STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225185	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Gardens Health and Rehabilitation Center	2045 Grand Army Highway Swansea, MA 02777

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225185	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Gardens Health and Rehabilitation Center	2045 Grand Army Highway Swansea, MA 02777

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had an activated Health Care Proxy (HCP), the Facility failed to ensure nursing staff notified his/her Health Care Agent (HCA), that he/she had changes in his/her condition which also included the need for new Physician's orders. Findings include:Review of the Facility's Policy titled Change in a Resident's Condition or Status, dated May 2023, indicated the following:-our facility shall promptly notify the resident's representative of change in the resident's medical/mental condition and/or status.-the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.During an interview on 09/09/25 at 10:42 A.M., Family Member #1 (who was Resident #1's HCA) said Resident #1 was re-admitted to the facility on [DATE], after a hospitalization. Family Member #1 said she called the facility on 07/04/25 to see how Resident #1 was doing and said she was told everything was fine, that he/she was doing okay. Family Member #1 said she was not notified by nursing that he/she required a diet change or that Resident #1 had a blister on his/her right heel.Family Member #1 said she also found out that Resident #1 had a vasovagal episode on 07/23/25 while working with therapy, that he/she became unresponsive for a period of time and said the facility had also not notified her of that event.Family Member #1 said it was not until after she had requested and reviewed a copy of Resident #1's medical record (sometime around the end of July 2025), that she became aware the incidents or/and changes that had occurred.Resident #1 was admitted to the Facility in January 2024, diagnoses included Dementia, bipolar disorder, type II diabetes mellitus, Parkinson's disease, hypertension, and hyperlipidemia (high cholesterol).Review of Resident #1's Documentation of Resident Incapacity Pursuant to Massachusetts Health Care Proxy Act, dated 02/01/24, indicated that Resident #1's Health Care Proxy (HCP) was permanently invoked.Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 04/24/25, indicated that he/she had moderate impaired cognition.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated that Resident #1 was evaluated by Speech Pathology, he/she was determined to be at risk for aspiration (inhalation of food, fluid or other foreign material into the lungs) and received a Dysphagia (difficulty swallowing foods or liquids) Carbohydrate (CHO) Consistent soft/easy to chew with thin liquids diet during his/her hospitalization. The Summary indicated that Resident #1's discharge diet instructions were for a Dysphagia Carbohydrate Consistent 1600-2000 calories (60-75 grams (g) CHO), soft/easy to chew with thin liquids.Review of Resident #1's Nurse Progress Note, dated 07/04/25 (written by Nurse #1), indicated that Resident had an empty fluid blister on his/her right heel, orders were confirmed with the Nurse Practitioner who gave a new order for skin prep three times a day and to offload his/her right heel on pillow while in bed. Review of Resident #1's medical record indicated there was no documentation to support his/her HCA was notified.During an interview on 09/10/25 at 2:23 P.M., Nurse #1 said she worked the 7:00 A.M. to 3:00 P.M. shift on 07/04/25, was assigned to Resident #1 and he/she had returned from the hospital that afternoon. Nurse #1 said she reviewed Resident #1's Hospital Discharge paperwork including all medication, treatments and diet orders. Nurse #1 said she was not aware that Resident #1 had a new order for a Dysphagia diet and thought she had reviewed all his/her orders but must have overlooked the new diet order.However, review of Resident #1's Diet Requisition Form indicated it was not completed until 07/07/25 and included that he/she was a re-admission with a diet change. The Form indicated the diet order was for a Dysphagia Advanced texture diet.Nurse #1 also said upon Resident #1's return to the facility that day, he/she had a fluid blister on his/her right heel, and the NP gave an order for skin prep and to offload his/her right heel on a pillow while in bed. Nurse #1 said she did not notify Resident #1's HCA of his/her return from the hospital, or that he/she had a new treatment order to his/her right heel and said she should have.Review of Resident #1's Nurse Progress Note, dated 07/23/25 (written by Former Unit Manager), indicated that Resident #1 became unresponsive to verbal and tactile stimuli while with Rehabilitation. The Note indicated that he/she was put into bed, his/her vitals and blood sugar were taken, legs were elevated, and he/she became responsive to tactile stimuli. The Note further indicated that the NP was notified and ordered STAT (immediately) bloodwork, a urinalysis (UA) and a culture and sensitivity (C&S).Review of Resident #1's Physician Progress Note, dated 07/24/25, indicated that Resident #1 was evaluated after an episode of unresponsiveness, likely vasovagal in origin.During an interview on 09/15/25 at 4:48 P.M., the Former Unit Manager said Resident #1 became unresponsive while working with therapy (could not recall exact date) and she notified the NP and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225185	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Gardens Health and Rehabilitation Center	2045 Grand Army Highway Swansea, MA 02777

