STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that professional standards of practice in delivery of care and services were being met for seven Resident's (#3, #5, #32, #15, #113, #108, and #2) out of a total sample size of 24 residents. Specifically, 1.For Resident #3, the facility failed to ensure that a Physician's order for CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) laboratory testing was obtained as ordered, placing Resident #3 at risk for worsening medical conditions. 2. For Resident #5, the facility failed to administer Insulin medication (Lispro) as prescribed by the Physician for 24 doses over a 19-day period and notify the Resident's Physician that the Resident's Lispro had not been administered as prescribed, placing Resident #5 at risk for variable blood sugar levels. 3. For Resident #32, the facility failed to ensure that output monitoring (any fluids leaving the body) was completed as Physician ordered for 15 days during a 21-day period, placing Resident #32 at risk for complications related to fluid imbalance. 4. For Resident #15, the facility failed to administer Enalapril Maleate (high blood pressure medication) as ordered on two non-consecutive dates, increasing the Resident's risk for medical complications.5. For Resident #113, the facility failed to administer Midodrine Hydrochloride [HCL] (orthostatic hypotension medication) as ordered on two non-consecutive dates, increasing the Resident's risk for medical complications.6. For Resident #108, the facility failed to ensure that repositioning and incontinence care was provided as documented by nursing staff on two separate occasions (8:00 A.M. and 10:00 A.M.) on 1/28/26, when the Resident was dependent on staff for ADL care and was at risk for skin impairment due to immobility.7. For Resident #2, the facility failed to ensure that Physician orders were followed for Furosemide (diuretic [increases urination] medication), Metoprolol Succinate Extended Release [ER] (high blood pressure medication), and Spironolactone (diuretic medication) when the order indicated to hold (not administer) the medications when the Resident's systolic blood pressure (SBP - top number of a blood pressure reading), was measured less than 110 mmHg (millimeters of mercury) and/or heart rate was less than 55 bmp (beats per minute). Findings Include: 1. Review of the facility policy titled Provision of Physician Ordered Services, dated 2/25/25 included but was not limited to the following: >The facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the Physicians orders. >Qualified nursing personnel will submit timely requests for Physician ordered services to the appropriate entity. Resident #3 was admitted to the facility in January 2026 with diagnoses including stricture (narrowing) of Artery, chronic vascular disorders of intestine and Clostridium Difficile (C-diff: bacteria that can cause severe watery diarrhea and bloody stools that could result in dehydration, loss of (continued on next page)

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
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appetite, blood loss, weight loss, fever and pain). Review of Resident #3's Medical Record included but was not limited to: -Resident #3 was prescribed Apixaban (blood thinning medication that increases the risk for bleeding) 5 mg (milligrams) by mouth twice a day, effective 1/8/26. -Resident #3 was prescribed Vancomycin (antibiotic used to treat Clostridium Difficile) 125 mg by mouth once a day, effective 1/8/26 -Physician's order for CBC and BMP weekly x (times) two weeks on 1/9/26 and 1/16/26, effective 1/8/26. -Evidence of a laboratory report dated 1/9/26 which indicated the following abnormal results: >Blood [NAME] Nitrogen (BUN: measurement of the urea nitrogen in the blood) = 9 mg/deciliter (dl) which was below the normal reference range of 10 - 24 mg/dl. >Creatinine (waste product that the kidneys filter from the blood) = 0.62 mg/dl which was below the normal reference range of 0.70 - 1.50 mg/dl. >Total Protein (concentration of protein in the blood serum) = 5.5 gram (g)/dl which was lower than the normal reference range of 6.4 - 8.3 g/dl. >Hemoglobin (protein that helps carry oxygen to the body's organs and tissues) = 10.9 g/dl which was lower than the normal reference range of 12.1 - 15.7 g/dl. >Hematocrit (volume percentage of red blood cells in the blood) = 33.2% which was below the normal reference range of 35 - 45%. Review of Resident #3's Person - Centered Care Plan included but was not limited to the following: -Resident #3 was at risk for increased/abnormal bleeding due to the use of Apixaban with interventions including obtaining labs as ordered and reporting results to the Medical Doctor, initiated 1/10/26. Further review of Resident #3's Medical Record failed to indicate any evidence that the CBC and BMP laboratory testing ordered on 1/8/26 was obtained as ordered for 1/16/26. During an interview on 2/2/26 at 9:45 A.M., Unit Manager (UM) #1 said that Resident #3 did not have his/her blood work drawn on 1/16/26 as ordered by the Physician. UM #1 said the floor Nurse did not complete the electronic requisition for both dates of ordered blood work when transcribing the order on 1/8/26. UM #1 said that the electronic requisitions are needed so that the laboratory would know to come to the facility to collect the blood sample on the correct day. UM #1 said that the ordered lab work was important for Resident #3 to monitor baseline labs because the Resident's blood work from 1/9/26 had previously been abnormal and therefore placed Resident #3 at risk for unidentified worsening of lab results. 2. Review of the facility policy titled Timely Administration of Insulin, revised 4/9/25, included but (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not limited to the following: -It is the policy of this facility to provide timely administration of Insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. >all Insulin will be administered in accordance with physician's orders. Review of the facility policy titled Medication Administration, dated 4/9/25 included but was not limited to the following: >Report and document any held (not administered) medications to the Physician/Nurse Practitioner/Physician Assistant. Resident #5 was admitted to the facility in January 2026 with diagnoses including Diabetes. Review of the Minimum Data Set (MDS) Assessment, dated 1/14/26 indicated Resident #5: -had moderate cognitive impairment as evidenced by a Brief interview of Mental Status (BIMS) score of 11 out of a total possible score of 15. -had a diagnosis of Diabetes. -was administered Insulin. Review or Resident #5's Person-Centered Care Plan initiated on 1/9/26 included but was not limited to: -Diabetes, at risk for hypo (low)-hyper (high) glycemia (presence of glucose in the blood) with interventions including: >providing medications as ordered. Review of the Resident #5's January 2026 Physician orders included but was not limited to: -Lispro Insulin Injection Solution 100 unit/milliliter (ml) inject 5 units subcutaneously (below the skin) three times a day at 8:00 A.M., 12:00 P.M., and 6:00 P.M., for Diabetes, start date 1/9/26. Review of Resident #5's January 2026 Medication Administration Record (MAR) indicated that Resident #5 was not administered Lispro Insulin Injection Solution as prescribed on the following dates and times: -1/11/26, 1/12/26, 1/15/26, 1/16/26, 1/17/26,1/18/26, 1/20/26, 1/21/26, 1/23/26, 1/26/26 at 8:00 A.M. -1/14/26, 1/15/26, 1/16/26, 1/17/26, 1/18/26, 1/21/26, 1/22/26, 1/26/26 at 12:00 P.M. -1/9/26, 1/17/26, 1/18/26, 1/19/28, 1/20/26, 1/27/26 at 6:00 P.M. Review of Resident #5's Medical Record included 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
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No evidence of medication parameters (when to administer or to withhold administration) relative to Lispro Insulin Injection Solution. -No evidence that the Resident's Physician had been notified about the 24 doses of Lispro Insulin not administered to Resident #5. During an interview on 1/28/26 at 1:59 P.M., Unit Manager (UM) #1 said that Resident #5 should have been administered Insulin Lispro 5 units three times a day as ordered by the Physician. The surveyor and UM #1 observed the Resident's MAR and UM#1 said the Resident did not have parameters in place to hold the Lispro Insulin. UM #1 said that she was unable to provide evidence that the Nurses who did not administer the Resident's Lispro Insulin doses had notified the Resident's Physician, but they should have. UM #1 said that Resident #5 could be at risk for mental status changes or hypoglycemia [sic] episodes when not receiving his/her Insulin as ordered. 3. Review of the facility policy titled Hydration, dated 12/2/25 included but was not limited to the following: -The facility offers each resident sufficient fluid (the amount of fluid needed to prevent dehydration and maintain health). >Documentation: Record output in designated locations (Medication Administration Record [MAR] or Output Record). Resident #32 was admitted to the facility in January 2026 with diagnoses including Congestive Heart Failure and obstructive and reflux (backflow) uropathy. Review of Resident # 32's January 2026 Physician's orders included but was not limited to: -Foley Catheter (specific type of soft flexible tube that drains urine from the bladder) 24 French (5.5 millimeter diameter)/10 milliliter balloon (fluid filled balloon at the end of the catheter which anchors the catheter in place in the bladder) every shift, start date 1/8/26. -Furosemide 40 milligrams (mg) one time a day for diuresis. -Spironolactone Oral Tablet 25 mg by mouth once a day for diuresis. -Document intake (fluids taken into the body) and output every shift, start date 1/16/26. Review of Resident #32's Person-Centered Care Plan included but was not limited to: -Urinary Foley catheter related to Urine Retention with interventions including monitoring and documenting output, initiated 1/8/26. -Potential for fluid deficit related to diuretic use with interventions including Physician notification for persistent output exceeding intake in the past 48 hours. Review of the Minimum Data Set (MDS) Assessment, dated 1/8/26 indicated Resident #32: -has an indwelling urinary catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-was administered diuretics. Review of Resident #32's Treatment Administration Record (TAR) for January 2026 included but was not limited to: -incomplete documentation of Output recordings for seven days over a 12-day period between 1/8/26 - 1/19/26. -omitted documentation of Output recordings for nine days over a nine-day period between 1/20/26 - 1/28/26. During an interview on 1/29/26 at 10:27 A.M., UM #1 said Resident #32 had a current Physician's order to monitor and document Intake and Output (I & O) because the Resident had a urinary catheter in place. UM #1 said that each Nurse assigned to the Resident should document I & O every shift (11:00 P.M. - 7:00 A.M., 7:00 A.M. - 3:00 P.M., and 3:00 P.M. - 11:00 P.M.). The surveyor and UM #1 reviewed Resident #32's medical record and UM #1 said that the Resident's output documentation from 1/8/26 - 1/19/26 was incomplete and there was no evidence for output documentation recorded for 1/20/26 through 1/28/26. UM #1 said that output documentation was important for Resident #32 because not monitoring output could place Resident #32 at risk for fluid overload or dehydration. 