein-calorie malnutrition, Parkinson's Disease with dyskinesia (involuntary muscle movements), and adult failure to thrive.Review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of three out of a possible15, indicating severe cognitive impairment. The MDS further indicated the Resident was dependent on staff for all activities of daily living.On 1/27/26 at 8:32 A.M. Resident #74 was in his/her bed and was unable to participate in an interview. The surveyor made the following observations: -Multiple dark purple and pink bruises to the top right hand. -Dark purple bruises to the right wrist, and three dark purple and pink bruises to the lower right arm. -Dried blood and scabbed areas between the middle and index finger of the left hand.-One round raised dark black scabbed area with surrounding pink and red tissue discoloration was observed on the outer left knee. -One oval area of light brown and pink discoloration with a small round swollen pin hole opening approximately 1 inch wide by 1.5 inches in length located on the right shin. Review of Resident #74's Skin Assessments, dated 1/20/26 and 1/27/26 indicated the following skin issues: -Skin Issue #1: Location: Rear Right Thigh. Issue type: Bruising. -Skin issue #2: Location: Lower Back. Issue type: Rash. -Skin issue #3: Location: Front Left Knee. Issue type: Skin tear. -Skin issue #4: Left Dorsum Left Hand. Issue type: Skin tear. -Skin issue #5: Location: Left Dorsum 3rd Digit (middle) - phalanx. Issue type: Skin tear. Review of The Skin assessment dated [DATE] failed to indicate the presence of the bruising to the top right hand, right wrist, and lower right arm, dried blood and scabbed areas on the left hand, dark scabbed area to the left knee or discoloration and open area to the right shin. Review of Resident #74's Active Physician orders indicated: -Weekly Skin Assessment every evening shift every Tue (Tuesday); Also complete skin assessment. Dated: 3/28/23.-Geri-Sleeves (protective covering for skin) to bilateral arms every day shift for skin integrity. Dated 7/10/25.-Doff (remove) Geri-Sleeves every evening shift. Dated 7/09/25.Review of Resident #74's skin integrity care plan dated as last revised on 6/19/24, indicated:-Resident is at risk for skin breakdown R/T (related to) frail fragile skin, HX (history) skin breakdown, incontinence, and limited mobility. Interventions dated 11/23/22 included:-Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. -Keep skin clean and dry. Use lotion on dry skin. -Use a draw sheet or lifting device to move resident. -Weekly skin check by licensed nurse. Review of the medical record failed to indicate documentation related to care plan interventions addressing the newly identified skin issues, or documentation regarding the etiology of the skin injuries.During an interview on 1/28/26 at 11:40 A.M., Certified Nursing Assistant (CNA) #8 said any new skin issues were reported to the nursing staff and said the Resident's bruising and skin tears had been present for some time.During an interview on 1/28/26 at 12:29 P.M., Hospice Nurse #1 stated she was unaware of any skin integrity issues for Resident #74 and said there is no documented skin issues or bruising reported or documented in Resident #74's record and stated she would expect to be (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified of skin concerns and treatment updates.During an interview on 1/28/26 at 12:31 P.M., Unit Manager #2 said she was unaware of the Resident's bruising and skin tears and said any newly identified skin issue should be reported, assessed, and care planned, with notification to the physician and hospice team. Unit Manager #2 said Resident #74 does not have treatment orders or assessment information for the areas identified.During an interview on 1/29/26 at 6:51 A.M., Nurse #4 said Resident #74 had bruising to the right thigh for a while and said the skin tears to the left knee, left hand and left leg were new and that she documented them on the skin check and notified the Unit Manager and Nurse Practitioner on 1/20/26. Nurse #4 said the Resident will sometimes bump his/her arms on the side rails and have a small bruising. On 1/29/26 at 7:57 A.M., Hospice Staff #2 and the surveyor observed Resident #74 lying in bed. Hospice Staff #2 said Resident #74 had a recent decline and has been in bed and said the Resident has bruising to his/her arms and legs and open areas to his/her legs and backside and said she notified the nursing staff. During an interview on 1/29/26 at 8:44 a.m., Nurse Practitioner (NP) #2 said Resident #74 is high risk for skin breakdown and said she was notified of the bruising and skin tears and provided verbal treatment orders and said she expects nursing staff to enter the orders and update the plan of care accordingly. NP #2 said she did not recall the specific orders and reported, The nurses call me and I give orders. I do not keep track of the orders or the number of skin tears or wounds in the building. When asked by the surveyor how resident response to treatments is monitored, NP #2 stated that nursing staff notify her and further stated, I don't always do a thorough skin check. I ask the nurses and they tell me.Review of Resident #74's Active Physician's orders failed to indicate an order for the treatment to Resident #74's left knee skin tear, front left knee skin tear, or the left middle finger skin tear.During an interview on 1/29/26 at 11:48 A.M., the Director of Nursing said she was unaware of the Resident's skin integrity issues and said she would expect skin tears and bruises to be documented, reported and monitored and said she expects physician orders to be implemented. During a follow-up interview on 1/29/26 at 1:40 P.M., Unit Manager #2 said Resident #74 should have been added to weekly wound rounds when the skin issues were first documented on 1/20/26, for monitoring and weekly assessment and said his/she was not added to the list. Refer to F686, F849

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and records reviewed, the facility failed to provide necessary treatment and services consistent with professional standards of practice, to promote healing, and prevent new pressure ulcers from developing for three Residents (#74, #3, and #48), out of a total sample of 38 residents. Specifically,1. For Resident #74 who has a history of and is at risk for the development of pressure ulcers, the facility failed to implement an air mattress as recommended by nurse practitioner resulting in the development of a Stage 2 Pressure Injury and failed to implement treatment orders for the newly developed Stage 2 Pressure Injury.2. For Resident #3, who has a pressure ulcer on his/her left heel the facility failed to implement a skin intervention of implementing Prevalon (off-loading) boots as ordered.3. For Resident #48, who has a history of and is at risk for the development of pressure ulcers, the facility failed to implement Prevalon (off-loading) boots and maintain air mattress settings as indicated in physician's orders. Findings include: Review of the facility policy titled Pressure Injury Prevention and Management, dated as revised 2025, indicated but was not limited to the following: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcer/injuries. 