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225185	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Gardens Health and Rehabilitation Center	2045 Grand Army Highway Swansea, MA 02777

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), whose hospital discharge summary indicated he/she required an altered textured diet (dysphagia diet), the Facility failed to ensure meals prepared and served to him/her met his/her individual need, when his/her new diet orders were not transcribed by nursing, and he/she received the incorrect diet for two days. Findings Include: Review of the Facility's Policy tilted Therapeutic Diet Orders Policy, dated as reviewed/revised March 2025, indicated the following: -the facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician.-a Mechanically Altered Diet is one in which the texture or consistency of food is altered to facilitate oral intake.-all diet orders are to be communicated to the dietary department in accordance with facility procedures.-dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. Review of the Facility's Policy titled Charting and Documentation, dated May 2023, indicated the following: -all services provided to the resident to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.-documentation in the medical record will be complete and accurate.Resident #1 was admitted to the Facility in January 2024, diagnoses included Dementia, bipolar disorder, type II diabetes mellitus, Parkinson's disease, hypertension, and hyperlipidemia (high cholesterol). Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated that Resident #1 was evaluated by Speech Pathology, he/she was determined a risk for aspiration (inhalation of foods, fluids, or other foreign objects into the lungs) and received a Dysphagia (difficulty swallowing or chewing) Carbohydrate (CHO) Consistent soft/easy to chew with thin liquids diet during his/her hospitalization. The Summary indicated that Resident #1's discharge diet instructions were for a Dysphagia Carbohydrate Consistent 1600-2000 calories (60-75 grams (g) CHO), soft/easy to chew with thin liquids.Review of Resident #1's previous Physician's Orders, dated as initiated 03/31/25, indicated his/her diet orders were for a Carbohydrate Consistent Diet (CCD) Regular texture with thin liquids consistency and upon re-admission on [DATE], he/she continued to receive that same diet. Further review of the Physician orders indicated that he/she was started on a CCD Dysphagia Advanced texture diet with thin liquids on 07/07/25, three days after being re-admitted .Review of Resident #1's Nurse Progress Note, dated 07/04/25 (written by Nurse #1), indicated that Resident #1 was readmitted to the facility and the kitchen was notified to resume his/her previous diet (CCD Regular texture).During an interview on 09/10/25 at 2:23 P.M., Nurse #1 said she worked the 7:00 A.M. to 3:00 P.M. shift on 07/04/25, was assigned to Resident #1 and that he/she had returned from the hospital that afternoon. Nurse #1 said she reviewed Resident #1's Hospital Discharge paperwork including all medication, treatments and diet orders, verified all orders with the Nurse Practitioner and entered the orders into Point Click Care (PCC) computer system. Nurse #1 said she notified the kitchen to resume Resident #1's previous diet order which was a CCD Regular texture thin liquids diet. Nurse #1 said she was not aware that Resident #1 had a new order for a Dysphagia diet and thought she had reviewed all his/her orders but must have overlooked the new diet order.During an interview on 09/15/25 at 4:48 P.M., Nurse #4 said she worked the 7:00 A.M. to 3:00 P.M. shift on 07/04/25 and was assigned to Resident #1. Nurse #4 said during change of shift report the 11:00 P.M. to 7:00 A.M. Nurse told her that Resident #1 was on a modified ground diet. Nurse #4 said she did not recall that Resident #1 was on a ground diet, and said she checked Resident #1's tray and the kitchen had sent him/her a regular texture diet.Nurse #4 said she reviewed Resident #1's Hospital Discharge paperwork and saw that he/she diet was supposed to be on a Dysphagia Advanced diet. Nurse #4 said she filled out a diet requisition form for Resident #1's new textured diet order and said she gave the form to the Food Service Director and waited for Resident #1's breakfast tray with the correct diet order.However, review of Resident #1's Diet Requisition Form, which was completed and dated 07/07/25, indicated that he/she was a re-admission with a diet change. The Form indicated the diet order was for a Dysphagia Advanced texture diet.During an interview on 09/17/25 at 11:19 A.M., the Food Service Director (FSD) said on 07/07/25 she received a diet requisition form for Resident #1's new diet order for a Dysphagia Advanced diet that morning from one of the nurses. The FSD said Resident #1 received a Regular texture diet on 07/05/25 and 07/06/25 because the kitchen had not been informed of his/her new diet order until the morning of 07/07/25.During an interview on 09/16/25 at 1:42 P.M., the Former Director of Nursing (DON) said she was not aware that Resident #1 had a new diet order when he/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225185	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Gardens Health and Rehabilitation Center	2045 Grand Army Highway Swansea, MA 02777