4. Resident #15 was admitted to the facility in August 2025 with diagnoses including Dementia and Chronic Kidney Disease. Review of Resident #15's Physician's orders, dated 10/17/25 and discontinued 11/18/25, indicated: Enalapril Maleate Oral Tablet 20 mg; give one tablet by mouth in the morning for Hypertension (HTN). Hold for SBP below or equal to 110 mmHg. Review of Resident #15's Minimum Data Set (MDS) Assessment, dated 11/5/25, indicated the Resident was severely cognitively impaired as evidenced by a BIMS score of five out of 15 total possible points. Review of Resident #15's October 2025 and November 2025 Medication Administration Records (MARs) indicated: -The Resident's SBP was 106 mmHg (below 110) on 10/25/25 at the time Enalapril Maleate was due to be administered. -Enalapril Maleate was administered to the Resident on 10/25/25. -The Resident's SBP was 110 mmHg on 11/3/25 at the time Enalapril Maleate was due to be administered. -Enalapril Maleate was administered to the Resident on 11/3/25. 5. Resident #113 was admitted to the facility in January 2025 with diagnoses including Dementia and Hypotension. Review of Resident #113's Minimum Data Set (MDS) Assessment, dated 12/17/25, indicated the Resident was severely cognitively impaired as evidenced by a BIMS of eight out of 15 total possible (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	points. Review of Resident #113's Physician's orders, dated 3/25/25 with no end date, indicated: -Midodrine HCL Oral Tablet 2.5 mg, give one tablet by mouth in the morning for management of Hypotension. Hold for SBP greater than 130. Review of Resident #113's November 2025 and December 2025 MARs indicated: -The Resident's SBP was 130 mmHg on 11/6/25 at the time Midodrine HCL was due to be administered. -Midodrine HCl was not administered to the Resident and was indicated as 4 (vitals outside of parameters for administration). -The Resident's SBP was 134 mmHg (greater than 130) on 12/4/25 at the time Midodrine HCL was due to be administered. -Midodrine HCl was administered to the Resident on 12/4/25. During an interview on 1/30/26 at 2:29 P.M., the Director of Nursing (DON) said he reviewed both Residents #15's and Resident #113's clinical records and that Enalapril Maleate was administered to Resident #15 outside of the Physician ordered parameters on 10/25/25 and 11/3/25. The DON further said Midodrine HCl was administered to Resident #113 outside of the Physician ordered parameters on 11/6/25 and 12/4/25. The DON also said all medications should be administered to Residents according to the Physician's orders. 6. Resident #108 was admitted to the facility in April 2022 with diagnoses including cognitive impairment and need for assistance with personal care. Review of the Minimum Data Set (MDS) Assessment, dated 11/5/25, indicated Resident #108: -was severely cognitively impaired as evidenced by a BIMS score of six out of 15 total possible points. -was dependent on staff for bathing, dressing, toileting hygiene, and transfers. -required the use of a wheelchair. -was always incontinent of bowel and bladder. Review of Resident #108's active Care Plan indicated: -was incontinent of bowel and bladder related to Dementia. -has an ADL deficit and was dependent upon two staff members for bathing, dressing, bed mobility, and personal hygiene. -Clean peri-area with each incontinent episode. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-was at risk for potential skin impairment due to impaired mobility, impaired safety and judgment, obesity, and incontinence. On 1/28/26, from 7:45 A.M. until 11:49 A.M., the surveyor observed Resident #108 seated in his/her wheelchair in the East Two Unit Dining Room. The surveyor failed to observe any staff repositioning and providing incontinence care to Resident #108 during the observation period where the Resident remained seated in his/her wheelchair in the East Two Unit Dining Room. Review of Resident #108's Certified Nurse Aide (CNA) Flow Sheets, dated 1/28/26, indicated: -The Resident was dependent upon two staff, and was boosted and turned to his/her right side in bed at 8:00 A.M. and 10:00 A.M. -The Resident was dependent upon two staff, and was incontinent of urine at 8:00 A.M. and 10:00 A.M. During an interview on 1/29/26 at 9:55 A.M., CNA #2 said she worked on the East Two Unit on 1/28/26 for the day (7:00 A.M. through 3:00 P.M.) shift and that she had been responsible to provide care for Resident #108. CNA #2 said she did not provide repositioning and incontinence care for Resident #108 any time after she assisted the Resident out of bed in the morning on 1/28/26. During an interview on 1/29/26 at 2:50 P.M., the Director of Nursing (DON) said CNA's were supposed to record the care that they provided to residents. The DON said CNA #2 should have recorded the care provided for Resident #108 on the 1/28/26 day shift and should not have recorded care that was not provided for the Resident. 7. Review of the facility policy titled Vital Signs, dated 12/2/25, included but not limited to:*The purpose of this policy is to provide guidelines for the measurement and reporting of vital signs.-Licensed nurses are responsible for knowing the usual range of a resident's vital signs, analyzing and interpreting routine vital signs, and notifying the physician of abnormal findings. -Vital signs will be obtained by the nurse or therapist, as indicated, when administering certain medications, or monitoring for effectiveness of medications or therapies. For Example, >Certain cardiac drugs are given only when a resident's pulse or blood pressure is within certain range. Resident #2 was admitted to the facility in October 2025, with diagnoses including Left Bundle Branch Block (LBBB - heart condition), presence of cardiac pacemaker, unspecified Diastolic Congestive Heart Failure, Non-ST Elevation Myocardial Infarction, and paroxysmal Atrial Fibrillation. Review of the Minimum Data Set (MDS) Assessment, dated 11/17/25, indicated Resident #2: -was able to make him/herself understood, and he/she understood others with clear comprehension. -was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15. Review of Resident #2's Physician orders dated 1/28/26, indicated:-Furosemide Oral Tablet 20 milligrams (mg), give 1 tablet by mouth one time a day for Congestive Heart Failure (CHF), Hold if systolic blood pressure (SBP) is less than 110 mmHg, initiated 11/26/25.-Metoprolol Succinate Extended Release (ER) tablet 24-hour 50 mg. Give 1 tablet by mouth one time a day for Hypertension (HTN). Hold for SBP less than 110 mmHg, or HR (heart rate) less than 55 bpm, initiated 11/19/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Spironolactone Oral tablet 25 mg, give 1 tablet by mouth one time a day for CHF. Hold for SBP less than 110 mmHg or HR less than 55 bpm, initiated 11/19/25. Review of Resident #2's November 2025 through January 2026 Medication Administration Records (MARs) indicated the following: 1. Furosemide 20 mg was signed off as administered by nursing staff when the SBP was less than 110 mmHg on the following dates: -11/27/25: SBP reading 88 mmHg-11/30/25: SBP reading 96 mmHg -12/18/25: SBP reading 106 mmHg-12/28/25: SBP reading 94 mmHg-1/11/26: SBP reading 107 mmHg-1/14/26: SBP reading 103 mmHg-1/18/26: SBP reading of 106 mmHg-1/21/26: SBP reading of 108 mmHg-1/23/26: SBP reading of 102 mmHg-1/28/26: SBP reading of 107 mmHg 2. Metoprolol Succinate Extended Release (ER) tablet 24-hour 50 mg was signed off by Nursing staff as administered when the SBP was less than 110 mmHg on the following dates: -11/3/25: SBP reading 101 mmHg-11/13/25: SBP reading 100 mmHg-11/14/25: SBP reading 98 mmHg-11/15/25: SBP reading 96 mmHg-11/30/25: SBP reading 96 mmHg -12/18/25: SBP reading 106 mmHg-12/28/25: SBP reading 94 mmHg-1/11/26: SBP reading 107 mmHg-1/14/26: SBP reading 103 mmHg-1/18/26: SBP reading 106 mmHg-1/20/26: SBP reading 105 mmHg-1/21/26: SBP reading 108 mmHg-1/23/26: SBP reading 102 mmHg-1/28/26: SBP reading 107 mmHg 3. Spironolactone Oral tablet 25 mg was signed off by Nursing staff as administered when the SBP was less than 110 mmHg on the following dates: -11/30/25: SBP reading 96 mmHg -12/18/25: SBP reading 106 mmHg-1/11/26: SBP reading 107 mmHg-1/14/26: SBP reading 103 mmHg-1/18/26: SBP reading 106 mmHg-1/21/26: SBP reading 108 mmHg-1/22/26: SBP reading 94 mmHg-1/23/26: SBP reading 102 mmHg-1/28/26: SBP reading 107 mmHg During an interview on 1/28/26 at 2:28 P.M., the surveyor and the Unit Manager (UM) #1 reviewed Resident #2's MAR for November 2025, December 2025 and January 2026, and observed the days in each month that Resident #2 was administered blood pressure and diuretic medications when the Resident's SBP reading was less than 110 mmHg. UM #1 said that the Physician orders indicated to hold the blood pressure medication if the Resident's SBP was less than 110 mmHg and heart rate less than 55 bpm. UM #1 said that the check mark on the MAR for November 2025, December 2025 and January 2026, indicated that the medications were administered and should have been held when the Resident's SBP was less than 110 mmHg. UM #1 said there would be an increased risk of Resident #2 experiencing hypotension (low blood pressure) which could lead to dizziness and falls when he/she was administered the Furosemide, Metoprolol and Spironolactone medications when the SBP was less than 110 mmHg. During an interview on 1/28/26 at 2:56 P.M., the Director of Nursing (DON) said it was his expectation that the nursing staff follow Physician orders when administering medications. The DON said Resident #2's blood pressure medications should not have been administered to the Resident when his/her SBP was less than 110 mmHg. The DON said when the nursing staff administered the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Furosemide, Spironolactone and Metoprolol medication to Resident #2 when his/her SBP was less than 110 mmHg there was a potential that the Resident's blood pressure could decrease which could lead to hospitalization.