STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225176	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam South Rehab and Nursing	65 Cooper Street Agawam, MA 01001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to maintain infection control practices relative to laundry services for three units (A Wing, C Wing and D Wing) out of three total units, placing all facility residents at risk for exposure to unsanitary linens, contamination and the spread of infections. Specifically, the facility failed to maintain infection control practices relative to laundry services when: -Resident #93 and Resident #32 indicated during a resident council meeting that their clothing washed by facility laundry smelled of mildew.-Feces were observed in the washer machine with a load of linens being washed. -the chemical programming box was not set to the correct program to ensure proper sanitization of resident's linens. -Washer machine #2 which was not functioning as required and not properly spinning or draining the linens was being used for one year. -Clean mop heads were being placed wet into a bin and not hung to dry as required. -A washed lift sling that smelled of urine was hung with clean lift slings. -wet linens were left overnight in the washer machine. Findings include: Review of the facility policy titled Laundry Handling and Processing effective March 2018 and revised February 2025, indicated but was not limited to the following: -Laundry.may include bed sheets, blankets, towels, personal clothing, patient apparel, gowns, and other linens. -Employees should collect soiled linens from resident/patient rooms throughout the day. Nursing Department personnel are responsible for physically removing solids (feces and vomit) before placing linens into soiled linen barrels. -The lip of the washer door should be disinfected prior to closing and starting the cycle. This reduces the risk of clean linens contacting soil or microorganisms. -Damp textiles (linens, clothing, etc.) should not remain in machines overnight. Final loads should be timed so that all laundry is dry prior to the end of the shift. -All items should be moved from the washer to the dryer as promptly as is practicable in a manner that minimizes the risk of contamination and/or re-soiling. -To prevent fire hazards, rags and mops should never be dried in a dryer- air dry only. -Do not operate damaged or broken equipment. -Damaged or broken equipment should be marked or communicated as Out of Order or Do Not Operate in a manner than ensures others will not accidentally utilize the equipment while awaiting repairs. Review of the facility policy titled Personal Laundry Handling and Processing effective March 2018 and revised February 2025, indicated but was not limited to the following: -Providing clean personal clothing is critical for resident care and dignity. Review of the Resident Council Meeting Minutes dated 11/28/25, indicated that residents reported that their clothing smelled like mildew. Review of the personal laundry list dated 3/6/26, indicated that Resident #93 and Resident #32 had their personal laundry washed by the facility. Resident #93 was admitted to the facility in December 2023 with diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke). Review of Resident #93's Minimum Data Set (MDS) assessment dated [DATE], indicated: -was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15. -was dependent for chair/bed-to-chair transfers and toilet transfers. Resident #32 admitted to the facility in January 2025 with diagnoses including Parkinson's disease, dementia, and overactive bladder. Review of Resident #32's MDS assessment dated [DATE], indicated the Resident was moderately cognitively impaired, as evidenced by a BIMS exam score of 11 out of a possible 15. On 3/4/26 at 1:25 P.M., the surveyor observed the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	following in the facility main laundry room: -A brown solid substance (the size of a walnut) spinning around in the washer machine with the linens being washed. -Washer machine #2 was set to the heavy soil setting. The chemical programming box was set to the personals setting. During an interview at the time, the Housekeeping and Laundry Manager said that the brown solid substance spinning around in the washer machine was feces. The Housekeeping and Laundry Manager said the feces should not be in the washer machine and that she reiterated all the time at morning meetings that feces should not be mixed in with the soiled laundry. The Housekeeping and Laundry Manager said that the washing machines were programmed based on the type of load to be washed. She said the chemical programming box did not work correctly and had to be programmed to the personals setting all the time. The Housekeeping and Laundry Manager said that the