2. The facility shall establish and utilize a systematic approach to r pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 4. Interventions for Prevention and to Promote Healing. a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. f. Interventions will be documented in the care plan and communicated to all relevant staff. 5. The RN Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medial record. c. A Focused Incident Review will be performed on each pressure injury that develops in the facility. Review of the policy titled Pressure Ulcer Prevention dates as revised July 2024, indicated but was not limited to the following: Pressure Ulcer Prevention -All residents identified as at risk on the Minimum Data Set (MDS) and/or by a score of 18 or less on Braden Scale and/or with a history of previous skin breakdown will have a pressure area prevention. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. Provide special treatment per Medical Practitioner's orders based on wound management team recommendations. Check the orders for specific instructions. Treatment: Residents who are admitted with or develop pressure areas will have a plan of treatment developed by the Unit Manager and Attending Provider. The provider will order a Wound Consult, after an evaluation, the wound physician/nurse will provide wound treatment recommendations. 1. Resident #74 was admitted to the facility in May 2022 with diagnoses of congestive heart failure, anemia (low red blood cells), dorsalgia (back pain), protein-calorie malnutrition, Parkinson's Disease with dyskinesia (involuntary muscle movements) with fluctuations and adult failure to thrive. Review of Resident #74's most recent (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of three out of a possible 15 which indicated severe cognitive impairment. Further review of the MDS indicated that he/she is at risk for developing pressure ulcers/injuries, and requires pressure reducing device for chair, pressure reducing device for bed, and did not currently have any pressure ulcers. Review of Resident #74's Hospice Documentation Log dated 1/11/26, indicated Staff requesting air mattress multiple red raised lesions lower back. Staff using hydrocortisone cream. On 1/27/26 at 8:32 A.M., the surveyor observed Resident #75 lying in bed. The Resident did not have a pressure reducing air mattress. On 1/28/26 at 7:36 A.M., the surveyor observed Resident #75 lying in bed. The Resident did not have a pressure reducing air mattress. Review of Resident #74's active physician orders failed to indicate an order for an air mattress was implemented. During an interview on 1/29/26 at 8:44 A.M., Nurse Practitioner (NP) #2 said Resident #74 is high risk for pressure injuries and said she made the recommendation for an air mattress on 1/11/26 because Resident #74 is declining and said nursing staff were aware on 1/11/26 that he/she needed an air mattress. NP #2 said she was not aware that the air mattress was not implemented and said she would expect nursing staff to implement orders when given. Review of Resident #74's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation, dated 12/17/25, indicated a risk score of 13, indicating that the Resident is at risk for skin breakdown and the development of pressure ulcers. Review of Resident #74's active skin care plan dated as last revised 6/19/24, indicated the following: -Resident is at risk for skin breakdown R/T (related to) frail fragile skin, HX (history) skin breakdown, incontinence, and limited mobility. Interventions included: -Avoid scratching and keep hands and body parts from excessive moisture. -Keep fingernails short. Dated: 11/23/22. Keep skin clean and dry. Use lotion on dry skin. Dated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/23/22. -Use a draw sheet or lifting device to move Resident. Date: 11/23/22. -Weekly skin check by licensed nurse. Dated 11/23/22. Review of Resident #74's skin assessment, dated 1/27/26, indicated the following: -Skin issue #6: New skin Issue. New Wound Pressure Ulcer/injury Left gluteus. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Length: 3cm (centimeters)., Width: 2cm., 2 Depth: 0cm. Review of Resident #74's active physician orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR) on 1/28/26, failed to indicate any orders for assessment, monitoring, or treatment of the documented Stage 2 Pressure ulcer to the left gluteus. Further review of the medical record failed to indicate hospice notification, or care plan interventions addressing the newly developed Stage 2 Pressure ulcer identified on 1/27/26. During an interview on 1/28/26 at 12:27 P.M., Hospice Nurse #1 said she was unaware of any skin integrity issues for Resident #74 and said there is no documented Stage 2 pressure wound reported or documented in Resident #74's record and said she would expect treatment orders and interventions to be implemented as the Resident is high risk for pressure injury development. During an interview on 1/28/26 at 12:31 p.m., Unit Manager (UM) #2 said Resident #74 has a new Stage 2 Pressure injury. The surveyor and Unit Manager #2 reviewed the hospice progress note dated 1/11/26 and Unit Manager #2 said recommendations were made for Resident #74 be placed on an air mattress at that time; however, Unit Manager #2 confirmed the air mattress was not implemented until 1/28/26; approximately 17 days after the recommendation was documented and after the Resident #74 developed the Stage 2 Pressure injury . Unit Manager #2 said nursing staff are required to report changes in condition to hospice services, and she contacted hospice the previous day, (1/27/26), to report the Resident's recent fall and said an air mattress and geriatric chair will be delivered today. Unit Manager #2 said Resident #74 is at high risk for pressure injuries and should have interventions in place to prevent further skin breakdown. On 1/29/26 at 7:57 A.M., Hospice Staff #2 and the surveyor observed Resident #75 lying in bed. Resident #74 did not have a dressing to his/her Stage 2 Pressure injury. Hospice Staff #2 said there has been no dressing or treatment for the pressure wound. Hospice Staff #2 said Resident #74 had a recent decline and has been in bed, and said the facility just got the Resident an air mattress. Review of Resident #74's physician orders indicated: -Cleanse coccyx with normal saline, pat dry, and cover with bordered foam every day shift every other day for wound care, dated 1/29/26; two days after the wound was initially identified. -Pressure Reduction Services: air mattress with settings at 140lb. (pounds) every shift for skin integrity, dated 1/28/26; 17 days after the initial recommendation was made for an air mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/26 at 8:44 A.M., Nurse Practitioner (NP) #2 said Resident #74 should have treatment orders in place for skin breakdown and said she gives orders verbally over the phone to the nurses and expects them to be implemented when given. NP #2 said she was made aware of the Stage 2 Pressure injury and said Resident #74 should have a dressing in place and wound monitoring documented daily. Review of the Nurse Practitioner progress note made available on 1/29/26 and dated 1/27/26, indicated: (Resident) who was noted to have an open area on the left buttocks. The wound appears to be a pressure injury, as described by the nurse and confirmed by provider review of wound images. Open area on left buttocks, wound