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, the facility failed to store all medications in a safe and secure manner in one central supply room (South Two Unit), out of two central supply rooms in the facility, and one Nursing Unit (East One). Specifically, the facility failed to ensure that the central supply room on the South Two Unit was locked on 1/28/26, allowing residents, visitors, and unauthorized staff ready access to over-the-counter medications. 2.the facility failed to ensure that two plastic bags containing muscle relaxant, diuretic, and psychotropic medications were appropriately stored on the East One Unit, placing unauthorized staff, visitors and facility residents at risk for accessing the medications. Findings include: Review of the facility's policy titled Medication Storage, dated 4/9/25, indicated but was not limited to the following: -Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper.security. -Policy Explanation and Compliance Guidelines: > All drugs.will be stored in locked compartments (For example:.medication rooms). > Only authorized personnel will have access to the keys to locked compartments. On 1/28/26 at 9:08 A.M., during a medication administration pass, the surveyor observed Nurse #6 open the unlocked door to the central supply room on the South Two Unit in an attempt to locate Vitamin E. The central supply room contained an unlocked cabinet where several over-the-counter medications including but not limited to: Aspirin, Melatonin (supplement to assist in treating sleep disorders), Nicotine patches, Ibuprofen, and Acetaminophen were stored. During an interview at the same time, Nurse #2 said the door to the central supply room was unlocked at the time of her entrance into the room. Nurse #6 said she did not have a key to access the central supply room and she had encountered the central supply room unlocked a couple of times on other occasions. Nurse #6 said the unlocked door to the central supply room was a concern because it would allow anyone access to the medications. During an interview on 1/28/26 at 3:20 P.M., the Medical Records and Central Supply Staff said that only herself, maintenance staff, Nurses and Unit Managers should have access to the central supply rooms. She said the expectation was that the central supply rooms were locked and required key access. The Medical Records and Central Supply Staff said the cabinet storing the over-the-counter medications had a lock but did not have a lock at this time. She said the importance of the door to the central supply room on the South Two unit being locked was that there were over-the-counter medications stored in the room, including Tylenol and Melatonin. The Medical Records and Central Supply Staff said the overnight staff would leave the door unlocked and once or twice she had encountered the door to the central supply room on the South Two unit unlocked. During an interview on 1/29/26 at 8:19 A.M., the Director of Nursing (DON) said the expectation was that the central supply room doors were locked at all times, to restrict access to unauthorized (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	persons. The DON said that residents should not have access to medications that were not ordered for them by the Physician. The DON said that in addition, he did not want a resident to wander into the unlocked central supply room and go missing. 2. On 2/2/26 between 9:25 A.M. and 9:40 A.M., the surveyor observed the following on the East One Unit nurses station: -No staff were present at the nurses station between 9:25 A.M. and 9:30 A.M. -One purple plastic bag was laying on the nurses station desk and contained 20 tablets of Baclofen (muscle relaxant medication) 10 mg tablets and 10 tablets of Spironolactone (diuretic medication) 25 mg tablets. -One white plastic bag was laying on the East One Shred-It box and contained 10 tablets of Mirtazapine (antidepressant/psychotropic medication) and 20 tablets of Trazodone (antidepressant/psychotropic medication) 50 mg tablets. -Between 9:30 A.M. and 9:40 A.M., Rehab Staff #1 arrived at the nurses station desk and was observed writing on paper while standing over the desk. Both the white and purple plastic bags remained at the nurses station, unsecured, and within Rehab Staff #1's proximity. -Between 9:35 A.M. and 9:40 A.M., Unit Clerk #1 arrived at the nurses station and began to conduct her work. Both the white and purple plastic bags remained at the nurses station, unsecured, and within proximity to Unit Clerk #1. During an interview on 2/2/26 at 9:41 A.M., Unit Manager (UM) #1 said all medications should be locked and secured on the East One Nursing unit in the medication room or in a medication cart. UM #1 said that only Nurses should have access to medications. The surveyor and UM #1 observed the white and purple plastic bags containing the medications at the nurses station with Unit Clerk #1 and Rehab Staff #1 present. UM #1 said that the medications had been packaged and left out for return to the pharmacy today but should have been put back into the medication room until pharmacy staff arrived. UM #1 said that the medications should not be left out because unsecured medications could be accessed by wandering residents, non-licensed staff or visitors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, record reviews, and interviews, the facility failed to complete an assessment for medication self-administration for one Resident (#4), out of a total sample of 24 residents. Specifically, for Resident #4, the facility failed to ensure that the Resident was assessed for his/her ability to safely and appropriately self-administer medications when unlabeled tablets in a medication cup were observed left at his/her bedside to be self-administered. Findings include:Review of the facility policy titled Medication Administration, last revised dated 4/9/25, included but not limited to: *Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. -observe resident consumption of medication. Review of the facility policy titled Medication Storage, dated 4/9/25, included but not limited to:*It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. -All drugs and biologicals will be stored in locked compartments (that is (i.e.,) medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature control.-During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Resident #4 was admitted to the facility in January 2022 with diagnoses including Major Depressive Disorder, Chronic Kidney Disease Stage 5, Dependence of Renal Dialysis, Type 2 Diabetes Mellitus, and Hypertension. Review of Resident #4's Minimum Data Set (MDS) Assessment, dated 12/18/25, indicated that the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. On 1/29/26 at 8:53 A.M., the surveyor observed Resident #4 seated in a wheelchair in his/her bedroom. A plastic medication cup containing two large white tablets, one small red tablet and one small white tablet were observed on the Resident's bedside table which was positioned next to him/her. During an interview at the time, Resident #4 said that the medications in the plastic cup were his/her morning medications that Nurse #1 left for him/her to self-administer. Resident #4 said that the two large tablets were his/her dialysis medications. During an interview on 1/29/26 at 9:00 A.M., Nurse #1 said that the medication cup the surveyor observed on Resident #4's bedside table contained the following scheduled morning medications:-Renvela (phosphate binder) Oral Tablets 800 milligrams [mg] (the two large white tablets - dialysis medication used to control high phosphorus levels in chronic kidney disease).-Famotidine (H2-receptor blocker) Oral Tablet 20mg (one white small tablet- medication that reduces stomach acid production to treat heartburn, acid reflux and stomach ulcers). -Multi-Vitamin (one red tablet).Nurse #1 further said the Resident's medication should not have been left at the Resident's bedside table for him/her to self-administer. Nurse #1 said there was a risk that Resident #4 may not have taken the medication, could have thrown the medication away and/or a risk of another resident taking the medications for themselves. Nurse #1 also said that the risk of Resident #4 not taking his/her scheduled dialysis medication was dangerous as it could lead to toxins building up and increase the Resident's risk of being hospitalized . Nurse #1 said Resident #4 did not have a Physician's order to self-administer his/her medications and had not been evaluated to self-administer his/her medications. Review of Resident #4's clinical records failed to indicate any evidence that assessment for self-administration of medications was completed for the Resident. During an interview on 1/29/26 at 1:00 P.M., the Director of Nursing (DON) said it was his expectation that the nursing staff administer medications to Residents and that the medications were not left at the Resident's bedside. The DON said the medications that were left at Resident #4's bedside included his/her dialysis medication, and the dialysis medication was important for the Resident to take to prevent toxins from building up in his/her blood leading to potential hospitalization. The DON said when the medications were left unattended by Nurse #1, Resident #4 could also have thrown (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	away the medications or given the medications to another resident. The DON said there were other residents who wandered on Resident #4's unit and there was a potential risk that other residents might have wandered into the Resident's room and consumed the Resident's medication. The DON further said that Resident #4 had not been assessed for self-administration of medications, and it was his expectation for nursing staff to stay with the Resident to ensure that he/she took their medication safely prior to the Nurse leaving the Resident's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview, the facility failed to accurately execute Advance Directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes) for one Resident (#13) out of a total sample of 24 residents. Specifically, the facility failed to ensure that the MOLST (Massachusetts Medical Order for Life-Sustaining Treatment) Form on record was valid and reflected the signature of Resident #13's invoked (made active by a Physician) Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) after the Physician had determined that the Resident lacked the capacity for informed medical decision making. Findings include: Review of the facility policy for Resident's Rights Regarding Treatment and Advanced Directives, last revised 3/25/25, indicated:-On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. -The facility will periodically assess the resident for decision-making abilities and approach the HCP or legal representative if the resident is determined not to have decision making capacities.