process of cleaning mop heads was that the mop heads were washed by the evening shift and then removed from the washer machine the following morning. The Housekeeping and Laundry Manager said the wet mop heads were placed in a bin and were not hung to dry, and in the morning the mop heads sometimes smelled bad. During a Resident Council meeting conducted on 3/4/26 at 2:00 P.M., Resident #32 said that he/she received damp clothing that smelled moldy on more than one occasion. Resident #93 said the linens smelled of urine, including the lift slings. Resident #93 said he/she has to then sit in the lift sling that smelled of urine all day long. Resident #93 said that the facility told them that the washer machines were broken. On 3/5/26 at 7:40 A.M., the surveyor observed the following in the facility main laundry room: -The washer machine (unlabeled) was set to the heavy soils setting, and the chemical programming box was set to white sheets. Bed sheets, towels, and resident gowns were observed in the washer machine. The washer machine was running at that time. -Washer machine #2 was set to the heavy soils setting, and the chemical programming box was set to white sheets. Resident gowns, cloth under pads, and towels were observed in the washer machine. The washer machine was running at that time. On 3/6/26 at 7:05 A.M. through 7:14 A.M., the surveyor observed the following in the facility main laundry room: -A load of wet linens (towels and bed sheets) that had completed washing was sitting in the unlabeled washer machine. -Three lift slings were hanging to dry after being washed. One of the lift slings was observed with a strong smell of urine. During an interview at the time, Housekeeper #1 said the evening staff leave at 9:00 P.M. and the day shift staff arrive at 7:00 A.M. Housekeeper #1 said the load of wet linens observed in the washer machine must have been washed during the evening shift the previous day. Housekeeper #1 said the mop heads were washed by the evening shift and put in the bin while still wet. Housekeeper #1 said the mop heads did not get hung to dry. During an interview on 3/6/26 at 7:14 A.M., the Housekeeping and Laundry Manager said the lift sling smelled of urine and the load of linens observed in the washer machine were washed before the evening shift left at 9:00 P.M. the previous day. The Housekeeping and Laundry Manager said that washer machine #2 did not work on the heavy soiled or whites settings and that these settings had not worked properly for the past year, that the washer machine did not spin or drain correctly and a code indicating that the load was overfilled would alarm frequently. The Housekeeping and Laundry Manager said the facility was still using the washer machine on the heavy soiled and whites settings even though the settings did not work correctly and was setting the chemical programming box to the personals setting. She further said the heavy soil program on the washer machine was for very dirty linens, including linens from isolation rooms or rooms with other identified viruses, as well as towels. The Housekeeping and Laundry Manager said the whites setting on the washer machine was for the washing of blankets and bed sheets. The Housekeeping and Laundry Manager said the chemical programming box setting had to match the setting on the washer machine in order for the chemicals to transfer to the washer machine and when personal laundry was left in residents' rooms for days that it was hard to get the smell out. The Housekeeping and Laundry Manager said she had complaints from residents that their clothes smelled of urine or mildew. The Housekeeping and Laundry Manager said after the observation made by the surveyor on 3/4/26 of feces in the washer machine, she removed the feces, wiped down the outside of the washer machine, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and re-washed the load of linens. The Housekeeping and Laundry Manager provided no evidence that the washer machine interior was sanitized prior to re-washing the load of linens. During an interview on 3/6/26 at 8:55 A.M., the Maintenance Director said the service vendor for the washer machines was not notified about the broken settings on washer machine #2 in the past year. The Maintenance Director said the process was that the laundry staff would enter the maintenance issue into the electronic tracking system, and maintenance staff would then be responsible for contacting the vendor to fix the broken machine. During an interview on 3/6/26 at 9:43 AM, the laundry service vendor's Territory Manager said that the vendor provided both the chemicals and the equipment necessary to sanitize the linens and input the chemicals into the washer machines. The Territory Manager said to ensure that the linens were washed with the correct chemicals, the