with partial thickness skin loss, red wound bed, surrounding erythema, no obvious purulence. -Assessment: Pressure injury, stage 2, left buttocks -Plan: Initiate wound care protocol: Cleanse wound with saline, pat dry, apply appropriate dressing, and change every 48 hours and as needed. Request Hospice to obtain an air mattress if not already in place. Reassess wound in 24 hours. Nursing staff to monitor for signs of infection (increased redness, swelling, drainage, fever) and notify provider of any changes. Continue current management of comorbid conditions. During an interview on 1/29/26 at 11:48 A.M., the Director of Nursing (DON) said she was unaware of Resident #74's newly developed Stage 2 pressure injury and said she has no involvement with the wounds and said the Unit Manager #2 is in charge of tracking wounds The DON said skin issues should be documented, reported and monitored. The DON said the Assistant Director of Nursing is responsible for the daily clinical oversight of the building, but she is out on medical leave. The DON said Residents who are high risk for pressure injuries should have interventions in place to prevent skin breakdown Refer to F849 2. Resident #3 was admitted to the facility in June 2024 with diagnoses that included vascular dementia, blindness in one eye, adult failure to thrive, and depression. Review of Resident #3's most recent Minimum Data Set (MDS) assessment, dated 12/28/25, indicated he/she scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Further review of the MDS indicated the Resident is dependent on staff for activities of daily living and is at risk for developing pressure ulcers. Review of Resident #3's physician order, dated 10/30/25, indicated Apply Prevalon Boots on both feet when in bed. Review of Resident #3's Braden Scale (Scale Predicting Pressure Ulcer Risk Evaluation), dated 9/17/25, indicated a score of 18, indicating the Resident is at risk for developing pressure ulcers. Review of Resident #3's skin checks, dated 1/16/26 and 1/23/26, indicated: Skin issues - Pressure ulcer/injury: left heel. Blister: Right dorsum first digit. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's wound provider progress note, dated 1/23/26, indicated on 1/16/26 the left heel wound has declined and now presents as a clustered area of two regions of maroon to deep purple discoloration, consistent with progression to a deep tissue pressure injury, raising concern for ongoing pressure. Continued adherence to the current wound care plan is recommended at this time, with strict offloading of the left heel. Review of Resident #3's nursing progress notes from 1/27/26 and 1/28/26 failed to indicate the Resident refused his/her booties. On 1/27/26 at 8:34 A.M., the surveyor observed the Resident in bed without Prevalon boots on and his/her heels directly on the mattress. One Prevalon boot was observed in corner of the Resident room. On 1/28/26 at 8:11 A.M., the surveyor observed the Resident in bed without Prevalon boots on and his/her heels directly on the mattress. One Prevalon boot was observed in corner of the Resident room. On 1/28/26 at 8:47 A.M., the surveyor observed the Resident in bed without Prevalon boots on and his/her heels directly on the mattress. The surveyor also observed a Certified Nurse Aide (CNA) go in and out of his/her room with breakfast but did not apply the boots. On 1/29/26 at 8:21 A.M., Nurse #3 said the Resident has a wound on their heel and should have his boots on as ordered in bed. Nurse #3 said if the Resident is in bed without them then it will cause more pressure to the wound which is not what is intended. On 1/29/26 at 8:23 A.M., CNA #3 said she does take care of the Resident sometimes and the Resident does have a wound on his/her heel and should have boots on while in bed. On 1/29/26 at 8:24 A.M., Unit Manager #1 said the Resident is at risk for pressure ulcers and has one on his/her left heel. Unit Manager #1 said the boots should be on as ordered and if his/her heels are flat on the mattress that puts more pressure on his/her heels. Unit Manager #1 said if he/she refused them then the nurse should write a progress note. On 1/29/26 at 8:44 A.M. the Director of Nurses was unable to tell the surveyor what interventions should be in place for his/her skin issues. 3.Resident #48 was admitted to the facility in April 2023 with diagnoses that included adult failure to thrive and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/3/25 indicated a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive impairment. The MDS further indicated that the Resident was at risk for development of pressure ulcers but did not currently have any pressure ulcers. On 1/27/26 at 8:37 A.M., the surveyor observed Resident #48 sleeping in bed. An air mattress was in place and was set at the max setting of 400 pounds. There was a sticker on the air mattress pump indicating to set the air mattress to 160 pounds. The Resident's heels were directly on the mattress; no offloading boots were in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/26 at 7:21 A.M., the surveyor observed Resident #48 sleeping in bed. An air mattress was in place and was set at the max setting of 400 pounds. There was a sticker on the air mattress pump indicating to set the air mattress to 160 pounds. The Resident's heels were directly on the mattress. On the floor next to the bureau, the surveyor observed off- loading boots. On 1/28/26 at 8:23 A.M., the surveyor observed Resident #48 sitting up in bed eating breakfast. The air mattress is at the max setting of 400 pounds. His/her heels were resting directly on the mattress. Off-loading boots were observed on the floor next to the bureau. During an interview on 1/28/26 at 8:23 A.M., Resident #48 said that he/she has a bed that can be adjusted up and down. He/she said that right now it is a little bit on the harder side. On 1/28/26 at 9:19 A.M., the surveyor observed the Resident sleeping in bed with the head of the bed elevated. The air mattress is set to the max setting of 400 pounds. The Resident did not have off-loading boots in place, and his/her heels were resting directly on the mattress. On 1/29/26 at 6:53 A.M., the surveyor observed the Resident sleeping in bed. The air mattress was set to the max setting of 400 pounds and off- loading boots are in the same spot as previous in the room, on the floor next to the bureau. His/her heels were directly on mattress. Review of Resident #48's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation, dated 12/1/25, indicated a risk score of 16, indicating that the Resident is at risk for skin breakdown and the development of pressure ulcers. Review of the medical record indicated that the Resident previously had a stage 3 pressure area to the right heel, most recently documented in September 2025. Review of active physician's orders indicated the following: -Pressure Reduction Services: Air mattress set to 160lb, dated 6/13/25. -Prevalon Boot to bilateral lower extremities while in bed, dated 7/3/25. -Cleanse right heel with wound cleaner, pat dry and apply skin prep, dated 9/26/25. Review of the active skin care plan indicated the following, updated 12/3/25: -[Resident] is at risk for skin breakdown D/T (due to) DX (diagnosis) Bullous Pemphigoid, frail fragile skin, and limited mobility. -Interventions in the care plan included air mattress