-During the care planning process, the facility will identify, clarify and review with the resident or legal representative whether they desire to make any changes related to advanced directives. -Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. Resident #31 was admitted to the facility in December 2024, with diagnoses including Dementia and repeated falls. Review of Resident #13's clinical record indicated:-a MOLST Form signed on 12/17/24 by Resident #13's HCP.-a HCP Activation Form dated 3/3/25 (after the MOLST Form had been signed by the HCP).-no evidence that the MOLST Form had been re-addressed with Resident #13's HCP after admission to the facility and prior to the surveyor bringing it to the facility's attention. During an interview on 1/29/26 at 1:29 P.M., the Social Worker (SW) said that the MOLST Form was not valid because it had been signed by the HCP prior to the Physician invoking the HCP. The SW also said that Resident #13 was still their own decision maker at that time and should have been the one to sign the MOLST Form. During an interview on 1/29/26 at 1:45 P.M., the Director of Nursing (DON) said that the MOLST Form was not valid and that the facility will get a new MOLST Form signed by the HCP now that it had been activated. The DON also said that it was important to have the primary decision maker review the MOLST Form to make sure that their wishes are being followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to resolve a grievance timely for two Residents (#13 and #121) out of a total sample of 24 residents.Specifically, the facility failed to ensure:1. for Resident #13, that a report of missing reading glasses was identified as a grievance and was resolved within a reasonable time frame.2. for Resident #121, that the Resident Representative (RR #1) was provided with the conclusion and corrective action to a documented grievance as required. Findings include: 1. Resident #13 was admitted to the facility in December 2024 with diagnoses including Dementia, Type 2 Diabetes and repeated falls. Review of Resident #13's clinical record indicated the following Nursing Progress Notes: -12/5/24: Client uses glasses.which he/she has with him/her. -2/2/25: Resident attending activities in the day room. Concerned on missing glasses. Supervisor is aware of ongoing concern. Review of Resident #13's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -the Resident was moderately cognitively impaired as evidenced by a BIMS score of 8 out of a possible score of 15. -the Resident's vision was adequate and he/she utilized corrective lenses (contacts, glasses or magnifying glass) for vision. Review of Resident #13's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -the Resident was severely cognitively impaired as evidenced by a BIMS score of 6 out of a possible score of 15. -the Resident's vision was adequate and he/she did not utilize corrective lenses (contacts, glasses or magnifying glass) for vision. During an interview on 1/27/26 at 8:54 A.M., Resident #13 said that he/she was missing his/her reading glasses. Review of the facility's 2025 Grievance Log failed to indicate that a Grievance Form had been completed on behalf of Resident #13 for their missing reading glasses. Review of Resident #13's clinical record indicated: -no evidence that a grievance had been filed or that any follow-up had occurred for the Resident's missing reading glasses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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	-a Social Services Progress Note dated 1/28/26, which documented Resident #13's family member confirming that the Resident has been prescribed reading glasses, but that the eyeglasses had been seen with the Resident for over a year. During an interview on 1/29/26 at 11:16 A.M., the Administrator said that Resident #13's missing reading glasses had not been brought to his attention by staff and that the missing glasses should have been brought to his attention because the facility staff discuss grievances daily during their morning meetings. The Administrator also said that the facility should have filed a Grievance Form on behalf of Resident #13 and that the facility had not addressed the Resident's concern. 2.Resident #121 was admitted to the facility in May 2023 with diagnoses including Dementia. Review of Resident #121's Minimum Data Set (MDS) Assessment, dated 10/16/25, indicated: -The Resident sometimes understood others and was sometimes understood. -The Resident was unable to complete the BIMS examination and had severely impaired cognitive skills for daily decision making. -The Resident required substantial assistance to dependence from staff for activities of daily living (ADLs). Review of the facility's 2025 Grievance Log indicated a Grievance Form, dated 10/31/25, filed with the facility by Resident #121's Representative (RR #1) which indicated: -RR #1 was concerned that ADL care had not been provided to Resident #121 in a timely manner. -RR #1 was concerned that staffing was not adequate for resident acuity. Further review of the 10/31/25 Grievance Form failed to include any evidence that the facility's conclusion and corrective actions following the investigation were communicated to RR #1. During an interview on 1/27/26 at 4:22 P.M., RR #1 said he/she filed a grievance with the facility relative to his/her concern that the facility did not have enough staff to adequately assist residents, including Resident #121, timely with ADL care. RR #1 said he/she never received a response back from the facility relative to the facility's conclusion and corrective actions following their investigation into his/her grievance and that the facility had not adequately addressed his/her concern for inadequate staffing. During an interview on 1/28/26 at 4:45 P.M., the Administrator said that he and the Social Worker (SW) worked together when investigating grievances. The Administrator said that following the completion of a grievance investigation, the individual who filed the grievance would be notified of the grievance conclusion and corrective actions. The surveyor and the Administrator reviewed RR #1's 10/31/25 Grievance Form and the Administrator said the section of the Form to be completed relative to the grievance conclusion and correctives actions was not recorded. The Administrator said he would review Resident #121's record to identify whether there was any evidence the conclusion and corrective actions relative to RR #1's 10/31/25 grievance had been communicated to RR #1. The facility failed to provide any evidence to the survey team prior to survey exit that the conclusion (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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	and corrective actions relative to RR #1's 10/31/25 grievance had been communicated to RR #1. Please Refer to F658 and F725.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 observations, interviews, and records reviewed, the facility failed to identify hazardous hot water temperatures in four shower rooms (East One, East Two, South One, and South Two) out of a total of five shower rooms in the facility, and for two Resident's (#20 and #22) with hot water concerns, increasing the risk for accidental burns to residents and staff in the facility. Specifically, the facility failed to identify hazardous hot water temperatures and implement interventions: -in one of the East One Unit's shower rooms when the shower room's shower head with built-in temperature gauge indicated a hot water temperature of 140 degrees ( ) Fahrenheit (F). -in the East Two Unit's shower room when the shower had a manual hot water temperature of 126 F. -in the South One Unit's shower room when the shower had a manual hot water temperature of 121.1 F, and the shower head with built-in temperature gauge indicated a hot water temperature of 69 F.