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	06/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure one Resident (#168), out of a total sample of 17 residents, was treated with respect and dignity. Specifically, the facility failed to ensure Resident #168's Foley catheter (tube inserted into the bladder to drain urine) drainage bag was consistently covered with a privacy shield and/or positioned away from the doorway. Findings include: Review of the facility's policy titled Promoting/Maintaining Resident Dignity, last revised March 2025, indicated but was not limited to: -It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality. -All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident's rights. -Maintain resident privacy. Resident #168 was admitted to the facility in May 2025 and had diagnoses including neurogenic bladder (a condition where the bladder muscles contract involuntarily, causing frequent and urgent urination). Review of the Minimum Data Set assessment, dated 6/3/25, indicated Resident #168 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15 and had an indwelling urinary catheter. Review of Physician's Orders indicated but was not limited to: -Foley catheter to drainage bag for diagnosis of neurogenic bladder, catheter size #18 French with 30 cubic centimeter (cc) balloon (6/1/25) -Foley catheter care daily as well as needed (PRN) and every shift (5/31/25) (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	06/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Empty Foley drainage bag every shift and record output, monitor urine for any abnormalities and notify MD/NP every shift for Foley output (5/31/25) On 6/17/25 at 9:01 A.M., the surveyor observed Resident #168 lying in bed watching television. A urinary catheter bag was secured to the bed frame and hanging from the side of the Resident's bed. The drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. On 6/17/25 at 9:47 A.M., the surveyor observed Resident #168 lying in bed asleep. A urinary catheter bag was secured to the bed frame and hanging from the side of the Resident's bed. The drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. On 6/23/25 at 8:07 A.M., the surveyor observed Resident #168 lying in bed asleep. A urinary catheter bag was secured to the bed frame and hanging from the side of the Resident's bed. The drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. During an observation with interview on 6/23/25 at 8:10 A.M., Unit Manager #1 and the surveyor observed Resident #168 lying in bed asleep. A urinary catheter bag was secured to the bed frame and hanging from the side of the Resident's bed. The drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. Unit Manager #1 said the Resident's catheter bag should be covered for privacy.

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	06/23/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and interviews, the facility failed to ensure the privacy and confidentiality of resident information was maintained on one of two nursing units. Specifically, the facility failed to ensure residents' private health information and Activity of Daily Living (ADL) schedule was secure and not accessible to be viewed by anyone walking by the East unit nurses' station. Findings include: Review of the facility's policy titled Promoting/Maintaining Resident Dignity, last revised March 2025, indicated but was not limited to: - Maintain resident privacy - Random observations and/or verifications are conducted by the Director of Nurses or designee to ensure compliance On 6/20/25 at 10:22 A.M., the surveyor observed a multi-page resident information flip chart open on top of the East unit desk, standing up and facing outward towards the hallways. The information that was available for review to people walking by included: four resident's names who were to be gotten up on the 11:00 P.M. to 7:00 A.M. shift and the opposite page included a list for showers and skin checks. On 6/20/25 from 10:22 A.M. to 10:47 A.M., the surveyor observed staff walking past the resident information that was in clear view at the nurses' station 20 separate times. Staff, including the Maintenance director, Maintenance assistant, Director of Nurses, Infection Preventionist, Nurse assigned to the unit, Administrator, Laundry Aide, Regional Food Service Manager, Regional Director of Operations, and Rehab staff all passed the resident specific available information without identifying that it may be a privacy concern. At 10:38 A.M., the Administrator assisted a resident in a wheelchair past the information and at 10:40 A.M., a different resident was observed to self-propel past the information. The information was observed to be available for a total of 37 minutes. During an observation with interview on 6/20/25 at 10:59 A.M., the surveyor observed the Administrator walk past the information again, at which point the surveyor stopped the Administrator and asked him about the information that was on the top of the East nurses' station facing out towards the hallway. He said it is a quick flip chart of information for the Certified Nurse Aides (CNAs) to know which residents need to get up or have showers and includes information on residents who wear splints and have any special needs. He said the flip chart was not supposed to be standing up on the outer perimeter of the nurses' station or facing the hallway and was supposed to be left behind the desk and facing inward towards the nurses' station to keep the residents' information secure. He said the manner in which the information was displayed, facing the hallway and open on the outer perimeter of the top of the nurses' station, was a potential issue for residents' privacy being violated and the flip chart should not be left where any passerby could see it.

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	06/23/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, observation, and document review, the facility failed to ensure residents/resident representatives had the right to voice and formulate grievances, have those grievances responded to promptly, and be provided a resolution to their grievance for one Resident (#51), out of a total sample of 17 residents. Specifically, the facility failed to ensure staff followed their policy and procedure when Resident #51's Health Care Proxy (HCP- healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions) notified staff that the Resident's denture (partial plate) was missing. Findings include: Review of the facility's policy titled Complaint/Grievance Policy and Procedure, dated September 2023, indicated but was not limited to: Policy: -All residents and their responsible representative will have a mechanism to voice grievances and complaints to the Grievance Official in order to facilitate communication and timely resolution of the matter. -Voiced grievances (e.g. those about treatment, care, management of funds, lost clothing, or violation of rights) are not limited to a formal, written process and may include a resident's verbalized complaint to facility staff. Procedure: -Staff shall complete a grievance form when residents or responsible representatives make verbal complaints, if not completed by the complainant. -Completed forms should be forwarded to the Grievance Official and notify the Executive Director. -The Grievance Official, or designee in his/her absence, will review the grievance within 24-48 business hours of receipt. -The Grievance Official will oversee the process, track grievances through the conclusion, lead investigations, issue written decisions to residents if requested, and coordinate with State and Federal agencies if necessary. -The Grievance Official will complete the Complaint/Grievance form and submit to the Social Service Department and Administrator (if not the Grievance Official). -The Grievance Official will complete the Grievance form to include date received, summary statement, steps taken to investigate, summary of findings, confirmation or no confirmation of grievance, corrective action taken or to be taken, and date written resolution was issued if requested. (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	06/23/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51 was admitted to the facility in August 2024 and had diagnoses including dementia. Review of the Minimum Data Set assessment, dated 4/22/25, indicated Resident #51 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of 15, was edentulous and received Hospice services. The assessment indicated Resident #51 had an activated HCP. Review of the medical record indicated a Hospice communication note, dated 6/7/25, indicating the Hospice Aide reported to the staff nurse that Resident #51 was missing his/her denture. Review of a Hospice communication note written by the Hospice Aide, dated 6/16/25, indicated Resident #51's denture was still missing. Review of the facility's grievance book failed to indicate a grievance form was completed for Resident #51's missing denture. Further review of the medical record failed to indicate any documentation regarding the Resident's denture was missing and any efforts to attempt a resolution. During an interview on 6/23/25 at 8:28 A.M., Nurse #5 said she let administration know that the Resident's denture was missing and gave the Resident's HCP a grievance form to complete. She said she is not sure if the HCP ever filled out the papers. The Nurse said she could not recall which staff member in administration she reported the missing denture to. During an interview on 6/23/25 at 9:35 A.M., Unit Manager #1 and the Social Worker reviewed Resident #51's Hospice note dated 6/7/25. The Social Worker said she did not know if a grievance form was completed when the missing denture was reported on 6/7/25. Unit Manager #1 said Resident #51's HCP called her on 6/18/25 and asked that the Resident be seen by the facility's dental provider to get a new denture. She said she faxed a request to the dentist on 6/18/25 and is still waiting to hear back when the Resident can be seen. During a telephonic interview on 6/23/25 at 11:03 A.M., Resident #51's HCP said she discovered that his/her upper denture was missing when she came to visit on 6/7/25. The HCP said she looked everywhere in the Resident's room and was unable to find it. She said staff told her the denture had been missing for a few days, and they were unable to find it either. The HCP said she told Nurse #1 on 6/7/25 that Resident #51's denture was missing and the nurse gave her a grievance form to fill out. The HCP said she did her best to fill out the grievance form and brought it into the facility the following week. She said she did not hear back from the facility and then called the Administrator and Unit Manager #1 on 6/18/25 and was told Resident #51 can be placed on a list to see the dentist the next time he comes in. (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	06/23/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/23/25 at 11:50 P.M., the Administrator said he was not aware of Resident #51's missing denture until he received a grievance form completed by his/her HCP on 6/13/25. Review of the grievance form, dated 6/13, indicated that on 6/7/25, the HCP went to get the Resident's denture from its storage cup, and it was empty. She reported the missing denture to the nurse and was told that the denture had been missing for a few days. Staff then came into the Resident's room and searched everywhere but were unable to find the denture. The Administrator said at the time when staff discovered that Resident #51's denture was missing, they should have completed a grievance form and documented the lost dentures so it could be followed through timely, but they did not.