in place, set to 160lb (pounds), and Prevalon boots to BLE (bilateral lower extremities) while in bed. Review of the medical record indicated the Resident's most recent weight was obtained on 7/22/25 and was 142.6 pounds. During an interview on 1/29/26 at 7:00 A.M., Certified Nurse Aide (CNA) #2 said that she just worked the overnight shift and was assigned to Resident #48. She said that Resident #48 does not refuse any care. CNA #2 further said that she is not aware of any history of skin breakdown for the Resident, but (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that at the current time she does not have any skin issues. CNA #2 and the surveyor observed the mattress setting and the sticker on the mattress pump that indicated to be set at 160 lbs. She said that she would need to follow up with the nurse for the proper setting but that right now it was on the max setting of 400 lbs. She further said that the Resident did not have any off-loading boots in place and did not have them on for the duration of her shift because she did not know that the Resident had orders for them while in bed. During an interview on 1/29/26 at 7:05 A.M., Nurse #4 said that Resident #48 has a history of pressure ulcers to his/her heels and is at risk for the development of pressure ulcers. Nurse #4 said that the Resident is on an air mattress that should be set based on their weight. She said that the Resident has an order to have an air mattress set at 160 lbs. She said she is not sure what effects it could have on the Resident if it was not set to the correct setting. Nurse #4 said that the Resident also has an order for Prevalon boots to be worn while in bed to prevent further skin breakdown that should have been implemented, but they were not. She said that Resident #48 does not refuse care. During an interview on 1/29/26 at 11:47 A.M., the Director of Nurses said that she would expect that physician's orders are implemented as ordered. She said the air mattress should be on the correct setting and Prevalon boots should be applied as ordered.

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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 (#187) out of a total sample of 38 residents. Specifically, the facility failed to ensure Resident #187 was utilizing a resting hand splint as ordered and recommended by the therapy department. Findings include:Resident #187 was admitted to the facility in May 2024 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/26/25, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Further review of the MDS indicated that the resident exhibited functional limitations in range of motion to the upper extremity with impairment on one side. On 1/27/26 at 8:28 A.M., the surveyor observed Resident #187 sitting up in bed, awake. His/her left hand was in a fist, with the exception of the pointer finger and the Resident said that he/she could not straighten their fingers. There was no splint or orthotic device in place. The surveyor did not observe any orthotic devices in the room. On 1/28/26 at 7:24 A.M., the surveyor observed Resident #187 sleeping in bed. There was no left-hand splint or orthotic device in place. The Resident's hand was resting in a fist. On 1/29/26 at 7:18 A.M., the surveyor observed Resident #187 sleeping in bed. There was no left-hand splint or orthotic device in place. The Resident's hand was resting in a fist. Review of the OT Discharge summary, dated [DATE] indicated the following:-Response to Treatment: Focus of patient's POC (plan of care) has been integrating appropriate splint as well as appropriate w/c (wheelchair) modifications to increase overall comfort on unit. Patient is demonstrating ability to tolerate LUE (left upper extremity) resting hand splint for 4+ hours on unit after assist with donning and doffing process, and LUE swelling has significantly improved when compared to presentation upon evaluation.-Discharge Plans: D/C to [facilities] LTC (long term care) unit with patient continuing to utilize splint and L w/c arm tray for maximum comfort.-Long Term Goals: Splinting Time- The patient will tolerate LUE resting hand splint for 3 hours in order to decrease risk of further contractures and reduce swelling. Goal met on 10/24/24. Review of active and discontinued physician's orders failed to indicate orders for LUE hand splinting were implemented. Review of Resident #187's active range of motion care plan, dated as revised 10/7/24 indicated the following:-[The Resident] has limited physical mobility r/t (related to) Stroke, resulting in left sided hemiplegia and hemiparesis. -Interventions included: Left hand splint. Currently being trialed with OT (Occupational Therapy), updated 10/7/24. During an interview on 1/29/26 at 8:35 A.M., Unit Manager #2 said that when a Resident is on therapy services, and recommendations are made, therapy communicates the recommendations to nursing and nursing is responsible for carrying out the recommendations. Unit Manager #2 said that she remembers that therapy was working with Resident #187 on different kinds of splinting to help manage the left upper extremity. She said at this time, nothing is being implemented for the Resident. The surveyor and Unit Manager #2 reviewed the OT discharge summary recommendations, and she said she would follow up on it. During a follow up interview on 1/29/26 at 9:47 A.M., Unit Manager #2 said that she followed up regarding the Resident's hand splint and confirmed that an order was never implemented as recommended for the resting hand splint. She said that therapy trialing splints was in the care plan but that nothing definitive was ever implemented, but it should have been. During an interview on 1/29/26 at 9:54 A.M., the Director of Rehab said that at the time of Resident #187's discharge from therapy services it was recommended to use a resting hand splint to prevent a contracture of the Resident's hand. She said that when recommendations are made by the therapy department, the therapists will educate primary care takers on the recommendations, including how to apply any orthotic devices. She said that nursing staff are responsible for obtaining physician's orders, updating (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's plan of care and implementing the recommendations. She said that OT has not seen the resident for treatment since this recommendation and has not been made aware of any noncompliance or non-use of the orthotic device. On 1/29/26 at 10:07 A.M., the surveyor and the Director of Rehab observed the Resident in his/her room, no resting hand splint was in place. The Director of Rehab found a resting hand splint in one of the Resident's bureau drawers. Resident #187 said, I haven't seen that in a while. Resident #187 further said it had been well over a month since the splint was applied for use. The Director of Rehab assessed Resident #187's range of motion and said that it has not gotten worse without the use of the resting hand splint. The Director of Rehab said that the ongoing recommendation would be to continue utilizing the resting hand splint to prevent a contracture from forming. During an interview on 1/29/26 at 11:41 A.M., the Director of Nurses said that nursing should have implemented therapy recommendations as indicated in the OT discharge summary, and she does not know why they were not implemented.

