STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225194	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimwell Nursing and Rehabilitation	495 New Boston Road Fall River, MA 02720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure residents had a homelike environment on three of three units. Specifically, the facility failed to: 1. Repair water damaged ceiling tiles on the K3 unit; 2. Ensure Resident #18 had a bedroom with walls, blinds, and durable medical condition in good repair; and 3. Ensure residents' bedrooms were homelike and free from holes and damaged window treatments on the K1 and K2 units.Findings include:Review of the facility's policy titled Homelike Environment, dated 2001, indicated but was not limited to the following:-the facility staff and management maximize to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These include a clean, sanitary, and orderly environment.-the maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.During an interview on 3/11/26 at 11:00 A.M., the Ombudsman Program Director said she observed ceiling tiles that were drooping from water damage, and one of them had a hole which she reported to staff on the unit last week.Throughout the survey, the surveyor observed the ceiling tiles drooping from water damage on the K3 unit at the following times:-3/10/26 at 10:06 A.M., two staff members were standing under the damaged tiles looking up at them.-3/11/26 at 8:39 A.M., one resident was sitting under the damaged tiles.-3/12/26 at 7:30 A.M., four residents were sitting under the damaged tiles.-3/12/26 at 1:00 P.M., two residents were sitting under the damaged tiles.Review of the TELS (a comprehensive building management platform that streamlines work order creation, preventive maintenance, and asset management for facilities, particularly in senior living communities) work order log failed to indicate the damaged ceiling tiles on the K3 unit were reported.During an observation with an interview on 3/11/26 at 1:40 P.M., Nurse #4 was passing medications near the damaged tiles and said if there is anything on the unit that is broken or damaged, she would report it in TELS. She said the maintenance department monitors the system and will repair the reported concern. She said she reported a concern related to a deflating air mattress today.During an interview on 3/12/26 at 11:19 A.M., the Maintenance Director said he starts his day by reviewing the work orders reported in TELS and if he sees something he will write it down on a scrap piece of paper to remind him to complete later. He said he was not aware the tiles were damaged. He said it was likely from the excessive snow and melting from a recent storm on 2/22/26.During an interview with an observation on 3/12/26 at12:14 P.M., the Administrator said he expects concerns like damaged ceiling tiles to be reported immediately and fixed quickly. He said all staff have access to the system and should be reporting any damaged part of the building they observe. 2. Resident #18 was admitted to the facility in February 2026 with a history of falls. Review of the Minimum Data Set assessment, dated 2/21/26, indicated Resident #18 scored 14 out of 15 on the Brief Interview for Mental Status indicating he/she is cognitively intact.During an interview on 3/10/26 at 11:40 A.M., Resident #18 said the wheelchair and his/her room have been in disrepair since he/she was admitted to the facility in February. The Resident said the wheelchair, provided to him/her by the facility, had a ripped armrest with the foam exposed. Resident #18 said he/she has (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a lot of interactions with various staff members daily, but it has not been identified by staff as needing repair despite its ripped appearance and foam exposure. In addition, the Resident said there are holes and scratches in the walls. The Resident said he/she would hope that as staff come into the room they would let someone know, especially since the staff providing care have better vision than him/her, they would report it to maintenance. The Resident also said the blinds have had a large rip in them since the day he/she moved into their room.During an interview on 3/12/26 at 11:19 A.M., the Maintenance Director said he doesn't have time to work on preventative maintenance projects because most of his day is filled with working on items in TELS and he depends on staff to inform him if something is in disrepair. He said he was unaware of the Resident's equipment or condition of the room. He expects the residents would have a clean and homelike environment.During an interview on 3/12/26 at 12:14 P.M., the Administrator said he expects resident rooms to be clean and in good repair prior to a resident admitting to the facility. He said there should be a process for ensuring the room is homelike for the resident. 3. During a tour of the K1 unit on 3/11/26 at 1:25 P.M., the surveyor observed the following:-The dining room had 8-inch scratches on the wall, paint chipped, and an air conditioner in the wall covered with a bed sheet. Four residents were in the room with two staff members.-room [ROOM NUMBER] had blinds that were ripped.-room [ROOM NUMBER] had blinds that were ripped and the curtain bracket was coming out of the wall. The blind was being held up by face masks tied together. There was a round hole in the sheetrock.-room [ROOM NUMBER] had broken curtain brackets and holes in the window wall approximately 5 inches in height. The wall had an approximate 6-inch gauge with areas in disrepair. The molding was detached off the wall and large areas of paint was removed from wall located next to the heating vent. There was a large gaping hole located on the right-hand side of window and with rotted wood around window.During a tour of the K2 unit on 3/11/26 at 1:55 P.M., the surveyor observed the following:-The dining area/living room area on the second floor had blinds with multiple rips in them.-room [ROOM NUMBER] had a broken cabinet on the nightstand.-room [ROOM NUMBER] had a windowsill in disrepair, appearing from water damage.-rooms [ROOM NUMBER] had blinds that were ripped.-room [ROOM NUMBER] had the curtain bracket detached from the wall.