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	06/23/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to ensure nursing staff developed and provided the resident with a summary of the baseline or comprehensive care plan within 48 hours of admission, which included the instructions needed to provide effective and person-centered care to the resident which meet professional standards of quality care for one Resident (#168), of a total sample of 17 residents. Specifically, the facility failed to ensure a baseline care plan was developed and a summary provided to the Resident for the use of an indwelling urinary catheter. Findings include: Review of the facility's policy titled, Baseline Care Plan, last revised May 2025, indicated but was not limited to: -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. -The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders. iv. Therapy services. v. Social Services. vi. PASARR recommendations, if applicable. -A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. -A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. -A supervising nurse or MDS nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided by the completion of the comprehensive care plan. -The person providing the written summary of the baseline care plan shall: (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	06/23/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Obtain a signature from the resident/representative to verify that the summary was provided. b. Make a copy of the summary for the medical record. Resident #168 was admitted to the facility in May 2025 and had diagnoses including neurogenic bladder (a condition where the bladder muscles contract involuntarily, causing frequent and urgent urination). Review of the Minimum Data Set (MDS) assessment, dated 6/3/25, indicated Resident #168 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15 and had an indwelling urinary catheter. Review of the Admission/readmission Nursing Assessment V3, dated 5/31/25, indicated Resident #168 had a urinary catheter. Review of Physician's Orders indicated but was not limited to: -Foley catheter to drainage bag for diagnosis of neurogenic bladder, catheter size #18 French with 10 cubic centimeter (cc) balloon (5/31/25, discontinued 6/1/25) -Foley catheter to drainage bag for diagnosis of neurogenic bladder, catheter size #18 French with 30 cc balloon (6/1/25) -Foley catheter care daily as well as needed (PRN) and every shift (5/31/25) -Empty Foley drainage bag every shift and record output, monitor urine for any abnormalities and notify MD/NP every shift for Foley output (5/31/25) On 6/17/25 at 9:01 A.M., the surveyor observed Resident #168 lying in bed watching television. A urinary catheter bag was secured to the bed frame and hanging from the side of the Resident's bed. Review of the entire medical record failed to indicate a baseline or comprehensive care plan for the use of an indwelling urinary catheter was developed within 48 hours of Resident #168's admission. During an interview on 6/23/25 at 2:25 P.M., Resident #168 said he/she was admitted to the facility with a urinary catheter. The Resident said he/she was not provided with or asked to sign a summary of a baseline care plan. During an interview on 6/23/25 at 2:30 P.M., Consulting Staff #3 said she is covering for the MDS Coordinator while she is on vacation this week. She said the MDS Coordinator is responsible for completion of MDS assessments and care plan development for triggered care areas, but nursing staff can also develop care plans. Consulting Staff #3 reviewed Resident #168's MDS assessment, dated 6/3/25, and the entire medical record and said the MDS triggered a care area for urinary catheter and a baseline or comprehensive care plan should have been developed within 48 hours but it was not.

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	06/23/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop, implement and individualize comprehensive care plans for one Resident (#168), out of a total sample of 17 residents. Specifically, the facility failed to ensure a comprehensive care plan was developed to address the Resident's indwelling catheter. Findings include: Review of the facility's policy titled Comprehensive Care Plans, revised May 2025, included but was not limited to: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. -The comprehensive care plan will be developed within 7 days after the completion of the comprehensive Minimum Data Set (MDS) assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. -The comprehensive care plan will describe, at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident #168 was admitted to the facility in May 2025 and had diagnoses including uninhibited neurogenic bladder (a condition where the bladder muscles contract involuntarily, causing frequent and urgent urination). Review of the comprehensive MDS assessment, dated 6/3/25, indicated Resident #168 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15 and had an indwelling urinary catheter. Review of the Admission/readmission Nursing Assessment V3, dated 5/31/25, indicated Resident #168 had a urinary catheter. Review of Physician's Orders indicated but was not limited to: -Foley catheter to drainage bag for diagnosis of neurogenic bladder, catheter size #18 French with 10 cubic centimeter (cc) balloon (5/31/25, discontinued 6/1/25) -Foley catheter to drainage bag for diagnosis of neurogenic bladder, catheter size #18 French with 30 cc balloon (6/1/25) -Foley catheter care daily as well as needed (PRN) and every shift (5/31/25) (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	06/23/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Empty Foley drainage bag every shift and record output, monitor urine for any abnormalities and notify MD/NP every shift for Foley output (5/31/25) On 6/17/25 at 9:01 A.M., the surveyor observed Resident #168 lying in bed watching television. A urinary catheter bag was secured to the bed frame and hanging from the side of the Resident's bed. Review of comprehensive care plans failed to indicate a care plan had been developed to address the Resident's use of an indwelling urinary catheter. During an interview on 6/23/25 at 2:30 P.M., Consulting Staff #3 said she is covering for the MDS Coordinator while she is on vacation this week. She said the MDS Coordinator is responsible for completion of MDS assessments and care plan development for triggered care areas, but nursing staff can also develop care plans. Consulting Staff #3 reviewed Resident #168's MDS assessment, dated 6/3/25, and the Resident's comprehensive care plans. She said the MDS triggered a care area for urinary catheter and a care plan should have been developed but it was not.