washer machine program should be set to the same setting as the chemical programming box. The Territory Manager further said that the program setting on the chemical programming box would dictate which chemicals and what amount were input into the washer machines. The Territory Manager said that the personals setting on the chemical programming box was for clothes and the personals setting did not include bleach. The Territory Manager said that the heavy soil setting would input the following chemicals: bleach, detergent, softener, and iron control. The Territory Manager said there was a difference between settings and that the heavy soil setting input more chemicals into the washer machine than the whites setting and the vendor recommended the heavy soil setting be used at all times for all healthcare facilities. The Territory Manager said that the heavy soil setting was recommended because healthcare facilities had to clean linens that contained feces, urine, and vomit. During an interview on 3/9/26 at 9:26 A.M., the Administrator said the expectation was that policies and procedures for the management of laundry were followed so residents were not affected. The Administrator said that the mop heads should be hung dry, linens should not be left in the washer machine overnight, lift slings that were still dirty should not be hanging with the clean lift slings, and feces should not be in the washer machine. The Administrator said the concern when laundry infection control practices are not followed is that residents could receive clothing that was not wearable and smelled bad, which could also be a resident dignity issue.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and interview, the facility failed to complete comprehensive assessments timely, according to the required Resident Assessment Instrument (RAI) process, for two Residents (#36 and #95) out of a total sample of 19 residents.Specifically, the facility failed to complete comprehensive assessments for Resident #36 and Resident #95 within the required 14 days of the Assessment Reference Date (ARD) date. Findings include:1. Resident #36 was admitted to the facility in November 2023 with diagnoses including chronic obstructive pulmonary disease (COPD), major depressive disorder, dementia and chronic respiratory failure with hypoxia. Review of the Annual Minimum Data Set (MDS) Assessment with an ARD of 10/23/25, indicated the assessment was completed by the facility staff on 11/11/25, five days late. 2.Resident #95 was admitted to the facility in August 2019 with diagnoses including protein malnutrition, anxiety disorder, mild cognitive impairment and a history of falling. Review of the Annual MDS Assessment with an ARD of 1/27/26, indicated the assessment was completed by the facility staff on 2/23/26, 13 days late. During an interview on 3/9/26 at 8:46 A.M., the surveyor and the MDS Nurse reviewed the most recent comprehensive MDS Assessments for Resident #36 and Resident #95. The MDS Nurse said the Annual MDS for Resident #36 with an ARD of 10/23/25 was not completed within the required 14 days as it was completed by facility staff on 11/11/25, five days after the required due date of 11/6/25. The MDS Nurse further said the Annual MDS for Resident #95 with an ARD of 1/27/26 was not completed within the required 14 days as it was completed by facility staff on 2/23/26, 13 days after the required due date of 2/1/26.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments timely, according to the required Resident Assessment Instrument (RAI) process, for four Residents (#6, #36, #70 and #95) out of a total sample of 19 residents.Specifically, the facility failed to ensure the following quarterly MDS assessments were completed no later than 14 days after the Assessment Reference Date (ARD): for Resident #6 on two occasions, (ARD 9/22/25 and ARD 12/4/25)for Resident #36, on one occasion, (ARD 1/22/26)for Resident #70, on two occasions, (ARD 10/28/25) and ARD 1/27/26) andfor Resident #95, on one occasion (ARD 10/28/25).Findings include:1.Resident #6 was admitted to the facility in June 2025 with diagnoses including chronic respiratory failure, stage 3 kidney disease, and atherosclerosis heart disease.Review of the Quarterly MDS Assessment with an ARD of 9/22/25, indicated the assessment was completed by the facility staff on 10/22/25, 16 days late.Review of the Quarterly MDS Assessment with an ARD of 12/4/25, indicated it was completed by the facility staff on 1/28/26, 41 days late. 2.Resident #36 was admitted to the facility in November 2023 with diagnoses including chronic obstructive pulmonary disease, major depressive disorder, dementia and chronic respiratory failure with hypoxia.Review of the Quarterly MDS Assessment with an ARD of 1/22/26, indicated the assessment was completed by the facility