-In the hallway, there were two areas of approximately one foot each of handrails that were not securely affixed to the wall and were loose to the touch.Review of the TELS log failed to indicate these areas observed by the surveyor were reported or identified by staff or the maintenance director.During an interview on 3/12/26 at 11:19 A.M., the Maintenance Director said he relies on staff to identify areas that need maintenance and report them in TELS.During an interview on 3/12/26 at 12:26 P.M., the Ombudsman said the environment takes a long time to get noticed and fixed. He said once he brings it to the facility's attention it will get fixed but sometimes there is a delay. He said he does not believe there is any preventative maintenance being done. During an observation with interview on 3/12/26 at 12:14 P.M., the Administrator said he expects the residents to have a homelike environment which is not what is reflected in some areas after touring the three units. He said he expects the issues to be addressed, and that staff are identifying and reporting these environmental issues every day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to implement a comprehensive infection control program to include timely surveillance data and a comprehensive analysis which identified interventions when patterns and trends were identified. Specifically, the facility failed to ensure timely and accurate surveillance data for all infection types to identify a pattern of E-Coli Urinary Tract Infections (UTI) (bacterial infection, caused by E-Coli bacteria, typically originating from the gut, entering the urinary tract, and causing inflammation, often due to improper wiping/perineal care) and implement interventions to decrease the risk of residents developing E-Coli UTIs. Findings include:Review of the facility's policy titled Surveillance for Infections, dated as last revised September 2017, indicated but was not limited to the following:-The Infection Preventionist (IP) will conduct ongoing surveillance for healthcare associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions (TBP) and other preventative interventions.-The purpose of surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent future infections.-Infections that will be included in routine surveillance include those with clinically significant morbidity or mortality associated with the infection (pneumonia, urinary tract infection (UTI), and C. difficile).-Nursing staff will monitor residents for signs and symptoms that may suggest infection and will document, and report suspected infections to the charge nurse.-Gathering Surveillance Data: If laboratory reports are used to identify relevant information, the following findings merit further evaluation: positive urine cultures (bacteriuria) with corresponding signs and symptoms that suggest infection.-In addition to collecting data on the incidence of infections, the surveillance system is designed to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted.-Data Collection and Recording: For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: Date of onset of infection, list symptoms, diagnostic test result, infection site, pathogens, pertinent remarks of symptoms, and treatment measures and precautions.-For targeted surveillance: Collect information, summarize monthly data by unit, site, and pathogen, identify predominant pathogens or sites of infections and observe for trends, and compare infection rates.-Interpreting Surveillance Data: Analyze the data to identify trends and consider how increases or decreases might relate to recent process changes, events, or activities in the facility (changes in handwashing preparations, increased turnover in personnel or residents). Review of the facility's Infections Line Listing reports from October 2025 through March 2026 indicated but were not limited to the following:OCTOBER 2025:-23 of the 31 entries had missing and/or incomplete data.-9 UTIs; 4 had the organism documented; 1 with no culture; 2 E-Coli.NOVEMBER 2025:-26 of the 42 entries had missing and/or incomplete data.-17 UTIs; 12 had the organism documented; 3 with no culture; 4 E-Coli.DECEMBER 2025:-11 of the 25 entries had missing and/or incomplete data.-7 UTIs; 5 had the organism documented; 1 E-Coli.JANUARY 2026:-17 of the 33 entries had missing and/or incomplete data.-13 UTIs; 10 had the organism documented; 1 with no culture; 4 E-Coli.FEBRUARY 2026:-33 of the 41 entries had missing and/or incomplete data.-8 UTIs; 3 had the organism documented; 2 with no culture; 3 E-Coli.MARCH 2026:-6 of the 11 entries had missing and/or incomplete data.-3 UTIs; 3 E-Coli. During an interview on 3/13/26 at 2:52 P.M., Unit Manager #2 said she runs an antibiotic report at the end of the month to complete the line list. She said they discuss things in morning meeting, but she fills out the Line List at the end of the month. During an interview on 3/13/26 at 3:34 P.M., the Infection Preventionist (IP) said if someone goes on an antibiotic then they are added to the Line List, the McGeer and Antibiotic Time-Out are done. She said the Line List is done on the units by the Unit Managers and then turned in. She said she does not always review the Line List for accuracy or review the notes/McGeer. The surveyor reviewed the Line List with the IP, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the IP said there was missing data and missing entries. She said she had seen a trend in UTIs a while ago but had not currently identified a trend with the E-Coli UTIs. She said overall the Line List is not very good because it doesn't show all the details for analysis since there is data missing. She said with the E-Coli pattern, that should have led to more education and training with the direct care staff, because they are usually from not washing well. She said we did that a while ago but not recently. During an interview on 3/13/26 at 4:31 P.M., the Director of Nurses said the Line List should be complete and accurate to be able to analyze the data. She said the progress notes should tell the story related to the infection and symptoms and they do not. She said she doesn't review the Line List monthly, the IP reviews it for trends, but the symptoms, type of organism, treatment, and follow up should all be documented and they are not. She said the E-Coli pattern indicates we should be doing more in-servicing around peri care. Refer to F881

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement an antibiotic stewardship program which included a system to monitor antibiotic use, including prophylactic antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance. Specifically, the facility failed:1. For Resident #56, to document the rationale for antibiotic treatment of an infection not meeting the criteria of an infection;2. For Resident #2, to ensure he/she was prescribed an antibiotic susceptible to the organism growth and to document rationale for antibiotic treatment of an infection not meeting the criteria of an infection;3. For Resident #35, to ensure he/she was prescribed an antibiotic susceptible to the organism growth and not treated with a prophylactic antibiotic concurrently and to document rationale for antibiotic treatment of an infection not meeting the criteria of an infection;4. For Resident #21, to document the rationale for antibiotic treatment from a Hospice recommendation of an infection not meeting the criteria of an infection and to document follow up with provider after a repeat culture was recommended; and5. For Resident #16, to document the rationale for antibiotic treatment of an infection not meeting the criteria of an infection and to document follow up with provider after the culture resulted. Findings include:Review of the facility's policy titled Antibiotic Stewardship, dated as last revised December 2016, indicated but was not limited to the following:-The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents.-When a nurse calls a physician/prescriber to communicate a suspected infection, he/she will have the following information available: Signs and symptoms, when they started, hydration status, infection type, and time of the last antibiotic dose.-When antibiotics are prescribed over the phone, the primary care practitioner will access the resident within 72 hours of the telephone order. Review of the facility's policy titled Antibiotic Stewardship-Orders for Antibiotics, dated as last revised December 2016, indicated but was not limited to the following:-Appropriate indications for use of antibiotics include criteria met for clinical definition of active infection or suspected sepsis and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending).-Empirical use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate. The staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record. Review of the facility's policy titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, dated as last revised December 2016, indicated but was not limited to the following:-The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship.-All clinical infections treated with antibiotics will undergo review by the IP.-All resident antibiotic regimens will be documented on the facility approved antibiotic surveillance tracking form. The information gathered will include date that symptoms appeared, name of antibiotic, start/stop date of antibiotic, date of culture, pathogen identified, and outcome. 1. Resident #56 was admitted to the facility in October 2025 with diagnoses which included Urinary Tract Infection (UTI), diabetes, and paranoid psychotic disorder. Review of the medical record including nursing notes, physician progress notes, McGeer Assessments (tool utilized to see if an illness meets the criteria for an infection), orders, Medication Administration Records (MAR), and lab results indicated but were not limited to the following: NOVEMBER 2025-11/1/25 through 11/25/25 no signs/symptoms of a UTI documented.-11/5/25 seen by the Nurse Practitioner (NP) and complained of dysuria (discomfort urinating) with new order for labs and a urine (UA C&S).-11/10/25 seen by the Physician (MD), no sign/symptoms of a UTI reported, and started on Bactrim twice daily for three days.-Urine culture report not provided by the facility to the surveyor.-He/she completed the course of antibiotics.-A McGeer Assessment was completed indicating additional symptoms not documented in the medical record had been present and the UTI met criteria.-The UTI was coded on the monthly Line List of Infections as a HealthCare Associated Infection (HAI) that met criteria for an infection (although it did (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not meet criteria per documentation).-11/25/25 noted with confusion, new order from NP for labs, chest X-Ray, and urine.-11/26/25 he/she had no documented signs/symptoms of a UTI, was started on Rocephin Igram (g) intramuscularly (IM) daily for five days, culture still pending.-11/28/25 the culture resulted positive for Klebsiella Pneumoniae greater than 100,000colonies /milliliter (c/ml) and to continue antibiotic as ordered.-He/she completed the course of antibiotics.-A McGeer Assessment was completed indicating additional symptoms not documented in the medical record had been present and the UTI met criteria.-The UTI was coded on the monthly Line List of Infections as a HAI that met criteria for an infection (although it did not meet criteria per documentation). DECEMBER 2025-12/20/25 started Clindamycin for cellulitis (skin infection)-12/23/25 Clindamycin discontinued due to loose stools.-12/28/25 he/she was behavioral and hallucinating and was transferred to the hospital.-12/31/25 returned to the facility with a UTI (diagnosed on [DATE]), to complete a course of Cefuroxime 500mg twice daily for a week.-A McGeer Assessment was not completed for cellulitis or the UTI.-The cellulitis was coded on the monthly Line List of Infections as a HAI that met criteria for an infection.-The UTI was not coded on the monthly Line List of Infections. JANUARY 2026-He/she completed the course of antibiotics for UTI on 1/8/26.-1/1/26 through 1/31/26 he/she had no signs/symptoms of UTI documented.-1/21/26 he/she was hallucinating and NP ordered labs, a urine, and for psych to see him/her.-1/21/26 urinalysis resulted negative.-A McGeer Assessment was not completed for the UTI diagnosed at the hospital.-The UTI was coded on the monthly Line List of Infections as a Community Acquired Infection (CAI) that met criteria for an infection (although it did not meet criteria per documentation) and should have been coded as a HAI as culture date was the date of transfer. 2. Resident #2 was admitted to the facility in October 2025 with diagnoses which included obstructive reflux uropathy (urine flow is blocked or flows backwards), UTI, and urogenital implants (medical device to treat incontinence). Review of the medical record including nursing notes, physician progress notes, McGeer Assessments, Hospital paperwork, orders, MARs and lab results indicated but were not limited to the following: NOVEMBER 2025-11/1/25 and 11/2/25 he/she had no signs/symptoms of a UTI documented.-11/2/25 he/she was transferred to the emergency room for chest pain and returned the same day after being treated for muscular chest pain, chest congestion, and viral respiratory illness.-11/3/25 verbal orders for labs, a UA C&S, and Prednisone (steroid) taper were given. No signs/symptoms of a UTI were documented.-11/7/25 he/she continued to have no signs/symptoms of a UTI, had congestion, cough, and wheezing noted. New order obtained for a chest X-ray.-11/7/25 UA C&S resulted positive for Klebsiella Pneumoniae and Enterococcus Faecalis both greater than 100,000 c/ml. Resident remained asymptomatic and was started on Ertapenem 1g IM for five days. Neither organism was susceptible to Ertapenem per the culture report.-A McGeer Assessment was not completed.-Nurse Practitioner (NP) note indicated the culture was reviewed and antibiotics started and failed to indicate any symptoms of a UTI had been present.-He/she completed the course of IM antibiotics for a positive urine culture with no clinical symptoms.-The UTI was coded on the monthly Line List of Infections as a HAI that met criteria for an infection (although it did not meet criteria per documentation). FEBRUARY 2026-2/1/26 through 2/10/26 he/she had no signs/symptoms of a UTI.-2/9/26 a UA C&S was obtained and pending results. The progress notes failed to indicate why a UA C&S was obtained.-2/10/26 he/she was transferred to the hospital with uncontrolled shaking and diagnosed with a UTI. He/she returned to the facility seven days later after completing a course of antibiotics at the hospital.