-in the South Two Unit's shower room when the shower had a manual hot water temperature of 131 F. -in Resident #20's bathroom sink, when the Resident's bathroom sink had a manual hot water temperature measured at 134.6 F. -when Resident #22 reported the water temperature concerns during Resident Council. Findings include: Review of the facility's policy titled Domestic Hot Water Policy, undated, indicated but was not limited to the following: -Purpose: This policy ensures domestic hot water is delivered safely, reliably, and in compliance with healthcare standards to prevent scalding . -Scope: Applies to all domestic hot water systems serving resident rooms, bathing areas . -Temperature standards: >Point-of-use bathing fixtures: Less than or equal to 110 F. -Monitoring: Routine monitoring and documentation shall be completed by Maintenance staff per schedule. -Unsafe conditions response: Immediate corrective action is required for unsafe temperatures or hot water outages. Review of the facility's Water Temperature Logs, dated 12/2/24 through 1/26/26, indicated: -Weekly hot water checks were performed on all four units (East One, East Two, South One, and South Two) with temperatures ranging from 105.0 F to 108.4 F. -No evidence on the specific locations for each unit where hot water temperature checks were performed, including whether the Unit shower rooms were checked. Review of the facility's Resident Council Meeting Minutes indicated that hot water had been discussed during the December 2025 and January 2026, Resident Council meetings, including the installation of hot water boosters. During the Resident Council Interview conducted on 1/28/26 at 1:45 P.M., the following information was provided: -Resident #20 said the water can be boiling hot at times. -Resident #22 said the Resident Council had informed the facility of ongoing water temperature concerns. Resident #20 was admitted to the facility in January 2023. Review of the MDS dated [DATE] indicated Resident #20: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points. -was independent with oral hygiene. -was independent with toileting hygiene. -required setup or clean-up assistance with showering/bathing. -was independent with personal hygiene (including washing/drying face and hands.) -was independent with walking 150 feet. Resident #22 admitted to the facility in January 2018. Review of the Minimum Data Set (MDS) Assessment, dated 1/28/26, indicated Resident #22: -did not have a short-term memory deficit. -independently made consistent/reasonable decisions regarding tasks of daily life. -did not have disorganized thinking. -did not have a BIMS exam completed. During an interview on 1/29/26 at 3:50 P.M., the Maintenance Director said he was the only Maintenance staff in the facility and was responsible for checking the hot water temperatures on each Unit once weekly. The Maintenance Director said the shower heads in the shower rooms had built-in temperature gauges that displayed the hot water temperatures and the shower rooms contained signage that indicated what the water temperature should be when providing a shower to the residents. The Maintenance Director said the hot water temperature should not exceed 120 F and that the staff providing the showers to residents should not turn the water temperature dial all the way up. The Maintenance (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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	Director said the hot water boosters recently installed were specific to the dishwasher in the kitchen and were not related to the water temperatures on the resident units. During an interview on 1/30/26 at 7:48 A.M., the Activities Director (AD) said the Resident Council members said there were times when they would take a shower, but the water was not hot enough, and there were times when the water got too hot. It was random, but enough to take notice. The AD said the Resident Council members discussed concerns for water temperatures a couple of times since the end of October 2025. On 1/30/26 the surveyor observed the Maintenance Director perform the following hot water temperature checks: *Shower Room on the South One Unit at 1:34 P.M.: -The signage on the wall indicated that the water temperature should be checked prior to giving a shower to residents and if the water temperature was greater than 110 F the resident should not receive a shower and the temperature should be reported immediately. -The shower head's built-in temperature gauge indicated a hot water temperature of 69 F, when the manual thermometer used by the Maintenance Director indicated a hot water temperature of 121.1 F. *Shower Room on the South Two Unit at 1:43 P.M.: -The signage on the wall also indicated that the water temperature should be checked prior to giving a shower to residents and if the water temperature was greater than 110 F the resident should not receive a shower and the temperature should be reported immediately. -There was no evidence that the shower head had a built-in temperature gauge. -There was no evidence that a manual thermometer was available for use by staff to check the hot water temperature when prior to showering residents. *Resident #20's bathroom sink at 2:03 P.M.:-The manual thermometer indicated a hot water temperature of 134.6 F. During an interview on 1/30/26 at 3:18 P.M., Certified Nurses Aide (CNA) #7 said the hot water got really hot and then cold, and it was hard to regulate the water temperatures at times. On 1/30/26 at 3:20 P.M., the surveyor observed the shower head's built-in temperature gauge indicated a hot water temperature of 140 F in the shower room on the East One Unit. During an interview on 1/30/26 at 3:25 P.M., CNA #6 said the showers got too hot at times. CNA #6 said the shower on the East Two Unit was hot and it was hard to control the water temperature. During an interview on 1/30/26 at 3:50 P.M., the Administrator said he believed the water temperature should be at 120 F. The Administrator said hearing of the surveyors' observations of hot water temperatures in the shower rooms in the facility, he had a concern for residents' safety. On 1/30/26, the surveyor observed the following hot water temperature checks performed by the Administrator: -Shower room on the East Two Unit at 4:30 P.M.: The manual hot water temperature indicated 126 F. -Shower room on the South Two Unit at 4:40 P.M.: The manual hot water temperature indicated 131 F. During an interview on 1/30/26 at 4:58 P.M., Resident #20 said the water in his/her bathroom sink could be boiling hot at times. Resident #20 said when the water was hot, he/she couldn't touch it because it would almost burn you. Resident #20 said the water in the bathroom sink would get very hot every two or three weeks. During a follow-up interview on 2/2/26 at 11:17 A.M., the Maintenance Director said water temperature checks were performed at random times during the day with no specific rotation. The Maintenance Director said he checked the water temperature in one room per Unit per week. The Maintenance Director said the rooms checked could include a kitchenette, resident room or staff bathroom. The Maintenance Director said he typically did not check the water temperature in the shower rooms because the shower heads had built-in temperature gauges.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, facility failed to provide respiratory care and services consistent with professional standards of practice for one Resident (#52) out a total sample of 24 residents. Specifically, for Resident #52, the facility failed to ensure:-oxygen tubing and nebulizer equipment changes were completed timely as required.-that the Resident's oxygen and nebulizer equipment and BiPAP (Bilevel Positive Airway Pressure) mask were maintained in a clean and sanitary manner and appropriately stored when not in use to prevent contamination and the spread of infections. Findings Include: Review of the facility policy titled Oxygen Administration, dated 4/9/25 included but was not limited to: >Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. >Keep delivery devices covered in plastic bag when not in use. Review of the facility policy titled Nebulizer Therapy, revised 4/9/25, included but was not limited to: >Change nebulizer tubing weekly. >Store the nebulizer cup and mouthpiece in a zip lock bag. Review of the facility policy titled CPAP/BiPAP cleaning, dated 11/6/25, included but was not limited to: >Clean mask daily . or soap and water. Cover with plastic bag .when not in use. Resident #52 was admitted to the facility in June 2023 with diagnoses including Acute on Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease (COPD), Obstructive Sleep Apnea (OSA), and Pneumonia. Review of the Person-Centered Care Plan, initiated 6/20/23 and revised 9/23/25, indicated: -has altered respiratory status/difficulty breathing related to COPD, Sleep Apnea, oxygen (O2) dependence with interventions including Bilevel Positive Airway Pressure (BiPAP- noninvasive ventilation device that assists with breathing) as ordered and medications as ordered. -required oxygen therapy related to impaired gas exchange and COPD with interventions including medications as ordered, BiPAP as ordered, and oxygen as ordered. Review of Resident #52's January 2026 Physician's orders indicated: -Oxygen 1 L (liter)/Min via nasal cannula (NC) every shift (11:00 P.M.-7:00 A.M., 7:00A.M.- 3:00 P.M., 3:00 P.M.- 11:00 P.M.), effective 12/30/24. -Ipratropium/Albuterol Solution 0.5/2.5 (3) milligram (mg)/3 milliliter (ml), 1 vial inhale orally every 6 hours as needed for wheezing, effective 12/20/25.-Apply BiPAP during hours of rest and bedtime with oxygen attached, per home settings, every shift, effective 8/27/25. -Change and date oxygen tubing weekly, every Saturday, night shift (11:00 P.M.- 7:00 A.M.), effective 7/6/24. Review of the Minimum Data Set (MDS) Assessment, dated 12/23/25 indicated Resident #52: -has oxygen therapy and non-invasive ventilator (BiPAP). -has moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 12 out of a total possible score of 15. Review of the Resident's active Medication Administration Record (MAR) included that the Resident #52 was administered:-Ipratropium/Albuterol Solution 0.5/2.5 (3) milligram (mg)/3 milliliter ml) medication via nebulizer on 1/19/26 at 18:24 P.M. and 1/27/26 at 9:15 A.M. On 1/27/26 at 10:10 A.M., the surveyor observed Resident #52 seated in a wheelchair at his/her bedside with oxygen in use via nasal cannula at 1 L/Min from an oxygen concentrator. The surveyor observed the nasal cannula tubing was dated 1/17/26. The surveyor observed an uncovered nebulizer mask with connecting tubing dated 1/17/26 on the Resident's nightstand that was in contact with an uncovered urinal containing yellow liquid. The surveyor also observed an uncovered, unbagged BiPAP mask covered with a dried white substance also laying on the nightstand surface. On 1/28/26 at 8:22 A.M., the surveyor observed Resident #52 seated at his/her bedside with oxygen tubing/ nasal cannula connected to his/her nose, dated 1/17/26. The surveyor also observed the Resident's nebulizer mask, dated1/17/26, was uncovered and the BiPAP mask covered with a dried white substance were laying on the Resident's nightstand surface. During an interview at the time, Resident #52 said he/she used the oxygen, nebulizer, and BiPAP every day but was unaware of how often the tubing should be changed. During an interview on 1/28/26 at 8:24 A.M., Nurse #8 said she was assigned to Resident #52. Nurse #8 said that Resident #52 was dependent on staff for oxygen, nebulizer, and BiPAP care. Nurse #8 said Resident #52 received oxygen at all times, last received nebulizer medication on 1/19/26 and wore (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the BiPAP every night. Nurse #8 said Resident #52 was ordered for weekly tubing changes to the oxygen and nebulizer which was done by the night (11:00 P.M.