staff on 2/23/26, 18 days late. 3.Resident #70 was admitted to the facility in July 2025 with diagnoses including cerebral infarction, Type II diabetes, depression, and chronic kidney disease.Review of the Quarterly MDS Assessment with an ARD of 10/28/25, indicated the assessment was completed by the facility staff on 11/12/25, 1 day late.Review of the Quarterly MDS Assessment with an ARD of 1/27/26, indicated the assessment was completed by the facility staff on 2/23/26, 13 days late. 4.Resident #95 was admitted to the facility in August 2019 with diagnoses including protein malnutrition, anxiety disorder, mild cognitive impairment and a history of falling.Review of the Quarterly MDS Assessment with an ARD of 10/28/25, indicated the assessment was completed by the facility staff on 11/12/25, 1 day late. During an interview on 3/9/26 at 8:46 A.M., the surveyor and MDS Nurse reviewed the most recent quarterly MDS Assessments for Resident's #6, #36, #70 and #95. The MDS Nurse said the following Resident Quarterly MDS Assessments were not completed within the required 14 days:-Resident #6, MDS Assessments ARD of 9/22/25 and 12/4/25-Resident #36, MDS Assessment ARD of 1/22/26-Resident #70, MDS Assessments ARD of 10/28/25 and 1/27/26-Resident #95, MDS Assessment ARD of 1/28/25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately code Minimum Data Set (MDS) Assessments for two Residents (#21 and #6), out of a total sample of 19 Residents. Specifically, the facility failed to: 1) For Resident #21, accurately code functional limitation in Range of Motion (ROM- the extent to which a body part can be moved around) when the Resident had an impairment in ROM to one upper extremity. 2) For Resident #6, accurately code the use of an anticoagulant medication (medicine that increases the time it takes for blood to clot). Findings include: 1. Resident #21 was admitted to the facility in December 2023 with diagnoses including osteoarthritis and osteoporosis. Review of the Resident's Occupational Therapy Discharge Summary with dates of service 10/29/24 - 2/9/26, indicated that Resident #21 had a goal to tolerate the most appropriate left hand WHFO (Wrist Hand Finger Orthosis - used to support injured or weak joints affected by stiffness or contractures) to support decreased risk for further contracture. Review of the Resident's MDS Assessments dated 12/9/25, 9/9/25, and 6/10/25, indicated that the Resident did not have a functional limitation in ROM to the upper extremities. During an interview on 3/4/26 at 12:40 P.M., Occupational Therapist (OT) #1 said in October 2024, Resident #21 was started on therapy services to address increased flexion and contracture of the left hand and wrist. OT #1 said the Resident was discharged from therapy services on 2/9/26 with a recommendation for a left-hand palm guard. During an interview on 3/10/26 at 8:53 A.M., MDS Nurse #1 said Resident #21's MDS Assessments with dates 12/9/25, 9/9/25, and 6/10/25, should have been coded to include a functional limitation in Range of Motion for one upper extremity but was not coded. 2. Resident #6 was admitted to the facility in June 2025 with diagnoses including chronic respiratory failure, stage 3 kidney disease, and atherosclerosis heart disease. Review of the most recent MDS assessment dated [DATE] indicated Resident #6 was receiving an anticoagulant medication during the seven-day look back assessment period. Review of the January 2026 Physician orders did not indicate that Resident #6 was prescribed an anticoagulant medication. During an interview on 3/9/26 at 8:46 A.M., MDS Nurse #1 reviewed Resident #6's Physician orders for January 2026 and said the Resident was not on an anticoagulant medication during the assessment period and this was marked in error.

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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 observations, interviews, and record review, the facility failed to ensure that Physician's orders were implemented in accordance with professional standards of practice for two Residents (#17 and #28), out of a total sample of 19 residents.Specifically, 1.For Resident #17, the facility failed to ensure the Wound Provider recommendations from January 2026 were implemented timely for the Resident's right heel and right superior ankle wounds, that new treatment recommendations were implemented in February 2026 for both right heel and right superior ankle wounds, and Physician orders were obtained for the Resident's right heel wound in March 2026, putting him/her at risk of decline in status of the wound and delayed wound healing.2.For Resident #28, the facility failed to ensure: -Physician orders were in place for a bowel regimen, when the Physician recommended initiating a bowel protocol, -Physician orders were in place prior to administering a suppository, and -Documentation was completed relative to bowel regimen interventions, when Resident #28 had complaints of constipation increasing the potential risk of discomfort and bowel obstruction. Findings include: 1. Resident #17 was admitted to the facility in December 2025 with diagnoses including osteomyelitis of right ankle/foot, Type II Diabetes, Peripheral Vascular Disease (PVD), and non-pressure chronic ulcer of the right heel and mid-foot.