STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225198	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Center	63 Locust Street Danvers, MA 01923

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews the facility failed to ensure a dignified dining experience on one out of three units. Specifically on the 1st floor unit, dining room staff failed to provide dignified dining experience and referred to residents as feeders, rather than by their name. Findings include: The facility policy titled Quality of Life- Dignity, dated as revised August 2009, indicated the following: -Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. - Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. On 6/17/25 beginning at 12:28 P.M., the surveyor made the following observations on the first floor unit: -At 12:41 P.M., a Certified Nursing Assistant (CNA) walked into the dining room, gestured at a resident across the room and asked Nurse #1 if the resident was a feeder. Nurse #1 responded yes and failed to inform the CNA that residents should be referred to by their name, not as feeders. -At 12:46 P.M., a Nurse said out loud We have a feeder left and gestured to a resident sitting at a table with four residents. During an interview on 6/17/25 at 1:27 P.M., the Assistant Director of Nursing said staff should not refer to residents as feeders. During an interview on 6/17/25 at 1:35 P.M., the Director of Nursing said staff should not refer to residents as feeders and said residents should be treated with dignity.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to 1.) report a fall, resulting in a head laceration requiring staples and, 2.) report a fall, resulting in a fracture of the right femoral neck (right thigh bone) requiring surgery, to the state agency as required for one Resident (#42), out of a total sample of 21 residents. Findings include: A review of the facility policy titled, Abuse Investigation and Reporting with a revision date of July 2017 indicated the following: -All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. -All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator or his/her designee to the following persons or agencies: The State licensing/certification agency responsible for surveying/licensing the facility. -An alleged violation of abuse, neglect, exploitation, or mistreatment, (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. 1. Resident #42 was admitted to the facility in March 2019 with diagnoses including bradycardia, adjustment disorder with anxiety, and anemia. Review of Resident #42's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that the Resident has a Brief Interview for Mental Status score of 2 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident is dependent on staff with activities of daily living. Review of nursing progress notes indicated the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dated 6/11/25: This nurse had just come back from doing rounds, when she heard noise coming from the patient's room. On inspection, patient was observed lying on the floor on his/her left side. Vitals were stable, neuro's intact. At baseline resident is alert and oriented to self therefore, unable to provide a description of what happened. Resident was safely transferred back to his/her bed with the help of the CNA and I. Resident was not moaning or grimacing, he/she did not appear to be in pain. Physician was notified, he stated that they will come in and see him/her and legal guardian was left a message. Later on, when the aids for the next shift got the resident up in his/her wheel chair, they observed him/her bleeding from the scalp. This nurse and the oncoming nurse on duty was notified, this nurse called NP (nurse practitioner) who gave an order to send him/her out to the ED (emergency department)for further evaluation and a head CT scan. (Local) ambulance service was called to pick the resident and transport him/her to hospital, and they let this nurse know that they would be there in an hours time. This nurse let the on duty nurse know and also the ADON was made aware of the situation. -Dated 6/11/25: Resident returned from Hospital s/p (status post) fall with injury to front head; via stretcher accompanied by 2 emergency personnel. Resident presented with laceration on front head. Resident returned with a staple to front of head. Review of Resident #42's Hospital Discharge paperwork dated 6/11/25 indicated the following: - -Head: Midline forehead at the hairline there is an elliptical 2 cm laceration with slight blood oozing. Wound was closed with one staple. CT scan showed left forehead soft tissue laceration and edema. Follow-up with primary care physician in 2-3 days if not improving or for further concerns or follow-up sooner as needed. Staple removal in 7 days. Review of the Health Care Facility Report System (HCFRS) failed to indicate the facility reported the incident to the state agency. During an interview on 6/17/25 at 2:27 P.M., the Director of Nursing said she would expect the incident to have been reported to the state agency and said she thought the Administrator had reported the fall with head laceration with the staple. During an interview on 6/18/25 at 8:08 A.M., the Administrator said he was aware of Resident #42's