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	06/23/2025

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 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 record review and interview, the facility failed to ensure one Resident (#21), out of a total sample of 17 residents, received the necessary care and treatment, consistent with professional standards of practice, to prevent the development of pressure ulcers. Specifically, the facility failed to reposition Resident #21 when he/she was identified to be a very high risk of developing a pressure area resulting in the development of a deep tissue injury (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue resulting from intense and/or prolonged pressure) to his/her left heel. Findings include: Review of the facility's policy titled Skin Integrity Management, undated, indicated but was not limited to: -Residents with pressure ulcer risk factors are identified, assessed, and provided treatment according to standards of practice. -Residents with actual skin breakdown are identified, assessed and provided treatment according to standards of practice. -Resident's skin integrity status and need for prevention intervention or treatment modalities is identified through review of assessment information. -Identify residents risk level -Care Plan for residents at high risk for skin breakdown -Perform and document skin inspection on admission and weekly Review of the facility's policy titled Pressure Injury Risk Assessment, last revised March 2025, indicated but was not limited to: - It is our policy to perform a pressure injury risk assessment as part of our systemic approach to pressure injury prevention. A risk assessment does not always identify who will develop a pressure injury but will determine which residents are more likely to develop a pressure injury. - Resident determined as at risk for developing pressure injuries will have interventions documented in a plan of care based on specific factors identified in the risk assessment. Resident #21 was admitted to the facility in May 2025 with diagnoses of left femur fracture, diabetes mellitus, and dementia. Review of the Minimum Data Set (MDS) assessment, dated 5/23/25, indicated Resident #21 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Further review of the MDS indicated Resident #21 was dependent on staff to roll from side to side and he/she was at risk of developing a pressure ulcer. (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	06/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #21's Admission/readmission Nursing Assessment indicated but was not limited to: -Skin Integrity: -Is Skin intact: No -Classify any wounds: Surgical -Site: Left hip status post left hip hemiarthroplasty (a surgical procedure that replaces only half of a joint) Review of Resident #21's Care Plans indicated but was not limited to: -Focus: Impaired skin integrity as evidenced by/related to: Diabetic, impaired mobility, occasional incontinence of bowel and bladder, anticoagulant/antiplatelet medications, use of splints, braces, immobilizers, status post surgery, left hip and left elbow fracture, diagnosis of diabetes mellitus (initiated 5/5/2025, revised: 6/11/25) -Goal: Skin will remain intact through next review period (initiated 5/5/2025, revised: 5/6/25), Free from additional skin breakdown through next review (initiated 5/5/2025, revised: 6/11/25), Wound/ulcer will show signs of improvement by next review (signs and symptoms of infection, decreased in size) (initiated 5/5/2025, revised: 6/11/25) -Interventions: Pressure redistributing mattress (initiated 5/5/25), Report changes in skin integrity promptly (redness, change in temperature, blisters, etc.) (initiated 5/5/25), Observe for changes in skin integrity related to splints, braces, tubing, positioning tendencies (initiated 5/5/25), Weekly skin checks per protocol (initiated 5/5/25), Barrier cream between incontinent episodes as indicated (initiated 5/6/25) Review of Resident #21's Care Plans indicated but was not limited to: -Focus: I am at risk of skin breakdown related to deconditioning/decreased mobility and incontinence, Surgical wound on left hip, deep tissue injury left heel (initiated 5/12/25, revised 6/13/25) -Goal: The remainder of my skin will be without breakdown through review date (initiated 5/12/25, revised 6/11/25) -Interventions: Identify/document potential causative factors and eliminate/resolve where possible (initiated: 5/12/25), Keep skin clean and dry. Use lotions on dry skin. Provide barrier cream to protect skin. Weekly body audit (initiated: 5/12/25) Review of Resident #21's Care Plans indicated but was not limited to: -Focus: I require assistance with activities of daily living care related to limited mobility, fracture to left upper extremity and left lower extremity (initiated 5/6/2025, revised: 5/8/25) (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	06/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal: I will be assisted with activities of daily living care to be clean, dry, and well-groomed. I will assist as able with activities of daily living care daily (initiated 5/6/2025, revised: 6/11/25) -Interventions: Bed mobility: Dependent (initiated 5/6/2025, revised: 5/8/25) Review of Resident #21's admission Norton Scale for predicting Risk of Pressure Ulcer Assessment (a tool used to assess the risk of a patient developing a pressure injury), dated 5/5/25, indicated but was not limited to: - Physical Condition: Fair - Mental Condition: Alert - Activity: Walks with help - Mobility: Very Limited - Incontinent: Occasional - Deductions: No deductions listed/identified - Score: 15 (Medium Risk) Review of Resident #21's Norton Scale for predicting Risk of Pressure Ulcer Assessment, dated 5/13/25, indicated but was not limited to: - Physical Condition: Poor - Mental Condition: Confused - Activity: Chair Bound - Mobility: Very Limited - Incontinent: Urine and Feces - Deductions: Diagnosis of Diabetes, Hematocrit (the ratio of the volume of red blood cells to the total volume of blood) less than 41%, Hemoglobin (a protein found in red blood cells that is responsible for transporting oxygen throughout the body) less than 14 grams (g)/ deciliter (dL), Albumin level less than 3.3 g/dL, and he/she is on 5 or more medications. -Score: 4 (Very High Risk) (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	06/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/23/25 at 3:12 P.M., the Director of Nursing (DON) said Resident #21's initial Norton Assessment, dated 5/5/25, was not fully completed by the admitting Nurse. She said Resident #21 was considered high risk for developing a pressure area and no care plan interventions were revised or implemented after the 5/13/25 Norton Assessment which indicated Resident #21 was very high risk for developing a pressure area. Review of Resident #21's Physical Therapy Evaluation, dated 5/6/25, indicated but was not limited to: -Resident #21 required Maximum Assistance (requires substantial help from another person to perform a task, typically 75% or more of the effort) for bed mobility. -Resident #21 had impaired range of motion in his left leg at his/her hip and knee. Review of Resident #21's Physical Therapy Discharge summary, dated [DATE], indicated he/she required Maximum Assistance for bed mobility. Review of Resident #21's Physician Orders indicated but were not limited to: -Skin prep apply to bilateral heels topically two times daily (5/8/25) -Elevated feet on pillows as tolerated while in bed every shift to prevent pressure heels (start 5/6/25 discontinued 5/19/25) -Elevated feet on pillows as tolerated while in bed every shift to prevent pressure heels (5/20/25) -Elevate heels every shift (start 5/8/25, discontinued 5/19/25) -Norton Assessment (used to assess the risk for pressure ulcer in adult patients), (5/5/25) -Hip precautions: Left posterior hip (limiting hip flexion (bending the hip past 90 degrees), avoid crossing the legs or ankles, and preventing internal rotation (turning the left leg inward) every shift (5/7/25) -Weekly skin check every week on Friday, (start 5/5/25, discontinued 6/23/25) Review of Resident #21's positioning documentation from 5/5/25 to 5/18/25 indicated he/she had not been repositioned on 15 out of 36 opportunities (42% of the time) as follows: -36 total opportunities (not including one hospital visit of less than 24 hours) -7 of the 36 opportunities were coded as Not Applicable -3 of the 36 opportunities were left blank -5 out of 36 opportunities were coded as No (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	06/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/23/25 at 3:12 P.M., the DON said the CNAs should not have left Resident #21's position sheet with blanks areas or marked them as not applicable because that indicated Resident #21 was not repositioned. Review of Resident #21's Nursing Notes indicated but was not limited to: -Date: 5/17/25 at 4:13 P.M., General: Resident #21 has open areas or marks on skin. Worsened areas: No, areas have not worsened. New Areas No new areas. Wound team: notified. -Date: 5/19/25 at 10:52 A.M. During care noted a deep tissue injury dark black 2.5-centimeter (cm) area hard intact cleansed patted dry, skin prep applied followed by abdominal pad and Kling. Nurse Practitioner and Healthcare proxy aware. Review of the Wound Physician's Initial Evaluation, dated 5/22/25, indicated but was not limited to the following: -Unstageable Deep Tissue Injury of the Left Heel -Etiology: Pressure -Size: 4 cm x 3.5 cm, depth is unmeasurable due to the presence of tissue overgrowth, Drainage: None During an interview on 6/20/25 at 1:40 P.M., Certified Nursing Assistant (CNA) #3 said Resident #21 did not have any pressure area and needed to be repositioned every two hours. During an interview on 6/20/25 at 2:05 P.M., CNA #2 said Resident #21 had an open area on their heel and needed to be repositioned every two hours. CNA #2 said she was unaware if Resident #21 was supposed to have his/her heels offloaded. During an interview on 6/23/25 at 8:37 A.M., CNA #4 said she would help with providing care for Resident #21. She said Resident #21 was supposed to be repositioned every two hours and the CNAs should have documented this in Resident #21's positioning sheets. During an interview on 6/23/25 at 8:13 A.M., Nurse #5 said when Resident #21 was admitted his/her skin was intact, and he/she only had a surgical incision. Nurse #5 said Resident #21 had impaired mobility because of a left hip fracture and had interventions in place to offload his/her heels on a pillow, apply skin prep to heels, and to turn and reposition every two hours. Nurse #5 said these were generic interventions for every resident who was considered high risk. During an interview on 6/23/25 at 3:12 P.M., the DON said Resident #21 did not receive their air mattress until 5/19/25 when the pressure area on his/her heel had developed. She said Resident #21 was incredibly high risk for developing a pressure area due to their immobility, comorbidities, and left hip fracture. During a telephonic interview on 6/23/25 at 4:10 P.M., Physician #3 said Resident #21 had a history of a previous healed left heel ulcer and when he/she was admitted to the facility his/her left heel was intact until 5/19/25. (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	06/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephonic interview on 6/25/25 at 3:06 P.M., Physician #2 said when he initially evaluated Resident #21's left heel pressure area it was his evaluation this wound was caused by pressure related to immobility.