ˆ ˆ Review of the facility policy titled Skin Prevention, Assessment and Treatment, revised 10/24/25, indicated: -Purpose: > To promote a systemic approach and monitoring process for the care of residents with existing wounds and for those at risk for skin breakdown. > To promote healing of existing pressure ulcers. -Procedure: >Any skin impairments, including pressure ulcers, non-pressure ulcer wounds, surgical wounds, skin tears, abrasions . should be assessed and documented weekly by the Wound Nurse, or designee, in the medical record. >Interventions for prevention or active skin alterations may include but are not limited to: Wound Consultant review . >The goals of wound treatment are to promote healing . >Residents with wounds should be reviewed during weekly Risk Management Committee meetings for progress, interventions, and care plan revisions as appropriate. >The Risk Management Committee should also monitor to assure the facility's policies and protocols are followed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	^ On 3/3/26 at 11:11 A.M., the surveyor observed Resident #17 awake and lying in bed. During an interview at the time, Resident #17 said he/she had a wound on the right foot which started prior to admission. Resident #17 said the facility's Wound Provider followed him/her for the wound.^^ ^ Review of the Minimum Data Set (MDS) Assessment, dated 12/13/25, indicated Resident #17: -Was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15 points. -Had range of motion impairment of his/her lower extremity on one side. -Had a diabetic ulcer and infection of the foot. -Had dressings to the feet. ^ Review of Resident #17's clinical record included the following: -Wound Assessment Reports, completed by the Wound Provider on 1/15/26 and on 1/22/26 indicated: >Right heel arterial wound: Recommend the following treatment: cleanse wound with 0.125% (1/4 strength) Dakin's solution, apply collagen particles, Alginate with silver and cover with a dry clean dressing daily and as needed (PRN) for soiling, saturation, or accidental removal. ^ -January 2026 Treatment Administration Record (TAR) indicated: >Right heel wound: cleanse with wound cleanser, pat dry. Apply collagen particles, Alginate with silver, cover with a dry clean dressing daily and PRN, initiated 1/23/26 (eight days after the recommendation was made) and was discontinued on 1/29/26. Further review of the TAR indicated the treatment orders to the right heel did not include to cleanse the wound with 0.125% Dakin's solution until 1/30/26 (15 days after the Wound Provider made the recommendation). ^ Review of Resident's #17 Wound Assessment Report, completed by the Wound Provider on 2/19/26 indicated: >Right heel arterial wound: Recommend the following treatment: Cleanse wound with 0.125% Dakin's solution, apply honey hydrogel and cover with a dry clean dressing daily and PRN . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident's right heel. ˆ On 3/4/26 at 12:38 P.M., the surveyor observed Resident #17 lying in bed and the Resident's right leg and foot were exposed and elevated on a pillow. The Resident's right foot and heel were observed to be swollen and there were no open areas on the right heel. A large rectangular bandage was observed on the outer side of the Resident's right lower leg and was dated 3/4/26.ˆ ˆ During an interview on 3/4/26 at 1:50 P.M., Nurse #1 said Resident #17 had two open areas on his/her right outer ankle, one open area was closer to the ankle, and the other open area was closer to the right heel. Nurse #1 said the treatment to both areas was to cleanse the areas with wound cleanser, apply honey hydrogel and a dry clean dressing daily and as needed. Nurse #1 said there have been numerous treatments to the Resident's open areas and that the Wound Provider assesses the areas weekly on Thursdays with the Unit Manager (UM). Nurse #1 said if there were recommendations from the Wound Provider, the UM would enter the new orders into the Resident's clinical record.ˆ ˆ During an interview on 3/5/26 at 11:42 A.M., UM #1 said Resident #17 was evaluated by the Wound Provider today (3/5/26) and made new recommendations to the Resident's open wound areas. UM #1 said Resident #17 had an open area on his/her right superior ankle and the other was below the right ankle on the lateral foot. UM #1 said she would round with the Wound Provider, and any recommendations from the Wound Provider would be documented and reviewed with the Provider (Physician or Medical Practitioner). If the Wound Provider recommendations were approved, they would be entered into the Resident's Physician's orders.