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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 observations, interviews, and record review, the facility failed to provide respiratory care services in accordance with professional standards of practice for one Resident (#74) out of a total sample of 38 residents. Specifically, the facility failed to ensure oxygen tubing was changed/dated as necessary, the oxygen concentrator filter was cleaned weekly and b.) ensure oxygen therapy was implemented as ordered by the physician.Review of the facility policy titled Equipment [NAME]/Disinfection undated, indicated:d. Oxygen Concentrators: Rinse and dry the external filter weekly and PRN when visibly dusty. Wipe compressor down for soiling PRN (as needed). -Nebulizers, Aerosols/Humidifiers: Every 7 days / PRN for soiling.Resident #74 was admitted to the facility in May 2022 with diagnoses including congestive heart failure, anemia, dorsalgia (pain in the back), protein-calorie malnutrition, parkinson's disease with dyskinesia, and adult failure to thrive.Review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. The MDS further indicated the resident was dependent on staff for all activities of daily living and was receiving hospice services.Review of Resident #74's active physician's orders indicated the following:-Dated 7/9/25 Oxygen: Continuous O2 at 2LPM via nasal canula to maintain sats >90%. Every shift for SOB related to heart failure, unspecified, Parkinsons's disease with dyskinesia with fluctuations. Start Date 7/9/25-Oxygen Saturation - check at room air weekly (off O2 x 10 minutes) every day shift every Fri. Start Date: 7/11/25 7:00.On 1/27/26 at 8:32 A.M., the surveyor observed Resident #74 lying in bed receiving oxygen via nasal cannula, running at 2L (liters) per minute. The oxygen humidification bottle was undated, and the oxygen tubing was dated 1/5/25. The oxygen filter on the side of the concentrator was covered with a thick coating of dust.On 1/27/26 at 1:12 P.M., the surveyor observed Resident #74 lying in bed receiving oxygen via nasal cannula, running at 2L (liters) per minute. The oxygen humidification bottle was undated, and the oxygen tubing was dated 1/5/25. The oxygen filter on the side of the concentrator was covered with a thick coating of dust.On 1/28/26 at 8:55 A.M., the surveyor observed Unit Manager (UM) #2 walked into Resident #74's room and placed the oxygen tubing that was hanging on the side table, to Resident #74's face and turned on the oxygen concentrator. The unit manager then exited the Residents room. Resident #74 was lying in bed receiving oxygen via nasal cannula, running at 2L (liters) per minute. The oxygen humidification bottle was undated, and the oxygen tubing was dated 1/5/25. The oxygen filter on the side of the concentrator was covered with a thick coating of dust.During an interview and observation on 1/28/26 at 8:59 A.M., the surveyor and Unit Manager #2 observed Resident #74 in bed receiving oxygen via nasal cannula, running at 2L (liters) per minute. The oxygen humidification bottle was undated, and the oxygen tubing was dated 1/5/25. The oxygen filter on the side of the concentrator was covered with a thick coating of dust. Unit Manager #2 looked at the dated tubing, humidification bottle and filter and said the oxygen tubing should not be dated 1/1/25 and needs to be changed weekly, and the humidification bottle has no date and also must be changed weekly. Unti Manager #2 observed the filter and said it needs to be cleaned and replaced because it has dust built up and said it must also be cleansed weekly.Review of Resident #74's Oxygen care plan dated as revised 7/9/25, indicated: Resident has oxygen therapy r/t (related to) SOB (shortness of breath), secondary to heart failure. Interventions included:-Administer medications as ordered and monitor for effectiveness.-OXYGEN SETTINGS: O2 (oxygen)via nasal canula at 2LPM continuously.Review of Resident #74's medical record including Treatment Administration Record (TAR) and Medication Administration Record (MAR) for the month of January indicated the order for Oxygen at 2L/min via Nasal Cannula (tube that delivers oxygen through the nostrils) continuously with Humidification every shift was documented as administered daily as ordered.Further review of the medical record failed to indicate the Resident had any documented refusals or behaviors for removal of the Oxygen tubing. (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 #74's medical record failed to indicate a physician's order or care plan for the care of the oxygen tubing, humidification bottle or oxygen concentrator, was developed or implemented.During an interview on 1/29/26 at 11:57A.M., the Director of Nursing (DON) said there should be an order and care plan for the oxygen tubing, the humidification bottle, and filter cleaning and said the respiratory equipment must be changed weekly and documented.b. The facility failed to ensure oxygen therapy was implemented as ordered by the physician During an observation on 1/27/26 at 1:14 P.M., the surveyor observed Resident #74 sitting in his/her wheelchair on the 2b unit. The Resident was not