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	06/23/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure staff provided residents with an environment free from accidents and hazards. Specifically, the facility failed to ensure medications were disposed of on the [NAME] Unit in a secure manner to prevent access to those medications on one of two nursing units. Findings include: Review of the facility's policy titled Destruction of Unused Drugs, last revised [DATE], indicated but was not limited to: -All unused, contaminated, or expired prescription and non-prescription drugs shall be disposed of per facility policy. -Drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements. Review of the facility Matrix (used to identify pertinent care categories for residents) provided to surveyors by the Director of Nursing on [DATE] indicated the [NAME] Unit had 37 out of 39 residents with diagnoses of Alzheimer's disease/Dementia. On [DATE] at 8:25 A.M., the surveyor observed Nurse #4 drop two medications on the floor: - Gabapentin (used to treat seizures and for nerve pain) - Sucralfate (to treat and prevent duodenal ulcer) The surveyor then observed Nurse #4 pick the medications up of the floor and dispose of them into an uncovered trash bin on the side of the medication cart. During an interview on [DATE] at 12:33 P.M., Nurse #4 said she should not have disposed of the medication in the trash on her medication cart. During an interview on [DATE] at 4:25 P.M., the Director of Nursing (DON) said the [NAME] Unit has a large population of residents with Alzheimer's Disease and Dementia. The DON said Nurse #4 should not have thrown the medications into the trash on the side of her cart but disposed of them in the medication disposal area for resident safety.