ˆ ˆ During an interview on 3/5/26 at 11:57 A.M., the Physician Assistant (PA) said she worked in the facility four days a week and the Wound Provider completed wound rounds in the facility weekly on Thursdays. The PA said the Wound Provider would review residents with wounds and would make recommendations for wound care. The PA said she had always approved the Wound Provider's treatment recommendations for Resident #17.ˆ ˆ On 3/5/26 at 4:13 P.M., the Director of Nursing (DON) said when the Wound Provider makes recommendations, it is expected that the facility would address those recommendations with the Provider within 24 to 48 hours.ˆ ˆ During a follow-up interview on 3/6/26 at 11:01 A.M., the DON said the Wound Provider will round with facility staff, either the UM, herself (DON) or Assistant DON. The Wound Provider would measure the resident's wounds and make recommendations for treatments which would be reviewed with the facility Provider. The DON said the facility Provider does not typically disagree with the Wound (continued on next page)

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	225176	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam South Rehab and Nursing	65 Cooper Street Agawam, MA 01001

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provider recommendations, but if they did not agree, they would enter a progress note in the resident's clinical record and enter an order for another treatment. The surveyor and the DON reviewed Resident #17's clinical record and the DON said there was no evidence that there was a treatment in place for Resident #17's right heel in March 2026 and that the Wound Provider's recommendations from 2/26/26 were not implemented. TheˆDON said if there were questions about the Wound Provider's recommendations, the facility would clarify them within 24 to 48 hours, and the clarified orders would be implemented. The DON said relative to Resident #17, the Wound Providers' recommendations were never clarified and should have been. The DON said if there were recommendations made by the Wound Provider that were not clarified and implemented, the Resident's wound condition could decline.ˆ 2. Resident #28 was admitted to the facility in February 2026 with diagnoses including aftercare following surgery for neoplasm, morbid obesity, mild intellectual disability, muscle weakness, unsteadiness on feet and diverticulosis. Review of the facility Policy titled Bowel Management Program Dietary and Nursing, revised 11/5/25, indicated: -This facility will utilize charting (nursing, Certified Nursing Assistants - CNA's, dietary) to monitor bowel function to identify cause factors that place the individual at risk for constipation. -Nursing will contact residents' provider for bowel management. Review of the facility policy titled Charting and Documentation, revised 10/25/25, indicated: -Documentation will include information on assessment, notifications, interventions and evaluation. During an interview on 3/3/26 at 11:37 A.M., Resident #28 said he/she was having issues with constipation, recently had something put up his/her rectum and that his/her rectum hurt. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #28 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of the February 2026 bowel monitoring flow sheet, titled Documentation Survey Report v2 Feb-26, indicated Resident #28 did not have a bowel movement on 2/25/26 through 2/28/26 (four days). Review of a Consulting Physician Note dated 2/27/26, indicated: -Patient reports constipation -Recommendation. initiate bowel regimen Review of the Nurses' Note dated 2/28/26, indicated the following in part: -Resident had concern of constipation but refused any bowel medication. -Resident stated he/she was given liquid yesterday. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Last documented bowel movement was 2/25/26. Review of Resident #28's February 2026 and March 2026 Physician orders did not include any bowel regimen medications. Review of Resident #28's February 2026 and March 2026 Medication Administration Record (MARs) did not indicate the Resident received any bowel regimen medications. Review of the Nurses' notes from 2/25/26 through 3/1/26, did not indicate the Resident received any bowel regimen medications. Review of the Provider Note dated 3/3/26, indicated the following: -Resident not moving bowels well -Resident had lactulose (laxative medication) yesterday without effect During an interview on 3/9/26 at 1:20 P.M., the DON said she maintained a bowel management list consisting