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 records reviewed and interviews, for one of three sampled residents, (Resident #1), who had new diet order instructions, the Facility failed to ensure they maintained a complete and accurate medical record, when nursing staff failed to transcribe his/her new diet order onto Resident #1's Physician orders.Findings Include:Review of the Facility's Policy titled Charting and Documentation, dated May 2023, indicated the following:-all services provided to the resident to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.-documentation in the medical record will be complete and accurate.Resident #1 was admitted to the Facility in January 2024, diagnoses included Dementia, bipolar disorder, type II diabetes mellitus, Parkinson's disease, hypertension, and hyperlipidemia (high cholesterol).Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated that Resident #1's discharge diet instructions were for a Dysphagia Carbohydrate Consistent 1600-2000 calories (60-75 grams (g) CHO), soft/easy to chew with thin liquids.Review of Resident #1's Physician's Orders, dated 07/04/25 through 07/07/25, indicated that he/she had orders for a Carbohydrate Consistent Diet (CCD) Regular texture with thin liquidsReview of Resident #1's Nurse Progress Note, dated 07/04/25 (written by Nurse #1), indicated that Resident #1 was readmitted to the facility and the kitchen was notified to resume his/her previous diet (CCD Regular texture).During an interview on 09/10/25 at 2:23 P.M., Nurse #1 said she worked the 7:00 A.M. to 3:00 P.M. shift on 07/04/25, was assigned to Resident #1 and that he/she had returned from the hospital that afternoon. Nurse #1 said she reviewed Resident #1's Hospital Discharge paperwork including all medication, treatments and diet orders, and said that she verified all orders with the Nurse Practitioner and entered the orders into Point Click Care (PCC) computer system. Nurse #1 said she notified the kitchen to resume Resident #1's previous diet order which was a CCD Regular texture thin liquids diet. Nurse #1 said she was not aware that Resident #1 had a new order for a Dysphagia diet and thought she had reviewed all his/her orders but must have overlooked the new diet order.During an interview on 09/16/25 at 1:42 P.M., the Former Director of Nursing (DON) said she was not aware that Resident #1 had a new diet order when he/she returned from the hospital on [DATE] and that Nurse #1 had not transcribed his/her new diet order. The Former DON said two nurses should have reviewed all of Resident #1's orders on his/her Hospital Discharge Summary to ensure that there were no errors made.During an in-person interview on 09/10/25 at 4:06 P.M and a telephone interview on 09/16/25 at 2:46 P.M., the Director of Nursing (DON) said it is her expectation that all nurses should be reviewing all orders on resident's discharge paperwork to ensure no orders are missed.