receiving oxygen and there was no portable oxygen tank attached to Resident #74's wheelchair. The surveyor made the following observations on 1/28/26: -At 7:36A.M., Resident #74 was observed lying in bed. Resident #74 was not receiving oxygen therapy and was on room air. The oxygen concentrator was off, and the oxygen tubing was placed on the table next to the bed. -At 7:47 A.M., a Certified Nursing Assistant was observed walking into Resident #74's room and closed the privacy curtain to provide care and then walked out of the room. The oxygen concentrator was off, and the oxygen tubing was placed on the table next to the bed. -At 8:51 A.M., Resident #74 was observed lying in bed. Resident #74 was not receiving oxygen therapy and was on room air. The oxygen concentrator was off, and the oxygen tubing was placed on the table next to the bed. -At 8:55 A.M., the surveyor observed Unit Manager (UM) #2 walk into Resident #74's room and placed the oxygen nasal canula tubing to Resident #74's face. Unti Manager #2 turned on the oxygen concentrator to 2L and then exited the Residents room.During an interview on 1/28/26 at 8:59 A.M., Unit Manager #2 said Resident #74 requires oxygen via n/c at 2L continuously and should not be on room air. Unit Manager #2 said physician orders for oxygen must be followed. During an observation on 1/28/26 at 11:32 A.M., Resident #74 was observed lying in bed. Resident #74 was not receiving oxygen therapy and was on room air. The oxygen concentrator was off, and the oxygen tubing was placed on the table next to the bed. During an interview on 1/28/26 at 11:30 A.M., Nurse #7 said Resident #74 has an order for oxygen therapy and said the Resident should not be without it. Nurse #7 then placed a pulse oximeter to Resident #74's finger, and his/her oxygen saturation was 91% on room and went up to 96%. Nurse #7 said physician orders must be followed. During an interview on 1/29/26 at 11:57A.M., the Director of Nursing (DON) said Resident #74 has an order in place for oxygen therapy and said he/she should be receiving oxygen continuously at 2L per min and said staff should not leave the resident in the room or in the hall without the use of oxygen.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide necessary behavioral healthcare services for one Resident (#68) out of a sample of 38 Residents. Specifically, the facility failed to timely approve or deny psychiatric recommendations.Findings include: Review of the facility policy titled ?Behavioral Health Services' with no revision date indicated the following:-It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and wellbeing.Resident #68 was admitted to the facility in February 2024 with diagnoses including Dementia with psychotic disturbance.Review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview Mental status (BIMS) score of 3 out of a possible 15 indicating severe cognitive impairment.Review of Resident #68's follow-up psychiatric evaluation, dated 1/23/26, indicated the following:-History of present illness-Anxiety, weepy, stealing and hiding food. [sic]-Assessment/Plan-Increase Seroquel (an antipsychotic medication used to treat psychosis) to 50 milligrams PO TID (by mouth three times a day. [sic]Further review of the medical record failed to indicate that the recommendation had been addressed.During an interview and medical record review on 1/28/26 at 9:13 A.M., Unit Manager #3 reviewed the medical record and said psychiatric recommendations should be followed up on immediately. The Unit Manager said the Physician or Nurse Practitioner should be contacted first for approval or denial, then the Health Care Proxy (HCP) is contacted for consent if the recommendation is approved by the Physician or Nurse Practitioner. The Unit Manager said any interaction with the HCP, Physician and Nurse Practitioner should be documented in the electronic health record.During a telephone interview and medical record review on 1/28/26 at 1:49 P.M., the Nurse Practitioner said she does not recall receiving a call from the facility regarding the Psychiatrist's recommendation made on 1/23/26. The Nurse Practitioner said when the Psychiatrist makes recommendations, she expects the facility to contact her immediately so she can have the time to come into the facility to meet with the Resident and approve or deny the recommendation. The Nurse Practitioner said she expects the facility to contact the Health Care Proxy after she has approved the recommendation to notify them of the approval and get their consent. The Nurse Practitioner said she expects the facility to document these interactions in the progress notes.During an interview on 1/29/26 at 8:54 A.M., the Director of Nurses said Psychiatric recommendations should be responded to in a timely manner. The DON said this particular recommendation was missed because the Assistant Director of Nurses who manages these recommendations has been away. The DON said after the Psychiatrist makes a recommendation, the Nurses should contact the Physician or Nurse Practitioner to get an approval or denial, then contact the Health Care Proxy for consent if there is an approval made by the Physician or Nurse Practitioner.