- A McGeer Assessment was not completed.-The infection was not tracked on the monthly Line List of Infections. 3. Resident #35 was admitted to the facility in June 2025 with diagnoses which included Benign Prostatic Hyperplasia (BPH-enlarged prostate) with lower urinary tract symptoms, neuromuscular dysfunction of the bladder (nerve damage to bladder), cerebral infarct (CVA-stroke), and resistance to Vancomycin (potent antibiotic to treat serious resistant bacterial infections). Review of the medical record including nursing notes, physician progress notes, McGeer Assessments, orders, MARs, and lab results indicated but were not limited to the following: JANUARY 2026-Methenamine Hippurate (Hiprex-antibiotic to reduce/prevent (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	UTIs) 1g twice a day indefinitely. (6/25/25)-1/5/26 seen by NP, lethargic and confused, insulin dose increased, and labs ordered.-1/6/26 lab work indicated high white blood cell count 11.9 (WBC-high levels often indicate inflammation or infection, normal range is 5-10).-1/6/26 through 1/10/26 he/she had no documented signs/symptoms of a UTI.-1/10/26 UA C&S resulted positive for Escherichia Coli (E-Coli) greater than 100,000c/ml. Resident remained asymptomatic and was started on Vantin 200mg twice daily for seven days. The culture and sensitivity report did not list Vantin as an antibiotic the organism was susceptible to or resistant to.-A McGeer Assessment was completed indicating an additional symptom not documented in the medical record had been present and the infection met criteria.-He/she completed the course of antibiotics for a positive urine culture with no clinical symptoms other than confusion and lethargy four days prior to the urine resulting and received the Hiprex daily.-The UTI was coded on the monthly Line List of Infections as a HAI that met criteria for an infection (although it did not meet criteria per documentation). FEBRUARY 2026-Methenamine Hippurate (Hiprex) 1g twice a day indefinitely. (6/25/25)-2/1/26 through 2/15/26 he/she had no signs/symptoms of a UTI.-2/15/26 he/she was confused, agitated, and attempted to walk (despite being unable to ambulate). Labs, urine, and Trazodone (medication to treat agitation) were ordered.-2/17/26 he/she was coughing, chest X-Ray showed air disease, and he/she was started on Levaquin 500mg for seven days. UA C&S remained pending with no documented signs/symptoms of a UTI.-2/18/26 Urinalysis resulted positive, culture was still pending. NP changed antibiotics from Levaquin to Bactrim twice a day for seven days, review culture when complete.-A McGeer Assessment was done for respiratory illness meeting criteria of an infection however the McGeer failed to address the UTI.-2/21/26 UA C&S resulted positive for E-Coli/Extended-spectrum beta-lactamase (ESBL-bacteria resistant to many antibiotics) 50,000-100,000c/ml. The organism was resistant to both Levaquin and Bactrim. NP ordered Macrobid 100mg twice a day for seven days.-Resident continued to present with no signs/symptoms of a UTI and completed the course of antibiotics and received the Hiprex daily until 2/26 when the pharmacist recommended it be held while on the Macrobid.-The Pneumonia and UTI were coded on the monthly Line List of Infections as a HAI that met criteria for an infection (although the UTI did not meet criteria per documentation). 4. Resident #21 was admitted to the facility in November 2023 with diagnoses which included hemorrhoids, chronic constipation, flaccid neuropathic bladder, and palliative care. Review of the medical record including nursing notes, physician progress notes, McGeer Assessments, orders, MARs, and lab results indicated but were not limited to the following: JANUARY 2026-1/1/26 through 1/13/26 he/she had no signs/symptoms of a UTI.-He/she had a Foley catheter in place.-1/13/26 he/she presented with hematuria (blood in the urine) in the catheter bag.-1/13/26 he/she was seen by the Hospice Nurse, and a recommendation was made for Keflex 250mg twice a day for five days for a suspected UTI. The only symptom noted was hematuria.-A urine was not ordered.-He/she completed the course of antibiotics. Hematuria continued off and on.-1/20/26 Foley catheter irrigation ordered.-1/21/26 Hospice advised staff to contact them with increased hematuria/clots.-A McGeer Assessment was completed indicating an additional symptom not documented in the medical record had been present and the infection met criteria.-The UTI was coded on the monthly Line List of Infections as a HAI that met criteria for an infection (although it did not meet criteria per documentation). FEBRUARY 2026-2/1/26 through 2/3/26 he/she had no signs/symptoms of a UTI documented.-2/3/26 he/she had hematuria and Hospice recommend obtaining a urine. No other signs/symptoms of a UTI were documented, and the Foley catheter remained in place.-2/6/26 he/she presented with respiratory symptoms, urine culture resulted positive for greater than 100,000c/ml mixed gram-negative organisms and recommended a repeat culture if clinically indicated.-2/7/26 he/she was seen by Hospice who recommended Doxycycline 100mg twice a day for upper respiratory infection (URI).-The notes failed to indicate the provider was made aware of the recommendation for a repeat culture.-He/she completed the course of antibiotics.-A McGeer Assessment was completed indicating an additional symptom not documented in the medical record had been present and the UTI (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	met criteria however the McGeer failed to address the URI.-The URI was coded on the monthly Line List of Infections as a HAI that met criteria for an infection. 5. Resident #16 was admitted to the facility in July 2025 with diagnoses which include BPH without lower urinary tract symptoms, urinary retention, and diabetes. Review of the Medial Record including nursing notes, physician progress notes, McGeer Assessments, orders, MARs, and lab results indicated but were not limited to the following: FEBRUARY 2026-2/1/26 through 2/18/26 no documented signs/symptoms of a UTI documented.-2/18/26 he/she was sent to the hospital for hip pain. He/she returned the same day with diagnoses of hip pain and urinary retention. Labs at the hospital indicate a WBC of 15.1 and urine culture was pending. Nursing to follow up on the culture with the hospital. Additional labs ordered.-2/19/26 call placed to hospital requesting culture. Repeat urine ordered due to glucosuria (glucose in the urine).-2/21/26 at 6:55 A.M., NP returned 12:00 A.M., phone call regarding the urinalysis and hematuria, covering NP ordered Cipro 500mg twice daily for seven days for UTI and to encourage fluids (the culture was still pending at this time).-2/21/26 at 8:29 A.M., the culture resulted with less than 10,000c/ml mixed gram positive and negative. The progress notes failed to indicate this culture result was reported to the NP/MD.