- 7:00 A.M.) shift Nurses. The surveyor and Nurse #8 observed Resident #52's Treatment Administration Record (TAR) which indicated the night Nurse had changed the oxygen tubing on 1/24/26. The surveyor and Nurse #8 observed the Resident sitting at his/her bedside and Nurse #8 said that the Resident's oxygen and nebulizer tubing were dated 1/17/26 and must not have been changed as indicated on 1/24/26. The surveyor and Nurse #8 observed the Resident's nightstand and Nurse #8 said that the BiPAP mask did not appear to have been cleaned after the last use as evident by the coating of white substance on the mask and that both the nebulizer and BiPAP masks were uncovered and making contact with the nightstand surface but should have been in a plastic storage bag to prevent the spread of germs. Nurse #8 said that Resident #52 was at higher risk for pneumonia because of the COPD diagnosis. During an interview on 1/28/26 at 4:24 P.M., the Infection Preventionist (IP) said Resident #52's oxygen and nebulizer tubing should be changed weekly and kept in a plastic storage bag when not in use. The IP said that the Resident's BiPAP masks should be cleaned with soap and water by the Nurse each day and then kept in a plastic storage bag when not in use. The IP said that Resident #52 could be at risk for infection due to the outdated and uncovered tubing and masks. During an interview on 2/2/26 at 12:00 P.M., the Director of Nursing (DON) said oxygen and nebulizer tubing should be changed weekly by the night Nurse as well as nebulizer and BiPAP cleaned after each use. The DON said a dirty mask and the tubing not being changed weekly could contain microbial growth and could result in Resident #52 getting redness/irritation to the skin or an infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide sufficient nursing staff for three Resident's (#121, #108, and #109) on two Units (East Two and South Two) out of four total resident units, to maintain the safety and well-being of the resident population. Specifically, the facility failed to provide sufficient nursing staff: 1.for two shifts on the East Two Unit over two consecutive days (1/27/26 and 1/28/26): a. when no staff were in attendance in the Unit Dining Room on the 1/27/26 evening (3:00 P.M. through 11:00 P.M.) shift and a resident seated next to Resident #121 placed fish sticks and tater tots, which were not pureed, in front of Resident #121 who required a pureed diet, increasing the risk of Resident #121 eating the non-pureed food items and choking with no staff present to intervene. b. which increased Resident #108's risk for alteration in skin integrity when the Resident was dependent on facility staff for repositioning and incontinence care, and repositioning and incontinence care was not provided for the Resident on 1/28/26 over a 4.25-hour period during the day (7:00 A.M. through 3:00 P.M.) shift. 2. to provide incontinence care during the day shift on the South Two Unit on 1/28/26 when Resident #109 requested staff assistance after experiencing bowel and bladder incontinence and was subjected to waiting over 30 minutes for staff assistance, increasing the Resident's risk for alteration in skin integrity, infection, and psychosocial harm. Findings include: Review of the facility's policy titled Nursing Services and Sufficient Staff, dated 2/5/25, indicated the following: -It is the policy of this facility to provide sufficient staff . to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. -The facility's census, acuity, and diagnoses of the resident population will be considered based on the facility assessment. -Providing care includes, but is not limited to, assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs. Review of the facility's policy titled ADLs (activities of daily living), dated 3/1/19 and reviewed and revised 12/1/25, indicated the following: -Care and services will be provided for the following ADLs: -Bathing, dressing, grooming, and oral care. -Transfer and ambulation. -Toileting. -Eating to include meals . -A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Incontinence, dated 11/25/25, indicated that residents that are incontinent of bladder and bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. 1a. Resident #121 was admitted to the facility in May 2023 with diagnoses including Dementia, abnormal weight loss, and mild protein calorie malnutrition. Review of Resident #121's active Physician orders, dated 9/2/25, no end date, indicated the Resident required a pureed diet texture. Review of Resident #121's active Care Plan indicated: -required assistance of one staff for eating (initiated 7/1/23, revised 2/26/25). -has oral/dental health problems and did not consistently wear his/her dentures (initiated 5/16/23, revised 2/26/25). -Diet as ordered (initiated 5/16/23). During an interview on 1/27/26 at 4:22 P.M., Resident #121's Representative (RR #1) said he/she was concerned for staffing sufficiency on the East Two Unit. RR #1 said the East Two Unit could house 24 residents and that there was currently only one Certified Nurses Aide (CNA) working on the unit at that time. RR #1 said one CNA for 24 residents occurred often on the evening shift on the East Two Unit. RR #1 said he/she visits the facility often and has observed residents wait for up to 20 minutes for assistance from staff to eat. RR #1 said that he/she has spoken with administration within the last couple of months relative to his/her concern for sufficient nursing staff on the East Two Unit and the nursing staffing has not improved. On 1/27/26 at 4:28 P.M., the surveyor observed the following on the East Two Unit: -There was one CNA (#1) working on the Unit. -There was one Nurse (#4) standing at the medication cart next to the nurses' station. -There was one Nurse (#3) seated at the nurses' station using the computer. During an interview with Nurse #3, CNA #1, and Nurse #4 at the time, Nurse #3 said she worked the day shift today (1/27/26) and stayed beyond her scheduled shift to complete required documentation for residents she cared for during the day shift. Nurse #3 said there were 23 residents currently residing on the East Two Unit. CNA #1 said there were supposed to be two CNAs working on the Unit for the evening shift and that she was the only CNA working at the time. CNA #1 said that CNA #8 was supposed to come into work at 3:00 P.M., but CNA #8 had not yet arrived. CNA #1 said no additional staff had been sent to the East Two Unit in the absence of CNA #8. CNA #1 said that working as the only CNA on the Unit from 3:00 P.M. until anytime between 3:30 P.M. and 4:00 P.M., and sometimes later than 4:00 P.M. occurred frequently. CNA #1 said several residents on the Unit required the assistance of two staff for ADL care and transfers and that she could not provide care to those residents without assistance from additional staff member. Nurse #4 said she would typically provide assistance to the CNA when there was one CNA working on the Unit, but that a new admission had just arrived and she needed to complete the new admission tasks for that resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 1/27/26 timecards for the East Two Unit indicated: -CNA #1 punched in for the evening shift at 2:55 P.M. -The two CNAs who had worked the day shift had punched out at 3:10 P.M. -CNA #8 punched in at 4:49 P.M. (one hour and 49 minutes after the start of the shift and one hour and 39 minutes after the last day shift CNA punched out). On 1/27/26 between 5:10 P.M. and 5:28 P.M., the surveyor observed the following on the East Two Unit: -Eight residents, including Resident #121, were seated in the dining room. -The evening meal cart had been delivered to the Unit. -At 5:18 P.M., six of eight residents in the Dining Room had been served their meals and were eating. Resident #121's meal had not been delivered, and no staff were present in the Dining Room at the time. -two fish sticks and three tater tots that had been placed directly on the table in front of Resident #121. No staff were present in the Dining Room at this time. At this time, a resident seated next to resident #121 said he/she had given some of his/her fish sticks and tater tots to Resident #121 because Resident #121 didn't have any food. The resident seated next to Resident #121 said, Don't you think [he/she] looks hungry? -One of the six residents eating reached out, touched, and pressed down on another resident's tater tot that was on their plate. No staff were present in the Dining Room at this time. -Activities Aide (AA) #1 and CNA #1 entered and exited the Dining Room intermittently and no staff were observed remaining in the Dining Room until approximately 5:25 P.M., when AA #1 entered and stayed in the Dining Room with the residents. -At this time, CNA #1 and an additional staff member also entered and remained in the Dining Room. -The additional staff member removed the fish sticks and tater tots from in front of Resident #121, following the surveyor's inquiry whether the food items were meant for Resident #121's consumption. -CNA #1 then brought a meal tray containing pureed food to Resident #121. During an interview at 5:30 P.M., Nurse #4 said that a staff member should stay in the Dining Room to supervise residents while they were eating. On 1/28/26 at 9:13 A.M., the surveyor observed the following in the East Two Unit Dining Room: -CNA #3 was assisting Resident #121 to eat breakfast by loading the Resident's utensil and bringing the utensil to the Resident's mouth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At one time during the meal, Resident #121 was able to reach forward and grasp CNA #3's hand that held the loaded utensil and guide the utensil and CNA #3's hand to his/her mouth. During an interview on 1/29/26 at 3:42 P.M., the Speech-Language Pathologist (SLP) said residents are typically prescribed pureed diets after trialing less restrictive diets and that the pureed diets are provided for residents who cannot adequately chew or manipulate less restrictive food textures in their mouths. The SLP said a resident who has been prescribed a pureed diet should not have fish sticks and tater tots due to the risk for choking and development of aspiration pneumonia. The SLP said it was scary to think that the Dining Room on the East Two Unit would be unsupervised during meals as residents may consume the wrong diet texture. 