of residents who were at high risk for constipation, and Resident #28 was not on the list. The DON said the CNA's document bowel movements on the computer and if they document no bowel movement three days in a row, it will trigger a warning message on the Nurse's dashboard. The DON said at that point the Nurse would notify the Provider and the resident would then receive lactulose or MiraLAX (medication used to treat constipation). The DON said if the lactulose or MiraLAX did not work, the Nurse would give the resident a suppository. The DON said if those two things were not effective, the Nurse would administer an enema. The surveyor and the DON reviewed the current Physician orders and all discontinued Physician orders since Resident #28's admission and the DON said there were no bowel regimen orders in place, including lactulose or MiraLAX, suppository, or an enema. The surveyor and the DON reviewed the Nurses note dated 2/28/26, and the DON said the Nurses note did indicate the Resident had concerns relative to constipation, that he/she refused bowel medications because he/she had liquid stuff yesterday. The DON further said there was no way to verify what exactly the Resident had received as there were no Physician orders in place for bowel medications nor were there any Nurses notes that indicated what medication had been administered to Resident #28. During an interview on 3/9/26 at 2:37 P.M., the DON said there should be an order for any laxative interventions and there was not. The DON also said if Resident #28 did receive medication she would have expected to see a new Physician's order, a Nurses Note, as well results of said medication and its efficacy. The DON said she would research this concern for Resident #28 to see how the Nurse became aware that the Resident was experiencing constipation and what medication was then administered. During a follow-up interview on 3/9/26 at 3:24 P.M., the DON said she spoke with the Nurse who administered the suppository and learned that the Nurse had not given any liquid to Resident #28 to address the constipation but rather administered a suppository. The DON said the Nurse administered a suppository with no Physician order. The DON further said the Nurse did not follow the facility bowel protocol by first utilizing lactulose or MiraLAX, then a suppository. The DON said the Nurse should have obtained a Physician's order, started lactulose or MiraLAX but went directly to a suppository. The DON said if the Nurse had started with the first step in the constipation protocol maybe such an invasive step such as a suppository could have been avoided. The DON said not only (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did the Nurse not follow the bowel protocol, but she also administered a medication without an order and did not document this information. During an interview 3/10/26 at 10:59 A.M., with the DON and Unit Manager (UM) #1, the DON said Resident #28 did not have bowel regimen in place when the suppository was administered. The DON said the risk of the Resident not moving his/her bowels could be a bowel obstruction. The DON said Resident #28 had a wound vac (medical device that uses negative pressure therapy to promote wound healing by applying controlled suction to the wound site) in place for recent surgery, and the risk of constipation could also cause the wound to dehiscence (a surgical complication where a closed incision reopens, exposing internal tissues and potentially leading to serious health risks). The DON said if there was a recommendation made from a Consult, it would be the expectation that the order would be reviewed and initiated within 24 hours. The DON also said that the facility had an admission order set in place for bowel protocol and for Resident #28, there were no Physician's orders for bowels medications to be administered and there should have been. During an interview on 3/10/26 at 11:46 A.M., the Physician Assistant (PA) said when residents are admitted to the facility, there is a standard procedure bowel regimen which included scheduled Colace (over-the-counter stool softener) and Lactulose as needed (PRN). The PA further said there is also PRN suppository as a part of the standard bowel regimen, if oral medication medications do not work. The PA said she was notified by the nursing staff that Resident #28 had complaints of constipation last week and usually the facility staff would administer Lactulose, if that didn't work, then they would do MiraLAX, if that did not work, they would use a suppository, if the suppository was not effective, they would then use an enema. The PA said she believed the Resident was given Lactulose after the staff notified her. The PA said she had not been notified of any additional concerns since the first notification. The PA said the nursing staff are not always consistent with documentation, so she makes sure to follow up with the residents when she is in the facility. The surveyor reviewed Resident #28's concerns with the PA, and the PA said the Resident should have had the bowel regimen in place. The PA said she would have expected to be notified that the Resident continued to have complaints of constipation. The PA said if she was going to assess a patient for constipation and medications received, she would refer to the MAR, and it was her expectation that any medications administered would have orders.