-2/21/26 through 2/28/26 he/she continued with off and on hematuria, but no other signs/symptoms of a UTI had been documented.-He/she completed the course of antibiotics.-A McGeer Assessment was completed indicating an additional symptom not documented in the medical record had been present and the UTI did not meet criteria.-The URI was coded on the monthly Line List of Infections as a possible UTI on prophylactic treatment. During an interview on 3/13/26 at 2:52 P.M., Unit Manager (UM) #2 said the nurses on the unit do the McGeer Assessment and she doesn't check them for accuracy. She said the Antibiotic time out is done by the nurse too and they do not write good notes, so she is unable to speak of what information may have been discussed and why these residents continued antibiotic treatment. UM #2 said she runs a report at the end of the month of all residents on antibiotics and those are the residents she puts on the Line List of Infections. She said she has two residents on prophylactic antibiotics but those are not tracked. She said the Infection Preventionist (IP) reviews it all. During an interview on 3/13/26 at 3:34 P.M., the IP said if a test resulted positive, they would go on the Line List to track the infection and anyone on an antibiotic. She said the UM's complete the Line List but she doesn't review it for accuracy. She said the line list is not great because it doesn't show all of the data accurately as it should. She said they do not have a tracking system for prophylactic antibiotics; she said they defer to the specialists and did not know what residents were on prophylactic treatment or if their medical record had an indication for use and follow up from the providers. She said every infection/illness should have an accurate McGeer assessment completed and the symptoms should be documented in the notes. She said the McGeer assessments are not all accurate. She said the antibiotic 48-hour review with the MD is a check box and the system doesn't prompt the nurses to write a note, but they should. Additionally, if the culture isn't back when the 48-hour alert populates there is not an additional one. She said if the infection does not meet criteria the provider should be notified, detailed notes written, and an additional note written about why the treatment is going to continue. The IP said the Hospice recommendations need to be reviewed with the provider and a note detailing why treatment is occurring if the infection doesn't meet criteria should be done and there is nothing in the record. These issues do not follow our Antibiotic Stewardship program to ensure residents are not on antibiotics they may not need. During an interview on 3/13/26 at 4:31 P.M., the Director of Nurses (DON) said the McGeer assessments and the Line List should be complete and accurate to ensure proper use of the antibiotics and tracking of infections. She said the signs/symptoms should be documented in the medical record to match the McGeer assessment and many do not match. Additionally, all applicable sections of McGeer assessments should be complete and they are not. She said for infections not meeting criteria there should be additional notes indicating why they are being treated and there are not. She said they need to do a better job to ensure residents are not being treated with antibiotics they may not need or are incorrect.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimwell Nursing and Rehabilitation	495 New Boston Road Fall River, MA 02720

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews, the facility failed to ensure activities of daily living (ADL) care was provided to maintain good personal hygiene for one Resident (#35), in a total sample of 21 residents. Specifically, the facility failed to ensure showers were offered and provided per his/her shower schedule. Findings include: Review of the facility's policy titled Activities of Daily Living (ADL) Support, dated as last revised March 2018, indicated but was not limited to the following:-Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.-Refusal of care and information are documented in the resident's clinical record.-Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including support and assistance with hygiene (bathing, dressing, grooming, and oral care). Resident #35 was admitted to the facility in June 2025 with diagnoses which included abnormal gait and mobility, cerebral infarct (stroke), osteoarthritis, and left hip pain. Review of the Minimum Data Set (MDS) Assessment, dated 3/11/26, indicated Resident #35 scored 10 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment, and was dependent on staff for ADLs, bathing, and showering, and had not refused care. Review of the Nursing Assignment roster indicated Resident #35 was scheduled for showers twice weekly, Tuesday 7-3 shift and Wednesday 3-11 shift. Review of the Certified Nursing Assistant (CNA) Assignment sheet indicated Resident #35 was scheduled for showers twice weekly, Tuesday 7-3 shift and Wednesday 3-11 shift. Review of the Comprehensive Care Plan indicated but was not limited to the following:FOCUS:-The Resident has an ADL self-care performance deficit related to deconditioning and fatigue.INTERVENTION:-Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated.-Maximum assistance with bathing.-May use Hoyer (mechanical lift) as needed (PRN). Review of the CNA Care Card/Kardex indicated but was not limited to the following:-Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated.-Maximum assistance with bathing.-May use Hoyer PRN. During an interview on 3/10/26 at 9:15 A.M., Resident #35 said he/she had not been showered in at least three weeks. The Resident said he/she would like a shower, but the staff don't do it because they must Hoyer me to the shower bed and it is a pain. The Resident said he/she cannot sit safely in the regular shower chair which is why they need to use the shower bed. Additionally, he/she said their nails are long and dirty, they have not been cut, and he/she has never had nail care done. The Resident said he/she was going to ask for them to be cut again today because he/she had an appointment. The surveyor made the following observations:-3/10/26 at 9:15 A.M., Resident lying in bed, hair long, greasy, nails long and dirty with dark substance under the nail bed.