1b. Resident #108 was admitted to the facility in April 2022 with diagnoses including Acute Kidney Failure, Diverticulitis, Cognitive Impairment, Obesity, and Need for Assistance with Personal Care. Review of Resident #108's active Physician orders, dated 11/21/24, no end date, indicated: Resident to be pair care (two staff members) until further notice, dated 11/21/24, no end date. Review of Resident #108's active Care Plan indicated: -The Resident was incontinent of bowel and bladder related to Dementia. -The Resident had an ADL deficit and was dependent on two staff members for bathing, dressing, bed mobility, and personal hygiene. -Clean peri-area with each incontinent episode. -The Resident was at risk for potential skin impairment due to impaired mobility, impaired safety, impaired judgment, obesity, and incontinence. -Keep skin clean and dry. On 1/28/26 between 7:45 A.M. and 11:49 A.M., the surveyor observed the following in the East Two Unit Dining Room: -Resident #108 was seated in the East Two Unit Dining Room, in his/her wheelchair. -At 8:35 A.M., Resident #108's Representative (RR #2) approached the surveyor in the East Two Dining Room and said: -that he/she came in daily in the mornings and sometimes in the afternoons to attend activities with Resident #108. -RR #2 said he/she thought the nursing staff on the Unit were good and worked hard, but that they needed more staff. -RR #2 said he/she thinks Resident #108 sits in his/her wheelchair for the whole day without receiving incontinent care because there are not enough staff. -RR #2 said Resident #108 will sometimes sit in his/her wheelchair from 7:00 A.M. through 2:00 P.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without moving. -RR #2 said Resident #108 was incontinent and was dependent on nursing staff to return the Resident to bed to perform incontinent care. -RR #2 said that he/she has brought his/her concerns for sufficient staffing up at Resident #108's care plan meetings and that the facility's response has been that the facility has enough staff. -At 8:43 A.M., RR #2 assisted with cutting up Resident #108's breakfast meal and assisted the Resident to eat. -Resident #108 was provided with a large cup of liquids at 10:15 A.M. and 11:29 A.M. and the Resident consumed both cups of liquids. -The surveyor did not observe between 7:45 A.M. and 11:49 A.M., any staff offer the following to Resident #108: -assistance for repositioning. -check for whether the Resident was incontinent. -Incontinence care. During an interview on 1/29/26 at 9:55 A.M., CNA #2 said she was usually responsible to provide care for 12 to 13 residents on the day shift and that two CNAs were always scheduled for the day shift on the East Two Unit. CNA #2 said there were three CNAs scheduled today and that she did not know why, but that having three CNAs was helpful for providing care to the residents. CNA #2 said Resident #108 was always incontinent of bowel and bladder and that the Resident never used a toilet. CNA #2 said to provide Resident #108 with incontinence care on the day shift, she would have another staff member assist her with getting the Resident back to bed using a mechanical lift. CNA #2 said Resident #108 was usually on her assignment and that Resident #108 was on her assignment on 1/28/26. CNA #2 said there were usually two CNAs to care for all of the residents on the Unit, so there was not enough time to provide rounds for incontinence care on the Unit until after lunch. CNA #2 said she did perform incontinence care rounds for some residents after lunch when she worked, but she did not usually perform incontinence care any time for Resident #108 after getting him/her out of bed unless the Resident had a bowel movement. CNA #2 said she was just one CNA for 12 residents, and all morning ADL care was required to be completed before lunch time. CNA #2 said Resident #108 did not usually receive incontinence care after getting out of bed in the morning until the evening (3-11) shift. CNA #2 said she did not provide any incontinence care to Resident #108 during the day shift after she assisted the Resident out of bed in the morning on 1/28/26. During an interview on 1/29/26 at 10:11 A.M., Nurse #2 said that incontinence rounds and repositioning were to be completed by the CNAs approximately every two hours for residents on the Unit. Nurse #2 said that Resident #108 was incontinent of bowel and bladder and should be included in the residents who required incontinence care and assistance with repositioning. Nurse #2 said she worked on the East Two Unit during the day shift on 1/28/26 and that she was not aware Resident #108 had not been repositioned and provided with incontinence care anytime between 7:45 A.M. and 11:49 A.M. Nurse #2 said that she would have to look into what happened because Resident #108 should have been repositioned and provided with incontinence care. Nurse #2 said repositioning and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinence care was important for Resident #108 to help reduce the Resident's risks for skin breakdown and infection. During an interview on 1/29/26 at 11:51 A.M., the Scheduler said she was told when first working at the facility that the East Two Unit was always to be scheduled for two CNAs on the day and evening shifts unless approval for an additional staff member to serve as a one to one for a resident with safety concerns was provided. During an interview on 1/29/26 at 2:50 P.M., with the Director of Nursing (DON) and the Assistant Director of Nurses (ADON), the DON said staffing was determined based on the facility's census and that resident acuity was considered. The DON said the East Two Unit was always scheduled with two CNAs on the day and evening shifts and that a third CNA could be moved to the Unit if resident behaviors occurred and one to one care was needed for a resident. The ADON said there should always be a staff member in the East Two Unit Dining Room if residents are in the room, eating, and require supervision. The ADON said the risk for not having a supervising staff member in the East Two Unit Dining Room on 1/27/26 was that the Resident could have choked if he/she had consumed the fish sticks and tater tots that were placed in front of him/her by another resident. The ADON said the risks for staff not providing repositioning and incontinence care for Resident #108 between 7:45 A.M. and 11:49 P.M. on 1/28/26 were skin breakdown and infection. 2. Resident #109 admitted to the facility in August 2024, with diagnoses including malignant neoplasm of the brain, severe obesity, malignant neoplasm of the kidney, anxiety disorder, depression, and need for assistance with personal care. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #109: -was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15 points. -did not exhibit behaviors of rejection of care. -was dependent on staff for toileting hygiene. -was always incontinent of bladder. -was always incontinent of bowel. -was not on a bowel toileting program used to manage his/her bowel continence. Review of Resident #109's Bowel and Bladder Care Plan, initiated 8/26/24, indicated but was not limited to the following: -The Resident was incontinent of bladder and bowel related to physical limitations. -Goal: The Resident would remain free from skin breakdown due to incontinence and brief use. -Interventions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clean peri-area with each incontinence episode. Monitor for signs and symptoms of urinary tract infection. On 1/28/26 at 7:32 A.M., on the South Two Unit, the surveyor observed Nurse #7 make a phone call to ask that CNA #4 come to the South Two Unit, stating that the unit was waiting for her. During a medication pass observation on 1/28/26, the surveyor observed the following: -At 7:40 A.M., Resident #109 told Nurse #7 that he/she needed to be changed. -At 7:41 A.M., Nurse #7 made a phone call, and said that she had called three times to ask that CNA #4 come to the South Two Unit and noted that the Unit really needed CNA #4. -At 7:44 A.M., CNA #4 arrived on the South Two Unit. On 1/28/26, the surveyor observed the following on the South Two Unit: -A CNA walked by Resident #109's room where the call light was on at 8:01 A.M., 8:03 A.M., and 8:04 A.M., and did not respond to the call light. -At 8:04 A.M., Resident #109's call light remained on. During an interview at the time, Resident #109 said that he/she needed to be changed. Resident #109 said that staff had not yet assisted him/her since he/she told Nurse #7 he/she needed incontinence care. -At 8:07 A.M., CNA #5 entered Resident #109's room, turned off the call light, and exited the Resident's room. During an interview at the time, CNA #5 said Resident #109 needed to be changed and the Resident required two staff to assist him/her with changing. CNA #5 said the other two CNAs were busy and the Resident would need to wait to be changed until CNA #5 could receive staff assistance. -At 8:17 A.M., two CNAs entered Resident #109's room to provide him/her with assistance. (37 minutes after Resident #109 informed Nurse #7 that he/she needed to be changed). Review of the Daily Schedule Report for 1/28/26 indicated that three CNAs were scheduled to work on the South Two Unit for the 7:00 A.M. - 3:00 P.M. shift on 1/28/26. During an interview on 1/30/26 at 9:35 A.M., Resident #109 said it made him/her feel awful when he/she had to wait more than 30 minutes on the morning of 1/28/26 to receive incontinence care. Resident #109 said he/she was prone to urinary tract infections. During an interview on 1/30/26 at 9:37 A.M., CNA #5 said there were three CNAs scheduled to work on the South Two Unit the morning of 1/28/26. CNA #5 said the CNAs were busy the morning of 1/28/26 when Resident #109 needed assistance with incontinence