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	06/23/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, records reviewed, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when two out of three nurses observed during a medication pass made three errors out of 28 opportunities, resulting in a medication error rate of 10.71%. Those errors impacted two Residents (#11 and #18), out of four residents observed. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to the following: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers. Review of the facility's policy titled Administering Medications, last revised August 2024, indicated but was not limited to: - Medications shall be administered in a safe and timely manner, and as prescribed. - Medications must be administered in accordance with the orders. 1. For Resident #18, Nurse #4 administered: - the incorrect formula of a probiotic (live microorganisms that provide health benefits when consumed, generally by improving or restoring the microbiota in the gut). On 6/18/25 at 8:25 A.M., the surveyor observed Nurse #4 prepare and administer medications to Resident #18 including: -Acidophilus (a bacteria-based probiotic) 1 capsule Review of Resident #27's Physician's Orders indicated but was not limited to: -Saccharomyces boulardii (a yeast-based probiotic), give one capsule by mouth two times daily for 14 days, dated 6/5/25 During an interview on 6/18/25 at 12:33 P.M., Nurse #4 said the facility had usually used Acidophilus as a probiotic because it was house stock. Nurse #4 said she had not administered the correct probiotic to Resident #27, and she should have followed the physician's order. 2. For Resident #11, Nurse #2 administered -the incorrect formula of Calcium (supplement used for bone health) -the incorrect formula of Multivitamin with Minerals (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	06/23/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 8:16 A.M., the surveyor observed Nurse #2 prepare and administer medications to Resident #11 including: -Oyster Shell Calcium 500 milligrams (mg) plus Vitamin D, 5 micrograms (mcg) -Multivitamin with Minerals (provides a broad range of vitamins and minerals for overall health and well-being) Review of Resident #11's Physician's Orders indicated but was not limited to: -Calcium 500 mg, give one tablet by mouth one time a day, dated 6/30/21 -PreserVision AREDS Tablet (a vitamin and mineral supplement, designed to support eye health), give one tablet by mouth two times a day, dated 4/27/21 During an interview on 6/18/25 at 10:44 A.M., Nurse #2 said she had administered the incorrect formula of Calcium and had administered a Multivitamin with Minerals instead of PreserVision AREDS Tablet to Resident #11. During an interview on 6/18/25 at 4:25 P.M., the Director of Nursing said the expectation was for nurses to administer medications per physician's orders.

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	06/23/2025

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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 4. Resident #8 was admitted to the facility in January 2024 with diagnoses including migraine (a neurological condition that can cause severe throbbing pain or a pulsing sensation, usually on one side of the head, accompanied by nausea, vomiting, and extreme sensitivity to light and sound) and restless leg syndrome (a neurological disorder characterized by an irresistible urge to move the legs, often accompanied by uncomfortable sensations). Review of the facility's policy titled Administering Medications, last revised August 2024, indicated but was not limited to: -The individual administering the medication must initial the resident's Electronic Medical Administration Record (EMAR) in the appropriate field after giving each medication and before administering the next ones. -As required or indicated for a medication, the individual administering the medication will record in the resident's electronic medical record: -the date and time the medication was administered. Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to: -When administering an as needed medication: -Document the time of administration. Review of the Minimum Data Set assessment, dated 4/24/25, indicated Resident #8 had received an opioid (a strong prescription pain reliever) medication during the review period. Review of Resident #8's Physician's Orders indicated but was not limited to: - Hydrocodone-Acetaminophen (opioid pain reliever) 7.5-325 milligrams (mg), give 1 tablet by mouth every 6 hours as needed for pain, (start date: 4/4/2025, discontinued: 5/16/2025) - Hydrocodone-Acetaminophen 7.5-325 mg, give 1 tablet by mouth every 6 hours as needed for moderate to severe pain (5/16/2025) Review of the EMAR indicated Resident #8 received Hydrocodone-Acetaminophen 41 times from 5/3/25 to 6/18/25. Review of the Narcotic Book (a record book used in healthcare settings to track and document the administration and handling of controlled substances) indicated Resident #8 had received his/her Hydrocodone-Acetaminophen 58 times. Further of Resident #8's EMAR indicated the use of his/her Hydrocodone-Acetaminophen had not been documented 17 out of 58 times (29% of the time). (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	06/23/2025

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 - Some	During an interview on 6/18/25 at 12:33 P.M., Nurse #4 said when a resident receives a PRN (as needed) medication, especially if it is an opioid, it should be documented in the EMAR and in the Narcotic Book. The EMAR and Narcotic Book documentation should match. During an interview on 6/18/25 at 3:57 P.M., Nurse #3 said when he administers a PRN medication, he checks the EMAR to see when a PRN medication dose had last been administered to ensure enough time had passed. Nurse #3 said documentation of the time, name, and amount of medication that was administered should match in both the EMAR and Narcotic Book. Nurse #3 said he should have documented in the EMAR but sometimes he would get busy and forget. During an interview on 6/18/25 at 4:25 P.M., the DON said it was her expectation for nurses to follow the standards of practice and the facility's policy and document the use of a PRN medication in the narcotic book and the EMAR. Based on record review and interviews, the facility failed to ensure staff maintained accurate medical records for four Residents (58, #40, #31, and #8), out of a total sample of 17 residents. Specifically, the facility failed: 1. For Resident #58, to ensure the Nurse Practitioner was accurately documenting advance directives as indicated on the Resident's Massachusetts Medical Orders for Life Sustaining Treatment form (MOLST); 2. For Resident #40, to ensure the Resident's active Physician's Orders accurately reflected the Resident's advance directives as indicated on the Resident's MOLST; 3. For Resident #31, to ensure the Resident's active Physician's Orders and Care Plans accurately reflected the Resident's advance directives as indicated on the Resident's MOLST; and 4. For Resident #8, to ensure nursing staff accurately documented the use of an as needed (PRN) medication on the medication administration record (MAR). Findings include: 1. Resident #58 was admitted to the facility in January 2025 with diagnoses including non-traumatic brain dysfunction. Review of the medical record indicated the Resident's Health Care Proxy (HCP) and Nurse Practitioner #1 initiated a new MOLST on 4/3/25. The MOLST reflected the following advance directives: Do not resuscitate (DNR), Do not intubate and ventilate (DNI), do not transfer to hospital (DNH) (unless needed for comfort). Review of Nurse Practitioner #1's 16 progress notes from 4/3/25 to her most recent visit on 6/19/25, indicated -Code Status: Full Code (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	06/23/2025

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 - Some	During an interview on 6/23/25 at 10:19 A.M., Nurse Practitioner #1 said her notes and the MOLST form should match. She said all her notes indicated the Resident was a Full Code. She said her notes are incorrect and the MOLST is the most accurate indicator of the advanced directives. She said her notes auto populate from each visit and it must have been an error that the Full Code status was carried over to each visit. She said she expected her documentation in a Resident's medical record to be accurate. During an interview on 6/23/25 at 10:25 A.M., the Director of Nursing (DON) said the information in the medical record should be accurate and complete. She said she expected the nurse practitioner's documentation to be accurate and reflect the Resident's advance directives. She said the nurse practitioner's notes are inaccurate and the Resident's advance directives/code status is DNR/DNI/DNH according to his/her MOLST. 2. Resident #40 was admitted to the facility in December 2023 with diagnoses including Alzheimer's disease. Review of the medical record indicated the Resident's HCP and Attending Physician initiated a new MOLST on 6/13/25. The MOLST reflected the following advance directives: Do Not Resuscitate (DNR); Intubate and Ventilate, but Short Term Only; Use Non-invasive Ventilation, but Short Term Only; Transfer to Hospital; No Dialysis; Use Artificial Nutrition, but Short Term Only; and Use Artificial Hydration, but Short Term Only. Review of Resident #40's current Physician's Orders indicated, but was not limited to, the following: -Code Status: (DNR/DNI) Refer to MOLST dated: (5/21/25) Do Not Resuscitate, Do Not Intubate and Ventilate, Use Non-Invasive Ventilation (e.g. CPAP), Transfer to Hospital, No dialysis, Use Artificial nutrition, but short term only, Use artificial Hydration, but short term only [order date: 5/21/25] Review of Resident #40's Physician's Progress Note for a visit on 5/21/25 indicated the Resident's MOLST form was reviewed and the Resident continued as a full code. During an interview on 6/23/25 at 10:25 A.M., the DON said the information in the medical record should be accurate and complete. 3. Resident #31 was admitted to the facility in July 2022 with diagnoses including Alzheimer's disease. Review of the medical record indicated the Resident's HCP and Nurse Practitioner #2 initiated a new MOLST effective 4/18/25. The MOLST reflected the following advance directives: Do Not Resuscitate (DNR); Do Not Intubate and Ventilate (DNI); Do Not Use Non-Invasive Ventilation; Do Not Transfer to Hospital (unless needed for comfort); No Dialysis; No Artificial Nutrition; and No Artificial Hydration. Review of Resident #31's current Physician's Orders indicated, but was not limited to, the following: (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	06/23/2025