-3/11/26 at 12:18 P.M., Resident sitting in reclining Broda chair (positioning chair), disheveled with hair long, greasy, and uncombed. Nails were trimmed at his/her request. During an interview on 3/11/26 at 12:18 P.M., Resident #35 said he/she was not showered last night or this morning. He/she said the CNAs are afraid to use the chair because he/she might fall out of it and they must use the big shower bed. He/she said they used it a couple of weeks ago, but there are not always enough staff to use it. Review of the CNA shower documentation from 2/1/26 through 3/12/26 indicated Resident #35 was not showered 6 out of 12 scheduled days and one out of the 12 scheduled days it was documented the Resident refused. Review of the nursing progress notes from 2/1/26 through 3/12/26 failed to indicate he/she was offered and refused a shower. Further review of the one refusal indicated it occurred on 3/11/26 on the 3-11 shift. During an interview on 3/12/26 at 12:05 P.M., Resident #35 said he/she did not get a shower yesterday, but this morning staff washed him/her up in bed. He/she said it's fine, but they would prefer a shower. During an interview on 3/12/26 at 2:15 P.M., CNA #1 said showers are given weekly, the schedule for every resident is on the assignment sheet. She said they have a shower chair and a shower bed for those residents that are Hoyer lifts. She said they document if they got the shower or not in the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	computer. During an interview on 3/12/26 at 2:20 P.M., Nurse #1 said showers are scheduled twice a week, one on day shift and one on evening shift. She said the CNAs document if they got it or not, but any refusal should be reported to the nurse and then documented int the progress notes. During an interview on 3/12/26 at 2:29 P.M., Unit Manager #2 said showers are to be given per the schedule on the assignment sheet. She said it is on both the nurses and CNAs' assignment sheet. She said one is during the day and one in the evening and she would expect the nurses to check with the aides to ensure it was done. Additionally, she said if someone refuses, the nurse should talk to them and then document in the progress note that they refused. She said the CNAs have been educated to let the nurse know if someone refuses so they can follow up. She said the CNAs document on the computer whether the resident got the shower or not, but the nurse does not have a check off on the treatment sheets. She said Resident #35 got a good bed bath today, hair was washed, combed, and trimmed. During an interview on 3/12/26 at 3:10 P.M., the Director of Nurses (DON) said showers should be given twice a week and if a resident refuses the nurse should be notified. Then the nurse should check with the resident and if they still refuse it should be documented in the progress notes. During an interview on 3/13/26 at 4:41 P.M., the DON said she would expect the shower to be given on each scheduled day, and it was not per the documentation. She said the CNAs should not be documenting not applicable (N/A) in the scheduled shower days, it should state the residents transfer status for the shower or refused if they refused the shower. Additionally, she said if he/she had refused for some reason there should be a progress note and there are not any.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident at with an alteration in skin integrity related to a wound, specifically chronic venous ulcers, received necessary treatment and services to promote healing for one Resident (#74), out of a total sample of 21 residents. Specifically, the facility failed to transcribe and implement wound care per the Hospital Discharge Summary for seven days. Findings include: Review of the facility's policy titled Medication Orders, dated as last revised November 2014, indicated but was not limited to the following:-A current list of orders must be maintained in the clinical record of each resident.-Treatment Orders: When recording treatment orders, specify the treatment, frequency, and duration of the treatment. Review of the facility's policy titled Charting and Documentation, dated as last revised July 2017, indicated but was not limited to the following:-All services provided to the resident, progress toward the care planned goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the Interdisciplinary Team (IDT) regarding the resident's condition and response to care.-The following information is to be documented in the resident medical record: Treatments or services provided.-Documentation in the medical record will be objective, complete, and accurate. Resident #74 was admitted to the facility in January 2026 with diagnoses which included Methicillin Resistant Staphylococcus Aureus (MRSA) infection, localized edema, chronic venous hypertension with ulcer of bilateral lower extremities, peripheral vascular angioplasty with implants and grafts, non-pressure chronic ulcer of part of the left lower leg, and chronic venous insufficiency. Review of the Minimum Data Set (MDS) Assessment, dated 3/5/26, indicated Resident #74 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact, was a risk for pressure ulcers, and had medication/ointments applied. Review of the medical record indicated he/she was transferred to the hospital and re-admitted to the facility after a 10-day stay at an acute care hospital for sepsis, pneumonia, and wound management. Review of the Comprehensive Care Plan indicated but was not limited to the following:FOCUS: The resident has potential/actual impairment to skin integrity related to fragile skin. Actual: LLE vascular Ulcers.INTERVENTIONS:-Follow facility protocol for treatment of injuries.-Monitor/Document location, size, and treatment of skin injury. Review of the Discharge summary, dated [DATE], indicated but was not limited to the following:-discharge date : [DATE]-Follow up issues for provider: Continue Wound Care.-Assessment and Plan: Left lower extremity (LLE) stasis ulcer: Antibiotic course for wound infection completed. Continue with local wound care: LLE: Cleanse with warm water and mild soap, dry, apply A&D ointment to intact skin, Aquacel AG to wound bed, cover with ABD pads, secure with kling. Change dressing every Monday-Wednesday-Friday. 2/5/26 wound culture +MRSA and Carbapenem resistant pseudomonas. Contact Precautions. Review of the admission orders on 2/24/26 failed to indicate a treatment was ordered for the LLE ulcer until 3/3/26. Review of the Treatment Administration Record (TAR) for February and March 2026 indicated but was not limited to the following:-A treatment was in place for the LLE ulcer prior to the hospitalization. (Cleanse LLE with wound cleanser, pat dry, apply xeroform, followed by 4x4 gauze, wrap with kling and change twice daily. 1/29/26)-No treatment was in place for LLE ulcer from 2/24/26 through 3/3/26.