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews and record reviewed, the facility failed to ensure resident meals were palatable and at appetizing temperatures on two (Units A and C), out of two units observed. Specifically, the facility failed to ensure that food served to the residents on Unit A and Unit C was attractive, palatable and hot foods were maintained at/above 135 degrees Fahrenheit (F) when served. Findings include: Review of the facility policy titled Food Preparation, revised February 2025, included the following:-The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F, or per state regulation. Review of the Food and Nutritional Services Meal Assessment Form, reviewed 10/6/13, included the following serving minimum temperatures at point of service:-Entree 135 degrees F-Starch 135 degrees F-Hot beverage 135 degrees F During the initial pool process on 3/3/26 from 7:30 A.M. through 2:30 P.M., facility residents relayed the following concerns to the survey team:-Food was awful, rice was too hard, portions of egg are small, bread was not toasted.-Hot items on meal trays were not hot.-Concerns have been addressed with Head Chef and nothing changes.-Preferences are not honored.-Alternates to meals include grilled cheese sandwiches and the cheese was not always melted or a peanut butter and jelly sandwich with too much jelly.-Food was bland and there was not enough seasoning.-Food was too cooked, alternate foods are usually cold sandwiches which he/she doesn't like. On 3/4/26 at 7:15 A.M., the surveyor requested test trays from the Food Service Director (FSD) with a calibrated thermometer sent to Units C and A as the last trays on the last meal carts. On 3/4/26 from 8:08 A.M through 8:29 A.M., the surveyor observed the following on Unit C:-8:08 A.M., the meal cart arrived on the Unit.-8:10 A.M., several staff began to distribute breakfast meals to residents in their rooms. -8:25 A.M., Resident #17 was observed with his/her breakfast tray. The Resident had an untoasted slice of white bread cut in half on his/her plate. The tray also contained a covered bowl of oatmeal, an unopened container of apple sauce, unopened container of milk, and 4 ounces (oz) of cranberry juice. During an interview at the time, Resident #17 said he/she was not eating breakfast today and he/she did not like the breakfast items served.-8:32 A.M., the test tray was obtained, and the surveyor completed a test tray with Unit Manager (UM) #1, the Director of Nursing (DON) and the Administrator, and obtained the following temperatures:>Square Casserole Bake: 108 degrees F, not palatable to taste and temperature.>Coffee: 102 degrees F, not palatable to taste.>untoasted slice of white bread cut in half: not palatable in appearance or taste.During an interview at the time, the DON said the untoasted slice of white bread was served for residents on a modified texture diet. On 3/4/26 at 8:23 A.M. through 8:42 A.M., the surveyor observed the following on Unit A:-8:23 A.M., the meal cart arrived on the Unit.-8:24 A.M., several staff began to distribute breakfast meal trays.-8:42 A.M., last resident meal tray was served, and the surveyor completed a test tray with Nurse #5 and the Administrator, and obtained the following temperatures:>Oatmeal: 124.2 degrees F, very bland and watery, not palatable to taste. >Coffee: 110.0 degrees F, not hot, not palatable to temperature.>Square casserole bake (egg, bread and cheese bake): 125 degrees F, surveyor was unable to tell what the food item was, tasted bland and was not palatable to taste or temperature.During interviews at the time, Nurse #5 said the square casserole bake did not have taste and she did not like the oatmeal. The Administrator said the square casserole bake and oatmeal were bland. During an interview on 3/6/26 at 10:15 A.M., the FSD said the facility started a new menu and resident meal ticket system in February 2026. The surveyor and the FSD reviewed the results of the test trays completed on Unit A and C on 3/4/26, and the concerns related to the temperatures obtained and palatability of the food/beverage items served/tasted. The FSD said the goal for the hot food/beverage items was 135 degrees F and the temperatures obtained did not meet that goal.