care. CNA #5 said she and another CNA assisted the Resident once another CNA was available to assist. CNA #5 said the CNAs provided Resident #109 with a bed bath and incontinence care. CNA #5 said that Resident #109 had been incontinent of bowel and bladder at the time. During an interview on 1/30/26 at 9:45 A.M., Nurse #7 said on the morning of 1/28/26 there was an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	issue with staffing on the South Two Unit, that there were only two CNAs on the unit and there should have been three CNAs. Nurse #7 said she called the Staffing Coordinator and informed her that there were only two CNAs on the Unit. Nurse #7 said that Resident #109 was always incontinent of bowel and bladder and required two staff to assist with incontinence care. Nurse #7 said her expectation was that residents would not have to wait to receive assistance and would receive assistance as soon as staff were available to assist them. During an interview on 1/30/26 at 10:22 A.M., the Staffing Coordinator said that the Units were fully staffed the morning of 1/28/26. The Staffing Coordinator said that Nurse #7 had called her and informed her that one CNA was missing on the South Two Unit. The Staffing Coordinator said that she located CNA #4 on the South One Unit and instructed her to report to the South Two Unit. The Staffing Coordinator said she did not notify her supervisor of the issue. During an interview on 1/30/26 at 11:03 A.M., CNA #4 said she believed she was assigned to the South One Unit the morning of 1/28/26. CNA #4 said she was informed by the Nurse on the South One Unit that she needed to report to the South Two Unit. CNA #4 said she believed it was around 8:00 A.M. that she was instructed to report to the South Two Unit. During an interview on 1/30/26 at 11:19 A.M., the DON said he was notified the morning of 1/28/26 that there was a staffing issue on the South Two Unit. The DON said the South Two Unit required three CNAs at that time. The DON said his expectation was that staff inform him when assistance was needed to address residents' needs. The DON said he thought that waiting over 30 minutes was too long for Resident #109 to wait to receive assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and records reviewed, the facility failed to coordinate an assessment with the PASARR program (screen to determine if a resident had an intellectual or developmental disability (ID or DD) and/or serious mental illness (SMI) and needed further evaluation) for two Residents (#7 and #11), of two applicable residents reviewed for PASARR, out of a total sample of 24 residents. Specifically, the facility failed to:1.For Resident #7, refer to the PASARR Office for a Level II Resident Review in a timely manner when the Resident: -Experienced suicidal remarks and an attempt to self-harm. -Required immediate transfer to the hospital for medical and psychiatric evaluation.2.For Resident #11, refer the Resident to the PASARR Office for Resident Review after the Resident experienced a significant change in status requiring psychiatric hospitalization. Findings Include:Review of the facility policy titled Resident Assessment-Coordination with PASARR Program, last revised on 9/21/25, included but limited to:*This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.-All applicants to this facility will be screened for serious mental disorder or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening.-PASARR Level I - initial pre-screening that is completed prior to admission.>Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later.>Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. -PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. -The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.-Recommendations, such as any specialized services, from a PASARR Level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. -Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a Level II resident review. Examples include:>A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).>A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.>A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment. 1.Resident #7 was admitted to the facility in May 2025, with diagnoses including Mood Disturbance, Anxiety Disorder, Depression, Unspecified Mood Affective Disorder, and Unspecified Dementia with Other Behavioral Disturbance. Review of the Level I PASARR, dated 11/19/25, indicated Resident #7:-had documented diagnosis of a mental illness or disorder (MI/D)-had substance use disorder (SUD) that may lead to chronic disability-Question Number Six was completed with an answer of Yes indicating currently or within the past six months, the Resident has had limitation in major life activities.(adaptation to change) or may be due to mental illness or disorder (MI/D). -If the answer to Question Number Six was Yes, check Positive SMI screen. Otherwise, check Negative SMI screen. -Positive SMI was checked. Next (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	step, complete section C-Section C not completed Review of the Physician Progress Note, dated 11/5/25, indicated Resident #7: -had suicidal remarks and self-harm attempt.-threatened to wrap a call bell wire around his/her neck. -expressed intent to his/her daughter to drive a car into a wall. -unplugged his/her roommate's oxygen tank and attempted to wrap the Oxygen tubing around his/her neck.-arrange immediate transfer to the hospital for medical and psychiatric evaluation. Review of the Physician Progress Note, dated 11/19/25, indicated Resident #7: -was assessed by the Physician for a follow-up depression. -had mood disorder, seen for worsening depression. -was noted to be more withdrawn.-was seen by Behavioral Health with recommended to increase their prescribed anti-depressant Sertraline to 75 milligrams (mg) from 50 mg daily. -nursing notes that the Resident was scratching at his/her upper arms, with no known irritants. Review of the clinical record indicated Resident #7: -was hospitalized from [DATE] to 11/6/25 for inpatient psychiatric care. -was started on Lorazepam 0.5 mg (anti-anxiety medication) every 6 hours as needed (PRN), initiated on 11/6/25 after hospitalization. -returned to the facility on [DATE]. -had no evidence that the Resident had been referred to the PASARR program after the hospitalization. Review of Resident #7's November 2025 Medication Administration Record (MAR) indicated:-Ativan Oral Tablet 0.5 milligrams (mg) (Lorazepam) give 0.5 mg by mouth every 6 hours as needed (PRN) for anxiety/agitation x 14 days, initiated 11/6/25. Further review of Resident #7's November 2025 MAR indicated medication had not been administered to the Resident. Review of the Minimum Data Set (MDS) Assessment, dated 11/12/25, indicated Resident #7: -was able to make him/herself understood, and he/she usually understood others with clear comprehension. -was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of six out of 15 total possible points. -active diagnoses included depression and anxiety. Review of Resident #7's clinical record on 1/30/26 failed to indicate any evidence that the Resident had been referred to the PASRR program when he/she experienced a significant change in mental status, immediate transfer to the hospital for medical and psychiatric evaluation and required the use of anti-anxiety medication. During an interview on 1/30/26 at 12:25 P.M., the Social Worker (SW) #1 said that a Level II had not been completed for Resident #7 and it should have been. SW #1 said that Resident #7 was sent out for mental status change for suicidal remarks and an attempt to self-harm back in November 2025 and a PASARR Level II should have been completed. 2. Resident #11 was admitted to the facility in May 2016 with diagnoses including Depression, Psychotic Disorder, and Dementia. Review of Resident #11's Minimum Data Set (MDS) Assessment, dated 4/4/24, indicated the following: -The Resident usually made him/herself understood and usually understood others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Rehabilitation and Nursing Center	59 Eastwood Circle Gardner, MA 01440

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 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	-The Resident had active diagnoses including Dementia, Psychotic Disorder, and Depression. -The Resident had no signs of delirium during the MDS observation period. -The Resident had no indications for psychosis during the MDS observation period. -The Resident did not demonstrate wandering behavior during the MDS observation period. Review of Resident #11's Nurse Health Status Note, dated 5/25/24, indicated the following: -Facility staff discovered that the Resident had been walking up the street from the facility at a local gas station. -The Resident was transferred to the hospital and was admitted to the psychiatric ward. Review of Resident #11's Hospital Emergency Department (ED) Note, dated 5/25/24, indicated the following: -The Resident presented in the ED for evaluation of erratic behavior. -The Resident had increasing behaviors over several previous months while at the facility, including refusal of taking psychiatric medications and exit seeking. -The plan was to admit the Resident to the GPU (Geriatric Psychiatry Unit). Review of Resident #11's Hospital Discharge summary, dated [DATE], indicated the following: -The Resident was being discharged back to the facility. -Discharge diagnoses included Schizoaffective Disorder, Bipolar type. Review of Resident #11's clinical record failed to indicate any evidence a PASRR had been completed for Resident Review and communicated to the PASRR Office any time after the Resident had been hospitalized at the GPU. During an interview on 1/28/26 at 1:20 P.M., the Social Worker (SW) said she reviewed Resident #11's clinical record and located no evidence a PASRR had been completed for Resident Review following the Resident's GPU admission in May 2024. The SW said she also called the PASRR Office and the PASRR Office reported no history of communication from the facility following the Resident's GPU admission. The SW said a PASRR should have been completed and submitted to the PASRR Office for Resident Review due to the Resident having had a significant change in condition requiring psychiatric hospitalization and that this had not been done.