fall with head laceration and staple and said the injury should have been reported to the state agency but was not. 2. Review of Resident #42's progress notes indicated the following: -Dated 2/23/25, Nurse Practitioner: Fall with injury. Patient had an unwitnessed fall. Patient does not ambulate independently, uses wheelchair at baseline. Staff did not see the fall, but patient was in common area for activity and attempted to get up unassisted, having a fall and was found on the floor. Patient complains of severe pain in the right knee and lower leg and will not allow staff to move or touch the leg. Indicates severe pain with any movements of the knee, not able to bear any weight on the joint with standing and there is moderate swelling/deformity of the knee. He/she also has a small hematoma to right side of forehead without active bleeding at this site. Limited flexion and extension of right knee, moderate right knees [NAME], guarding due to pain. Skin pink and dry, small hematoma about 1.5 inches in diameter to right forehead above the brow. This is an acute new problem condition is worsening. Significant knee pain with swelling and limitations to movement, concern for fracture given the injury/trauma. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dated 2/27/25, Nursing: Resident alert with baseline confusion. Returned from hospital last night s/p fall 3 days ago where he/she sustained a fracture in his/her right hip. Dressing on right hip intact with no drainage or signs of infection noted. Hip abduction pillow in place during shift. Resident received PRN Tylenol for pain with good effects. Resident was seen today by NP, new order placed to change hip dressing daily and as needed. Review of Resident #42's Hospital Discharge paperwork dated 2/26/25 indicated the following: Fall and right hip fracture. Diagnosis: Close displaced fracture of right femoral neck. Status post-operative repair of closed fracture of right hip. Posterior Hip Precautions for 3months. Review of the Health Care Facility Report System (HCFRS) failed to indicate the facility reported the incident to the state agency until 3/5/25, 10 days after the fall resulting in right femur fracture. During an interview on 6/17/25 at 2:30 P.M., the Director of Nursing said she would expect the incident to have been reported to the state agency as required due to a resulting right leg fracture requiring surgery. During an interview on 6/18/25 at 8:14 A.M., the Administrator said he would expect the fall with fracture to be reported per the state requirement and said he was not present during the time of the incident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop a person-centered behavior care plan for one Resident (#10) out of a total sample of 21 residents. Specifically, the facility failed to develop a person-centered care plan for a history of chronic paranoia and delusions. Findings include: A review of the facility policy titled 'Behavioral Assessment, Intervention and Monitoring' with a revision date of December 2016 indicated the following: -Behavior is the response of an individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes. -As part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, or mental illness (e.g., bipolar disorder or schizophrenia). -As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations, the resident's usual patterns of cognition, mood and behavior, the resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers. Resident #10 was admitted to the facility in April 2025 with diagnoses including schizophrenia, intellectual disability and post-traumatic stress disorder. A review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 indicating moderate cognitive impairment. A review of the hospital discharge medical record dated 3/20/25 indicated the following: -Per social work notes: Resident has a history of chronic delusions, however staff from the respite, report his/her paranoia has been worse. The resident notes he/she does not want to go back to respite because the male staff scare him/her. He/she notes that he/she would like to go to a nursing home and have female staff. Staff confirm that the resident has paranoia around black males, and this has contributed to him/her refusing his/her medication when the staff is a black male. Resident reported his/her neighbors, who drink alcohol, whiskey, and do drugs broke into his/her apartment, beat him/her, did wicked things, sexually. Resident reports urinating in bottles in his/her room because he/she does not want to leave his/her room to use the bathroom.[sic] A review of Resident #10's care plan failed to indicate a history of delusions and paranoia person-centered care plan. During an interview and record review on 6/17/25 at 9:17 A.M., the Social Worker reviewed the hospital discharge paperwork with the surveyor. The Social Worker said a person-centered care plan with the Resident's chronic paranoia and delusions should be added to his/her care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/25 at 10:40 A.M., the Director of Nurses said the Resident's paranoia and delusions should be added in the care plan and person centered. Refer to F699.