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M I Nursing & Restorative Center	172 Lawrence Street Lawrence, MA 01841

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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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on record review and interviews, the facility failed to ensure that recommended specialist appointments were scheduled for one Resident (#14) out of a total sample of 38 residents. Specifically, the facility failed to follow up with Resident #14's cardiologist to schedule a pacemaker check as indicated in physician's orders.Findings include:Resident #14 was admitted to the facility in November 2025 with diagnoses that included paroxysmal atrial fibrillation and presence of cardiac pacemaker. Review of Resident #14's most recent Minimum Data Set (MDS) Assessment, dated 11/16/25, indicated a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. Review of physician's orders indicated the following: Please change reason for Jardiance to CHF, not afib (atrial fibrillation). Please schedule pacemaker checks per cardiology recommendations [with resident's cardiologist], dated 11/12/25. Review of the Physician/ Provider visit note dated 11/13/25 indicated the following: Clinical Notes: He/she has a pacemaker. Cardiologist is [cardiologist named]. Will arrange pacemaker checks as recommended. Further review of progress notes since admission to the facility failed to indicate that staff had scheduled an appointment for the Resident to be seen by cardiology for a pacemaker check. Review of the unit's appointment book failed to indicate any upcoming or previous appointments for Resident #14. During an interview on 1/29/26 at 1:39 P.M., Unit Manager #4 said that no appointment had been scheduled for Resident #14 to have a pacemaker check as indicated in the physician's orders, so staff are following up now.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviewed and interviews the facility failed to maintain complete and accurate medical records for two Residents (#74 and #14) out of a total sample of 38 residents. Specifically, 1.For Resident #74 the facility failed to accurately document the application of Geri-Sleeves to bilateral arms as ordered by the physician. 2.For Resident #14 the facility failed to accurately document the location of a wander guard device (part of a system to ensure the safety of residents who are at risk for elopement). Findings include:Review of the facility policy titled Documentation in Medical Record, dated as revised 2025, indicated but was not limited to the following: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 4a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented. 4b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. 1.Resident #74 was admitted to the facility in May 2022 with diagnoses including congestive heart failure, anemia (low red blood cells, dorsalgia (pain in the back), protein-calorie malnutrition, parkinson's disease with dyskinesia (involuntary muscle movements), and adult failure to thrive. Review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. The MDS further indicated the Resident was dependent on staff for all activities of daily living. Review of Resident #74's Active Physician orders indicated the following: -Geri-Sleeves (protective covering for skin) to bilateral arms every day shift for skin integrity. Dated 7/10/25. -Doff (remove) geri sleeves every evening shift. Dated 7/09/25. On 1/27/26 at 8:59 A.M., the surveyor observed the Resident sleeping in his/her bed. The Resident was not wearing Geri-sleeves. On 1/27/26 at 1:12 P.M., the surveyor observed the Resident sleeping in his/her bed. The Resident was not wearing Geri-sleeves. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/26 at 8:55 A.M., the surveyor observed the Resident sleeping in his/her bed. The Resident was not wearing Geri-sleeves. Review of the January 2026 Treatment Administration Record indicated the Geri-sleeves to bilateral arms was documented as in place, 1/27/26 through 1/28/26. During an interview on 1/28/26 at 11:39 P.M., Nurse #7 said Resident #74 has an order for Geri-Sleeves and said she didn't realize he/she didn't have them on and said the order should not be signed off if the Resident is not wearing them. During an interview on 1/28/26 at 12:31 P.M., Unit Manager #2 said staff should not sign off that the Geri-sleeves were put on when they were not. During an interview on 1/29/26 at 11:51 A.M., the Director of Nurses said that staff should not sign off that the Geri-sleeves were put on the resident's arms when they were not. 2. Resident #14 was admitted to the facility in November 2025 with diagnoses that included dementia and anxiety disorder. Review of Resident #14's most recent Minimum Data Set (MDS) Assessment, dated 11/16/25, indicated a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. The MDS failed to indicate that wandering was a behavior exhibited by the Resident. Review of active Physician's orders as of 1/28/26 indicated the following: -Wander guard on right ankle, check placement evert shift. Expire date: 9/2026, dated 1/3/26. -Wander guard- check function evert week, every Wednesday, dated 1/7/26. On 1/27/26 at 8:59 A.M., the surveyor observed the Resident sleeping in his/her recliner chair in their room. The surveyor observed slipper socks on his/her feet. There was no wander guard to the right ankle observed by the surveyor. On 1/27/26 at 12:42 P.M., the surveyor observed the Resident sitting in his/her recliner chair, there was no wander guard on the Resident's ankle. On 1/28/26 at 8:19 A.M., the surveyor observed the Resident sitting on the side of the bed. The Resident is wearing elastic compression stockings and there was no wander guard observed to the right ankle. Review of the progress note, dated 1/3/26, indicated the following: Supervisor notified writer that pt. (patient) hand been noted attempting elopement and made it downstairs via the elevator. Pt. did not leave building. Pt. was helped back to [his/her] room. Supervisor attempted to place a wander guard on pt. but [he/she] was refusing. Dtr (daughter) came in and helped with encouraging pt. to accept the wander guard, which was placed on right ankle. Message left for NP (Nurse Practitioner). Safety maintained. [sic] Review of the progress note, dated 1/17/26 indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wander guard on right ankle, check for placement evert shift. EXP date: 9/2026 evert shift- no wander guard observed, supervisor notified. Review of Resident #14's active care plan indicated the following, initiated on 1/5/26: -The Resident is at risk for wandering/ Elopement related to impaired cognitive function/ dementia. -Interventions included: Alarm/ device: wander guard on right ankle. Review of the January 2026 Treatment Administration Record indicated that the wander guard was in place, on the right ankle from 1/3/26 through 1/28/26, with the exception of one shift on 1/17/26. During an interview on 1/28/26 at 12:26 P.M., Nurse #4 said that a few weeks ago the Resident had increased swelling to the right ankle and the wander guard was moved from the ankle to the walker. She said that nursing should not sign off that it is in place to the right ankle when it is not. During an interview on 1/28/26 at 12:41 P.M., Unit Manager #2 said that it should be accurately documented where the Resident's wander guard is located. She said staff should not sign off that a wander guard is in place to the right ankle when it is not. She said it is important to know where a wander guard is located on a resident due to risk of elopement. During an interview on 1/29/26 at 11:45 A.M., the Director of Nurses said that staff should not sign off that the wander guard was on the resident's ankle when it was not. She said that the order should be updated to indicate the actual placement of the wander guard.