-A treatment was ordered for LLE ulcer on 3/3/26. (Cleanse LLE with wound cleanser and pat dry. Apply xeroform to open areas, apply Abd pad followed by kerlix wrap one time day. 3/3/26). Review of the Nursing Progress note, dated 2/24/26, indicated Resident #74 was readmitted and the LLE treatment remained in place. Review of the Nursing and Physician progress notes from February and March failed to indicate the physician declined to order the treatment per the Discharge Summary to the LLE upon return from the hospital. During an interview on 3/13/26 at 2:44 P.M., Nurse #6 said she did the admission and the LLE treatment was not entered into the computer. She said it was the first one she had done, had some help, but the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order was missed. She said orders from the Discharge Summary should have been entered into the computer when Resident #74 returned from the hospital. She said she was off for a few days and when she returned to work, she realized there was not a treatment order in place for the LLE ulcer and obtained an order for one on 3/3/26. She said when they do an admission a second nurse checks the medications, but she was unsure if anyone checks the treatments to ensure nothing was missed. During an interview on 3/12/26 at 2:52 P.M., Unit Manager (UM) #2 said all medication and treatment orders from the Discharge Summary should have been reviewed with the provider and entered into the computer. She said she follows up for appointments, labs, etc. Additionally, she said a second nurse checks the medications and then the UM completes an audit tool, but she could not recall if the audit was done for this readmission and was unsure why the orders were not implemented for a week. During an interview on 3/13/26 at 4:30 P.M., the Director of Nurses (DON) said the nurse confirms the meds and treatments with the provider and enters them into the computer. She said the audit tool should be done by leadership and then given to her, but in this case the order was missed, and the audit was not done due to the snowstorm.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review, the facility failed to ensure all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. Specifically, the facility failed to:1. Properly monitor medication refrigeration temperatures in one of three medication storage rooms reviewed to ensure the safety and integrity of vaccines stored; and2. Provide a permanently affixed compartment and separate from all other medications for the storage of schedule IV (low potential for misuse and dependence) controlled substance in two of three medication room refrigerators reviewed. Findings include:Review of the facility's policy titled Medication Storage in the Facility, dated November 2021, indicated but was not limited to the following:-Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations.-Controlled substances that require refrigeration are stored within a locked box within the refrigerator.-This box must be attached to the inside of the refrigerator.-The facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC (Centers for Disease Control and Prevention) guidelines. Review of CDC guidance titled Epidemiology and Prevention of Vaccine-Preventable Diseases: Chapter 5: Vaccine Storage and Handling, dated 4/3/24, indicated but was not limited to the following:Monitoring Vaccine Temperatures:-To ensure the safety of vaccines, the storage unit minimum and maximum temperatures should be checked and recorded at the start of each workday. If using a TMD (temperature monitoring device) that does not display minimum and maximum temperatures, then the current temperature should be checked and recorded a minimum of two times (at the start and end of the workday). 1. On 3/11/26 at 10:34 A.M., the surveyor reviewed the facility's medication storage room on the K1 Unit with Nurse #3 and observed the following inside the medication refrigerator:-One dose of Afluria Quadrivalent (inactivated influenza vaccine).-One dose of Prevnar 20 (vaccine used to prevent pneumococcal pneumonia and invasive disease). During an interview on 3/5/26 at 11:39 A.M., Nurse #3 said vaccines are stored in this refrigerator for the residents on the unit. She said the temperature is monitored only once a day on the 11:00 P.M.-7:00 A.M. shift. Review of the medication refrigerator Temperature Logs dated September 2025 through March 2026 indicated temperatures were being monitored and recorded only once daily. 2. On 3/11/26 at 11:04 A.M., the surveyor reviewed the facility's medication storage room on the K2 Unit with Nurse #5 and observed the following inside the medication refrigerator:-A locked box glued to a removable glass shelf. Nurse #5 opened the lock box and inside was the following medications:-Two bottles of liquid Lorazepam 0.5 milligrams (mg) (a schedule IV narcotic used to treat anxiety)Nurse #5 said the locked box is not secure inside the refrigerator and can be easily removed. Nurse #5 said it is supposed to be secured. On 3/11/26 at 11:12 A.M., the surveyor reviewed the facility's medication storage room on the K3 Unit with Nurse #2 and observed the following inside the medication refrigerator:-A locked box glued to a removable glass shelf. Nurse #2 opened the lock box and inside was the following medication:-One bottle of liquid Lorazepam 0.5 mgNurse #2 said the locked box is supposed to be secured to the refrigerator and not removable. She said it is not secure as it should be. During an interview on 3/16/26 at 11:51 A.M., the Director of Nursing (DON) said her expectation is for refrigerator temperatures to be monitored twice a day for all vaccine storage to maintain the efficacy of the vaccines. The DON said all narcotics must be stored with a double locking method. She said the lock boxes must be affixed to the refrigerator and not a shelf that can be removed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure a complete and accurate medical record was maintained for two Residents (#74 and #35), out of a total sample of 21 residents. Specifically, the facility failed to ensure:1. For Resident #74, the Medical Orders for Life Saving Treatment (MOLST) in the Electronic Medical Record (EMR) matched the active Do Not Resuscitate, Intubate, or Ventilate physician's order; and2. For Resident #35, with a diagnosis of dysphagia (difficulty swallowing), he/she did not have conflicting therapeutic diet orders of Regular texture versus Mechanical Soft/Ground texture in the active medical record. Findings include: 1. Review of the facility's policy titled Electronic Medical Record (EMR), dated 12/19/22, indicated but was not limited to the following:-The EMR's quality and integrity shall be maintained by adhering to identified standards in entering complete, concise, accurate and updated information that produces clear and useful medical record.