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 - Some	-Attempt resuscitation, Do no [sic] intubate and ventilate, use non-invasive ventilation, transfer to Hospital, Use dialysis, use artificial nutrition, use artificial hydration [order date: 7/17/24] Review of Resident #31's Care Plans indicated, but was not limited to, the following: -Focus: ADVANCE DIRECTIVES: are as follows: Full Code. Established HCP is invoked. During an interview on 6/23/25 at 10:25 A.M., the DON said the information in the medical record should be accurate and complete.

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	06/23/2025

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to electronically submit direct care staffing data to Centers for Medicare and Medicaid Services (CMS) for the entire reporting period, Fiscal Year (FY) Quarter 2 2025 (January 1 -March 31) in accordance with the schedule specified by CMS. Findings include: Review of the Payroll Based Journal (PBJ) Staffing Report, CASPER Report 1705D, FY Quarter 2 2025 (January 1 - March 31), indicated the facility triggered for: -Failed to Submit Data for the Quarter (No Data Submitted for Quarter) -One Star Staffing Rating (Staff Staffing Rating Equals 1) During an interview on 6/18/25 at 9:37 A.M., the Director of Operations said the company had a change in the corporate Human resource position at the time of PBJ submission for Quarter 2 and they were unaware that the submission had not taken place. He said he attempted to reach out to CMS so they could submit the data after the fact but was informed that wouldn't be possible. He said the PBJ information should have been submitted as required and was not.

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	06/23/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, review of the Quality Assurance Performance Improvement (QAPI) policy, and interview, the facility failed to ensure that the Quality Assessment and Assurance (QAA) Committee developed, implemented and maintained a comprehensive QAPI program with projects that were data driven and had metrics that benchmarked their current status, established goals and defined measurements for improvement for outcomes that were sustainable. Findings include: Review of the facility's policy titled Quality Assurance and Performance Improvement Program, last dated, January 2025, included but was not limited to the following: - Our QAPI program will be ongoing and comprehensive and includes all employees, all departments, and all services provided. - QAPI will utilize best available evidence (data, benchmarks, published best practice, clinical guidelines) to define and measure goals. - Data to be monitored includes, but is not limited to: quality measures, previous survey deficiencies, complaints or facility monitored incidents, ombudsman concerns, resident/family input - grievance log/resident council, adverse events and med errors. - Evidence and data will be used to benchmark, establish goals and define measures for improvement - The facility Administrator is responsible and accountable for developing, leading, and closely monitoring the QAPI program - QAPI activities are governed and monitored by the QAA committee, which includes the Medical director, Director of Nurses (DON), Administrator, Infection Preventionist (IP) and two additional staff members. - Our organization will conduct Performance Improvement Projects (PIPs) that are designed to take a systematic approach to review and improve care or services in areas that we identify as needing attention; an important aspect of our PIPs is to determine the effectiveness of our performance improvement activities and whether improvement is sustained. - The QAA committee will prioritize topics for PIPs and provide guidance on how to address issues that arise and need corrective action and designate a PIP team - The PIP team will: consider each PIP as a learning process, follow steps for any quality improvement project, determine information needed, determine a timeline for the project, request supplies, staff and equipment as needed, use systematic analysis and systematic actions to identify and implement change. Systematic Analysis and Action: (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	06/23/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- a systematic approach is used to determine when in-depth analysis is needed to fully understand identified problems, causes of the problems, and implications of a change; to get to the underlying cause of the issue teams work together to identify the root cause and contributing factors using tools such as the five whys. - To prevent future events and promote sustained improvement the organization uses Plan-Do-Study-Act cycles to test actions and recognize and address unintended consequences of planned changes - To ensure planned changes are implemented and effective in making a sustained change the organization uses measure that tie directly to the new action and conducts ongoing periodic measurements and review to ensure the new action has been adopted and performance is consistent. During an interview on 6/23/25 at 1:30 P.M., the Administrator said he is in charge of QAPI and all QAA activities. He said he was involved himself in a project to improve the number of grievances that were communicated accurately using the grievance process. He said he identified that the facility had very few grievances brought forth and it didn't seem the process was being used correctly and he wanted to increase the number to ensure things were not being missed. He said he did not complete a data driven analysis or use a benchmark for the starting point of his project and did not have any measurable data to show an improvement had been made, except that he felt people better understood the grievance process as it is defined within the facility and he felt more grievances had been filed. He said he considered the project recently completed with sustainable results. He said he was aware that a grievance that was recently missed and brought to his attention by the survey team and was a concern. On 6/23/25 at 1:48 P.M., the DON joined the Administrator during the QAPI interview. She said she is currently working on a project to improve the completion of resident incident reports within the facility. She said the regional team identified an issue during a recent audit indicating not all the steps in the incident report and follow up process were being completed. She said the goal is 100% completion but did not know what her starting point was and had no data driven metric to determine how many incident reports were reviewed during the audit or how many were complete versus incomplete. She said she was not measuring improvement periodically and would just consider the project completed once the goal of 100% incident report follow up was met. Throughout the interview both the Administrator and DON said that they are not fully trained or educated on how the process works for determining if a QAPI project is a facility wide QAA project or a PIP and could not indicate what method or cycles of activity the facility and organization used to move throughout the identification, analysis, implementation and measurement checks needed to identify improvement. The Administrator and DON said they had not previously heard of Plan-Do-Study-Act and were unaware of the tools in use by their organization to systematically manage and sustain improvement. The Administrator and DON said they identify a problem, provide education and then monitor the issue, sometimes daily, until they reach their goal of 100% and then consider the project completed. They said they do not seek feedback from their line staff to determine if the education completed for their projects is effective at that level. The DON discussed a project the facility had the previous year for weekly skin checks not being completed as ordered/required. She said the project was initiated off a deficiency from their survey results. She said today she started the project again when a surveyor had brought some concerns regarding skin and the missing skin checks to her attention. She said she was not aware the change had not been sustained. Both the Administrator and the DON said they felt they needed more resources and training on the process of QAA and improvement projects for the program to be fully implemented. (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	06/23/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/23/25 at 3:27 P.M., the Director of Operations said the expectation is for the facility leadership to use data-based evidence and metrics to help sustain improvements in identified areas. He said the process would involve a root cause analysis of the situation to identify necessary change and measurable goals and outcomes to determine if the project is effective in creating the desired change or if it would require adjustment for the desired outcomes that could be measured and sustained. He said the facility leadership should be using the organizational process and based on the information provided to the surveyor it seemed that the process for QAA and improvement projects was not in place as it should be. He said that the current process was not comprehensive or inclusive of the organizational requirements.