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed, the facility failed to ensure coordination of hospice care and services in accordance with a written agreement with a Medicare-certified hospice provider for one Resident (#74) out of a total sample of 38 residents. Specifically, the facility failed to ensure a current hospice plan of care was present in the Resident's medical record and failed to notify and consult with the hospice provider regarding significant changes in the Resident's physical condition.Findings include: Review of the facility policy titled Basics of Hospice Care in Long-Term Care, undated, indicated but was not limited to: Goal- To provide comfort and symptom management to enhance the patients and family's quality of life. -Care Team: Includes physicians, nurses, social workers, certifies [SIC] nurse aids, medical providers, spiritual counselors from both the long-term facility as well as the hospice agency, and the patients' family, all collaborating as a team.Resident #74 was admitted to the facility in May 2022 with diagnoses including congestive heart failure, anemia (low red blood cells), dorsalgia (pain in the back), protein-calorie malnutrition, Parkinson's Disease with dyskinesia (involuntary muscle movements), and adult failure to thrive. Review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. The MDS further indicated the resident was dependent on staff for all activities of daily living and was receiving hospice services.Review of Resident #74's medical record indicated a physician's order dated 12/8/25: May have hospice eval (evaluation) and admit. Review of Resident #74's Hospice Care Plan dated 12/15/25, indicated, Resident has a terminal prognosis, and has been admitted to hospice services with [NAME] Hospice as of 12/12/25.-Consult with physician and Social Services to have Hospice care for resident in the facility.-Encourage resident to express feelings, listen with non-judgmental acceptance, compassion.-Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free.-Keep lighting low and familiar objects near.-Work cooperatively with hospice team to ensure the resident's spiritual, emotional intellectual, physical and social needs are met.-Work with nursing staff.During an interview on 1/28/26 at 12:19 P.M., Unit Secretary #1 said the facility does not have a hospice binder for Resident #74 and said there may be progress notes in the Residents chart. Review of the medical record failed to indicate the hospice agency's plan of care was available to the staff at the facility.Review of Resident #74's Hospice Documentation Log dated 1/11/26, indicated Staff requesting air mattress multiple red raised lesions lower back. Staff using hydrocortisone cream. During an interview on 1/28/26 at 12:25 P.M., Hospice Nurse #1 who was visiting Resident #74, said she was unable to locate the hospice binder for Resident #74 and said usually there is a Hospice binder in place with the plan of care and service schedule. Hospice Nurse #1 said she was unaware of any skin integrity issues for Resident #74 and said there are no documented skin issues reported or documented in Resident #74's hospice record and said she would expect to be notified of any changes in condition including skin concerns and treatment updates.During an interview on 1/28/26 at 12:31 P.M., Unit Manager #2 and the surveyor reviewed the medical record and one form indicated PLAN OF CARE AND CTI (Certificate of Terminal Illness) ARE PENDING. The medical record failed to include a hospice plan of care. Unit Manager #2 said Resident #74 does not have any additional information related to a hospice plan of care or schedule of aids that provide him/her care one hour per day. Unit Manager #2 said skin issues must be reported to the physician and hospice team and said Resident #74 has had a decline and has opened skin areas including a new Stage 2 Pressure Injury and should have an air mattress in place. Unit Manager #2 said she would expect the recommendation for the air mattress on 1/11/26 to be communicated to the hospice team and followed up on but it was not. During an interview on 1/28/26 at 11:54 P.M., the Director of Nursing (DON) said hospice nurses will write the daily visit notes on a form in the Residents chart and said she has no involvement with the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordination of care or care plans with the hospice program and said the unit managers are responsible for reviewing the care plan. The DON said she does not receive any electronic communication or documents from hospice and said the plan of care should be between the hospice company and the unit managers. The DON said the facility had a hospice meeting this week and said they review the information for the residents on hospice and go over the plan of care and visit notes. When the surveyor asked the DON if she discussed resident #74 at the hospice meeting, she said she does not attend the hospice meetings and does not have any involvement with them. During an interview on 1/30/26 at 2:46 P.M Social Worker (SW) #1 said she usually helps with the coordination of hospice services and knew Resident #74 was admitted to Hospice in December and said she did not have any involvement with the coordination of hospice services for Resident #74 and said he/she may have been missed. SW # 1 said she did not attend the recent hospice meeting. SW #1 said residents placed on hospice must have a care plan and service contract in place and available to staff on the units. The facility did not have any additional Hospice information or documents available as requested throughout the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interview the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically,1.On the 3A Rehab Unit, the facility failed to ensure the shared vitals machine was disinfected after each resident. 2. On the 2B Unit, staff failed to maintain infection control practices around the disposal of soiled linen. Findings include:Review of facility policy titled Infection Prevention and Control Program, undated, indicated the following: -This facility has established and maintains 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 asper acceptable national standards and guidelines. -10. Equipment Protocol: all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. -12. Linens: soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the ball shall be closed and securely placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. 1. On 1/27/26 from 8:02 A.M. to 8:16 A.M., the surveyor observed Nurse #2 obtain blood pressures on four different residents in three different rooms on the 3A Rehab Unit without disinfecting the shared blood pressure machine in between residents. The surveyor observed the shared vitals machine which did not have any disinfecting wipes in the basket of the machine. During an interview on 1/29/26 at 8:21 A.M., Nurse #3 said it is a must to clean the shared vitals machine including the blood pressure cuff after each resident use to prevent the risk of infection. During an interview on 1/29/26 at 8:24 A.M., Unit Manager #1 said every nurse needs to disinfect the shared vitals machine including the blood pressure machine after each resident to prevent the risk of infection. During an interview on 1/29/26 at 10:24 A.M., the Director of Nurses and the Infection Preventionist said that the vitals machine should be disinfected and wiped down between every resident. The Director of Nurses said that they attached baskets to hold disinfecting wipes on the carts to streamline the process. 2. On 1/27/26 at 12:44 P.M., the surveyor observed a staff member exit a resident room on the 2B Unit carrying dirty, unbagged linen in her hand. The staff member walked across the hall to a room, opening a door to dispose the linen with her potentially contaminated hand. On 1/28/26 at 7:28 A.M., the surveyor observed a staff member assisting with care for a resident on the 2B Unit. The staff member opened the door to the resident's room twice with gloved hands, coming into the hallway and moving the dirty linen cart, with her gloved and potentially contaminated hands, to the resident's doorway to dispose of dirty linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/26 at 8:39 A.M., Unit Manager #2 said that dirty linens should be bagged when brought out of a resident's room for disposal. She also said that staff should not be coming out of a resident's room with potentially contaminated gloves on and handling the linen carts, she said these are both infection control concerns that could potentiate the spread of infection. During an interview on 1/29/26 at 10:24 A.M., the Director of Nurses and the Infection Preventionist said that staff should be bagging dirty linen when transporting it in the hallway for disposal and that staff should not be touching things in the hallway with gloved and potentially contaminated hands.