-Staff making entry into the EMR are responsible for checking for contradictory information and ensuring the accuracy of the medical necessity of any information that is imported. Review of the facility's policy titled Do Not Resuscitate (DNR) Order, dated as last revised March 2024, indicated but was not limited to the following:-DNR orders must be signed by the resident's attending physician on the physician's order sheet and maintained in the resident's medical record. Resident #74 was admitted to the facility in January 2026 with diagnoses which included myocardial infarction (MI/heart attack), malignant neoplasm of the skin, heart failure, and heart block. Review of the active Physician's Orders in the EMR indicated but was not limited to the following:-Honor most recent MOLST-DNR, Do Not Intubate and Ventilate (DNI), Do Not use CPAP, Transfer to the Hospital, May use Dialysis, No Artificial Nutrition, Use Artificial Hydration. (2/26/26). Review of the EMR indicated but was not limited to the following:-The scanned documents section had one MOLST, dated 1/6/26, indicating Resident #74 was a Full Code and wanted to be resuscitated, intubated, and ventilated. Review of the paper chart/medical record indicated but was not limited to the following:-A pink MOLST, dated 2/26/26, indicated Resident #74 was a DNR, DNI. During an interview on 3/12/26 at 2:20 P.M., Nurse #1 said when a MOLST is updated, the original is put in the paper chart, and a copy is placed into the bin to be scanned. She said Medical Records scans them in, usually within a week. She looked in the bin and there were not any documents for Resident #74. She said she always checks the paper chart, but the most recent and accurate MOLST should be scanned into the EMR. During an interview on 3/12/26 at 2:29 P.M., Unit Manager #2 said when a MOLST is changed the original goes in the paper record and a copy goes in the bin to be scanned. She said everything should be scanned within a week. She said we have had some issues with things not being scanned in timely. During an interview on 3/12/26 at 3:10 P.M., the Director of Nurses (DON) said when a MOLST is updated the original goes in the paper chart and a copy is made and placed in the bin for Medical Records to scan. She said they scan documents a couple times a week but would expect it to be scanned within a week. She said the nurses have been educated to check the paper charts for the MOLST and to go by that one, but she could see how there is potential for someone to get the wrong information. 2. Review of the facility's policy titled Therapeutic Diets, undated, indicated but was not limited to the following:-Diet will be determined in accordance with treatment goals and wishes.-Therapeutic diet must be prescribed by the attending physician.-A Therapeutic diet is considered a diet ordered to modify specific nutrients or to alter the texture of a diet, for example: diabetic/calorie controlled or altered consistency diet.-If a mechanically altered diet is ordered, the provider will specify the texture modification.-The dietician, nursing staff, and attending physician will regularly review the need for and acceptance of his/her therapeutic diet.-Snacks will be compatible with the therapeutic diet. Resident #35 was admitted to the facility in June 2025 with diagnoses which included diabetes mellitus, heart disease, and cerebral infarction (stroke). Review of the Minimum Data Set (MDS) Assessment, dated 3/11/26, indicated Resident #35 scored 10 out of 15 (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment, was on a therapeutic diet, and not on a mechanically altered diet. During an interview on 3/10/26 at 9:15 A.M., Resident #35 said he/she didn't think the facility was managing his/her diet very well. Review of the active Physician's Orders indicated the following:-CCHO/Diabetic Diet: Mechanical Soft (ground meat) texture, thin consistency. (3/2/26)-CCHO/Diabetic Diet: Regular texture, thin consistency, diabetic diet, DOUBLE PROTEIN, half portion of starch, sugar free ice cream with lunch and dinner. (8/29/25) Review of the ST evaluation and notes indicated but were not limited to the following:-3/3/26 Evaluation: Diagnosis: Dysphagia (difficulty swallowing). Patient was referred by nursing for a swallowing evaluation due to difficulty masticating (chewing) solids/meats. Assessment Summary: Patient requires ST for dysphagia management, compensatory strategies, and education. Diet Considerations: Thin liquids and Mechanical soft/chopped textures.-3/3/26 through 3/12/26 visit notes indicate functional status as a result of skilled interventions: Thin liquids and Mechanical soft/chopped textures During an interview on 3/12/26 at 12:10 P.M., Unit Manager (UM) #2 said the nurse on Team One checks the lunch trays for correct texture and for thickened liquids if needed. After reviewing the meal ticket for Resident #35, UM #2 said she thought the word Regular referred to the liquids because it also says Mechanical Soft/Ground but was not sure. She said no one should have two active diet orders because they could get the wrong one. Additionally, she said she wasn't sure where the CNAs got diet information from if it was outside of mealtime. During an interview on 3/12/26 at 12:13 P.M., the Infection Preventionist (IP) said the CNAs and other staff get diet information from a daily printed diet report. During an interview on 3/12/26 at 12:14 P.M., the Activities Director said there is a report that gets printed daily with everyone's diet order. He printed the report and provided it to the surveyor. Review of the Diet Type Report indicated but was not limited to the following:-Resident #35: Diet Type: CCHO/Diabetic; Diet Texture: Mechanical Soft (ground meat); Fluid Consistency: Thin-Resident #35: Diet Type: CCHO/Diabetic; Diet Texture: Regular; Fluid Consistency: Thin; Additional Directions: diabetic diet, DOUBLE PROTEIN, half portion of starch, sugar free ice cream with lunch and dinner During an interview on 3/12/26 at 12:16 P.M., the Activities Director said Resident #35 had two diet orders listed and that is an issue because it is not clear which one is correct. During an interview on 3/12/26 at 12:16 P.M., the Assistant Director of Nurses said the aides should be asking the nurse about a diet if they have questions. She said the accurate diet for Resident #35 is a regular diet. She said there are two different orders in the computer and there shouldn't be. She said when a new diet order is written the previous one should be discontinued. During an interview on 3/12/26 at 12:19 P.M., UM #2 said she reviewed the orders and speech downgraded the diet to ground meat on 3/2/26 and the nurse that reviewed and signed the order must have forgotten to discontinue the other diet and that is why there are two different orders. She said the kitchen is sending ground meat, but orders need to be fixed. During an interview on 3/12/26 at 3:10 P.M., the Director of Nurses (DON) said the nurse checks the tray at meals to ensure the correct texture. She said the CNAs or Activity staff have questions; they should ask the nurse. She said the meal ticket does show both the Ground and Regular texture, the orders in the computer show both as active orders, and the Diet report has Resident #35 listed twice with two different diet orders. She said the CNAs and Activities staff use the daily report to reference diets and this is not clear what Resident #35 should in fact be getting. She said the nurse should have questioned why there were two orders and clarified to ensure they only get the correct diet. She said when the nurse took the diet downgrade order on 3/2/26 they did not discontinue the previous order. She said the computer program used for meal tickets communicates with the physician orders and that is why both diets are listed. She said there should be only one active order.