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	06/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 3. Review of the facility's policy titled Administering Medications, last revised August 2024, indicated but was not limited to: -Staff shall follow established facility infection control procedures for the administration of medications. On 6/16/25 at 8:25 A.M., the surveyor observed Nurse #4 prepare 10 medications for Resident #8. Nurse #4 dropped one pill on to the top of the medication cart, picked up the pill, placed it into the medication cup and administered it to Resident #8. During an interview on 6/16/25 at 8:43 A.M., Nurse #4 said she had cleaned the top the of the medication cart at the beginning of her shift at 7:00 A.M. and the pill had not fallen on the floor but on top of the medication cart. During an interview on 6/16/25 at 4:25 P.M., the Director of Nursing said Nurse #2 should not have administered the medication after it fell on top of the medication cart. The Director of Nursing said the top of the medication is not considered a clean surface and if a medication falls on top of the medication cart it should be disposed of and a new pill should have been administered as it is an infection control concern. Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to: 1. Maintain an infection prevention and control program which included a complete and accurate system of surveillance to identify any trends or potential infections; 2. Ensure contact tracing and outbreak testing were completed on two occurrences in February 2025; and 3. Ensure that sanitary practices were used by nursing while preparing and administering medications. Findings include: 1. Review of the facility's policy titled Infection Prevention and Control Program, undated, indicated, but was not limited to, the following: -An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. -The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. (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	06/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infections) are used as measures of the IPCP effectiveness. -Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. -Outbreak management is a process that consists of: 1) determining the presence of an outbreak; 2) managing the affected residents; 3) preventing the spread to other residents; 4) documenting information about the outbreak 5) reporting the information to appropriate public health authorities; 6) educating the staff and the public; 7) monitoring for recurrences; 8) reviewing the care after the outbreak has subsided; 9) recommending new or revised policies to handle similar events in the future. -Specific criteria will be used to help differentiate sporadic cases from true outbreaks or epidemics. Review of an untitled and undated facility policy indicated, but was not limited to, the following: -It is the policy of this facility to complete Infection Control Line Listings each month. The data on the line listings will be used to identify improvement opportunities. These line listings will be utilized to produce a roll up of data that will be reviewed for improvement opportunities. -Line Listing will include - *Resident Name or Identifier *Room # *Category of Infection *Date of Onset (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	06/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Symptoms *Date of Culture *Site of Infection *Results of Culture *Treatment - including name of ABX (antibiotic) used *Date Infection cleared *Final Status - HAI (healthcare-acquired infection) or CAI (community-acquired infection) -These listing [sic] will be entered into a standardized spreadsheet that will provide a breakdown and comparison of data. The report will look at Infection trends over a period of time. Review of the facility's infection surveillance line listings indicated, but was not limited to, the following: July 2024 -8 out of 8 resident infections had no documented signs and symptoms of an illness or date of symptom onset -1 out of 1 blood infections failed to include culture results identifying the organism/bacteria -Review of the Infection Control Report provided by the facility's consultant laboratory indicated that a urine specimen collected from a resident on 7/27/24 resulted positive for ESBL (extended-spectrum beta-lactamase producing bacteria - bacteria that produce enzymes that break down certain antibiotics, making them ineffective). This culture result was not included on the facility's July 2024 line listing document. August 2024 -9 out of 9 resident infections had no documented signs and symptoms of an illness or date of symptom onset -1 out of 2 urinary tract infections failed to include culture results identifying the organism/bacteria September 2024 -2 out of 7 resident infections had no documented site/type of infection -7 out of 7 resident infections had no documented signs and symptoms of an illness or date of symptom onset (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	06/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	October 2024 -6 out of 6 resident infections had no documented signs and symptoms of an illness or date of symptom onset -Review of the Infection Control Report provided by the facility's consultant laboratory indicated that a urine specimen collected from a resident on 10/3/24 resulted positive for Proteus penneri (a type of bacteria associated with healthcare-acquired infections). This culture result was not included on the facility's October 2024 line listing document. November 2024 -10 out of 10 resident infections had no documented signs and symptoms of an illness or date of symptom onset December 2024 -11 out of 11 resident infections had no documented signs and symptoms of an illness or date of symptom onset -1 out of 6 urinary tract infections failed to include culture results identifying the organism/bacteria No facility surveillance line listings were provided to the surveyor for the months of January 2025 through May 2025. The facility's Infection Prevention Nurse provided the surveyor with Infection Control Reports from the consultant laboratory with resident culture results and monthly Order Listing Reports from the facility's electronic health record (EHR) with a list of antibiotics prescribed each month. The Order Listing Reports and Infection Control Reports failed to include dates of symptom onset and signs and symptoms of infection present. Additionally, the reports failed to include laboratory results from specimens collected outside of the facility. Further review of the Infection Control Reports provided by the facility's consultant laboratory indicated the Reports for July 2024 through February 2025 were not generated until April 2025. Further review of the facility's line listings failed to indicate that suspected infections that were not treated with antibiotics, such as suspected gastrointestinal or urinary tract infections with negative culture results, were included on the facility's infection surveillance line listings. During an interview on 6/18/25 at 2:04 P.M., the Infection Prevention Nurse said she uses the facility's EHR generated report of residents that have been prescribed antibiotics each month and the Infection Control Report generated by the facility's consultant laboratory as her monthly infection surveillance logs. The Infection Prevention Nurse said the EHR and laboratory reports do not include a description of symptoms, symptom onset date, tracking of suspected infections not treated with antibiotics, or culture results from laboratories outside of the facility's consultant laboratory. The Infection Prevention Nurse said she had used a handwritten line listing tool through December 2024 and tried an electronic spreadsheet for infection surveillance before switching to the EHR and laboratory reports. The Infection Prevention Nurse said symptoms and laboratory results should be included as part of the infection surveillance program. (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	06/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/23/25 at 7:39 A.M., the Director of Nursing said the facility's line listings should include date of onset and signs and symptoms of infection. 2. Review of the facility's policy titled Infection Prevention and Control COVID-19, revised 6/30/23, indicated, but was not limited to, the following: -An outbreak investigation is initiated when a new nursing home onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). -The Infection Preventionist will conduct ongoing surveillance for all Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections such as COVID-19 that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. -The Infection Preventionist, or designee, will be responsible for the following protocols for contact tracing: *Identify residents, employees, and visitors who the confirmed positive case had contact with the 48 hours prior or 10 days following the positive test or symptoms. -Outbreak Testing *Document the date the case was identified, the date that other residents and staff are tested, the date that all residents and staff who tested negative are retested, and results of all tests. *Staff test results may be maintained on a log in a secure location. Review of the facility's line listings indicated that a resident on the [NAME] unit tested positive for COVID-19 on 9/28/24. Subsequently, 14 additional residents on the [NAME] unit tested positive for COVID-19 between 10/1/24 and 10/25/24. The surveyor requested documentation of the facility's outbreak investigation, including contact tracing and outbreak testing logs for staff and residents. The Infection Prevention Nurse provided the surveyor with a line listing of COVID-19 positive residents. The line listing failed to include information on the residents' signs/symptoms of COVID-19 and date of symptom onset. The facility failed to provide the surveyor with a list of who had been exposed to COVID-19 positive residents and when they were tested. During an interview on 6/18/25 at 2:04 P.M., the Infection Prevention Nurse said the facility had no infectious disease outbreaks since the previous survey in July 2024. (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	06/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/23/25 at 12:20 P.M., the Infection Prevention Nurse said the facility did have an outbreak of COVID-19 in October 2024. The Infection Prevention Nurse said she had no additional outbreak investigation documentation other than what was included on the line listing of COVID-19 positive residents provided to the surveyor. The Infection Prevention Nurse said residents on the [NAME] unit were tested every 48 hours until seven days passed with no new cases of COVID-19 identified and results were documented in each resident's medical record. The Infection Prevention Nurse said staff were tested before reporting to the unit for their shift during the outbreak period, but the facility did not keep documentation of staff testing dates and/or test results. The Infection Prevention Nurse said she kept a list of the COVID-19 positive residents, but did not maintain documentation of any contact tracing or additional outbreak investigation information.

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	06/23/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel record review and interview, the facility failed to ensure the new hire employee records contained evidence of the 2024-2025 COVID-19 vaccination for four of five newly hired employees. Specifically, the facility failed to ensure the employee record contained evidence of the 2024-2025 COVID-19 vaccination or proof the newly hired employees were offered an updated COVID-19 vaccine when he/she was eligible. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance, Staying up to date with COVID-19 vaccinations, dated as revised June 6, 2025, indicated but was not limited to the following: - CDC recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 years and older. This includes people who have received a COVID-19 vaccine, people who have had COVID-19, and people with long COVID. Importance of staying up to date: - Getting the 2024-2025 COVID-19 vaccine is important because protection from the COVID-19 vaccine decreases with time; Immunity after COVID-19 infection decreases with time; COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. - Administer recommended vaccines if vaccination history is incomplete or unknown. - Routine vaccination: age [AGE]-64 years: a. Unvaccinated: 1 dose 2024-25 Moderna or Pfizer-BioNTech; 2 doses 2024-25 Novavax at 0, 3-8 weeks b. Previously vaccinated before 2024-25 vaccine with: 1 or more doses Moderna or Pfizer-BioNTech: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose. 1 dose Novavax: 1 dose 2024-25 Novavax 3-8 weeks after most recent dose. If more than 8 weeks after most recent dose, administer 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech. 2 or more doses Novavax: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech at least 8 weeks after the most recent dose. 1 or more doses [NAME]: 1 dose 2024-25 Moderna or Novavax or Pfizer-BioNTech. - Routine Vaccination: age [AGE] years and older: a. Unvaccinated: follow recommendations above for unvaccinated persons ages 19-64 years and administer dose 2 of 2024-25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). b. Previously vaccinated before 2024-25 vaccine: follow recommendations above for previously vaccinated persons ages 19-64 years and administer dose 2 of 2024-25 Moderna or Novavax or Pfizer-BioNTech 6 months later (minimum interval 2 months). (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	06/23/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Unvaccinated persons have never received any COVID-19 vaccine doses. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available. Administer an age-appropriate COVID-19 vaccine product for each dose. Staff member #1 was hired on 6/3/25 as a Nurse. Review of the employee file failed to indicate that the facility had offered the new employee the most recent COVID-19 vaccination to assist in protecting themselves against COVID-19. Staff member #3 was hired on 2/19/25 as an Activity assistant. Review of the employee file failed to indicate that the facility had offered the new employee the most recent COVID-19 vaccination to assist in protecting themselves against COVID-19. Staff member #4 was hired on 5/6/25 as a Nurse. Review of the employee file failed to indicate that the facility had offered the new employee the most recent COVID-19 vaccination to assist in protecting themselves against COVID-19. Staff member #5 was hired on 3/19//25 as a Maintenance assistant. Review of the employee file failed to indicate that the facility had offered the new employee the most recent COVID-19 vaccination to assist in protecting themselves against COVID-19. Review of the employee timecards indicated that the four new hires, who had not been offered the most recent COVID-19 vaccination, had been actively working in the facility. During an interview on 6/23/25 at 8:32 A.M., the Human Resource (HR) staff at the facility said he provides a list to new employees prior to hire of items they need to bring in with them at the time of orientation, including current vaccination with the COVID-19 vaccine. He said he does not confirm whether or not the files contain an offer of the current COVID-19 vaccination once he receives the information back from the Infection Preventionist (IP) because he was unaware that the facility was required to offer its staff the most recent COVID-19 vaccination. During an interview on 6/23/25 at 9:03 A.M., the IP said the facility has newly hired staff bring a copy of their vaccine history with them at the time of hire, which includes the COVID-19 vaccination and information should be in the employee files. She said the staff should have a signed declination or consent on file if they choose to receive the newest vaccine. During an interview on 06/23/25 at 2:41 P.M., the IP said the facility does not offer COVID-19 vaccination or boosters to new staff upon hire and that is why no documentation could be located in the employee files.