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review, the facility failed to provide Nursing services consistent with professional standards of practice for two Residents #24 and #11 out of a total sample of 21 residents. Specifically; 1. For Resident # 24, the facility failed to include how much oxygen the Resident should be taking via nasal cannula, and how often the oxygen tubing should be changed in the physician's orders. 2. For Resident #11, the facility failed to implement a physician's order to administer tube feeding with correct enteral feeding and correct rate. Findings include: A review of the facility policy titled 'Oxygen Administration' indicated the following: -The purpose of this procedure is to provide guidelines for safe oxygen administration. -Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. A Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize errors. 1. Resident #24 was admitted to the facility in December 2024 with diagnoses including dementia with behavioral disturbances and Chronic Obstructive Pulmonary Disease (COPD). A review of the Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15 indicating moderate cognitive impairment. On 6/16/25 at 9:17 A.M., and 11:10 A.M., the surveyor observed Resident #24 in bed wearing a nasal cannula, oxygen was set at 4 liters, and the oxygen tubing was not labeled and dated. During an interview on 6/16/25 at 11:10 A.M., Resident #24 said he/she has been on oxygen since admission. On 6/17/25 at 7:47 A.M., and 9:48 A.M., the surveyor observed Resident #24 in bed wearing a nasal cannula, oxygen was set at 4 liters, and the oxygen tubing was not labeled and dated. A review of the Respiratory therapist's progress note date 6/12/25 indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident utilizes an oxygen concentrator from O2 (oxygen) safe. Oxygen saturation on 3 LPM (Liters Per Minute) is 97 percent, and his/her respiratory rate is 73 bpm (breatbs per minute). A review of the Respiratory therapist's progress note dated 6/16/25 indicated the following: The Resident utilizes an oxygen concentrator from O2 (oxygen) safe. His/her oxygen saturation on 3 LPM (Liters Per Minute) is 99 percent and his/her respiratory rate is 86 bpm (breaths per minute). A review of Resident #24's physician's orders failed to indicate an oxygen administration via nasal cannula physician's order. Further review of the shortness of breath (SOB) and COPD care plan initiated 4/10/25 failed to indicate an oxygen administration via nasal cannula plan of care. During an interview, observation and record review on 6/17/25 at 10:15 A.M., the surveyor and the Assistant Director of Nurses (ADON) observed the Resident in bed, wearing the nasal cannula, oxygen set at 4 liters, and the oxygen tubing not labeled and dated. The ADON reviewed the physician's orders and could not find an order for oxygen administration. The ADON said there should be a physician's order in place indicating how much oxygen the resident should be taking, and how often the oxygen tubing should be changed. During an interview and record review on 6/17/25 at 10:21 A.M., the Director of Nurses (DON) reviewed Resident #24's physician's orders and said oxygen administration physician's order should be in place. The DON said the physician's orders should indicate how much oxygen the resident should be on and how often the oxygen tubing should be changed.2. Resident #11 was admitted to the facility in March 2021 with diagnoses including respiratory failure, gastrostomy status, tracheostomy, and quadriplegia. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/25/25, indicated Resident #11 had a Brief Interview for Mental Status (BIMS) assessment, which indicated severe cognitive impairment. Further review indicated Resident #11 had tube feedings, and a tracheostomy. Review of Resident #11's physician's order, initiated 5/9/25, indicated: - Enteral Feed Order every shift Jevity 1.5 calories (cal) at 55 milliliters (ml) per hour (hr). On 6/16/25 at 8:02 A.M., the surveyor observed Jevity 1.2 cal at 58 ml/hr being administered via gastrostomy (G-tube) to Resident #11. On 6/17/25 at 7:33 A.M., the surveyor observed Jevity 1.2 cal at 58 ml/hr being administered via G-tube to Resident #11. During an interview on 6/16/25 at 10:45 A.M., Nurse #1 reviewed Resident #11's physician's order and then observed the enteral feeding that was being administered to Resident #11 with the surveyor. She said she was not aware that Resident #11 was not receiving the enteral feeding that was ordered by the physician. She said she would expect that the physician ordered enteral feeding would match what the Resident was receiving. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/25 at 11:50 A.M., the Director of Nursing (DON) said nurses should always follow the physician's orders. The DON said that if the enteral feed orders need to be changed for any reason, she would expect the order to be updated and to be followed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide treatment and care in accordance with professional standards of practice for one Resident (#56) out of a total sample of 21 residents. Specifically; the facility failed to change a wound dressing for three days. Findings include: Review of the facility policy titled Dressings, Dry/Clean dated revised September 2013, failed to indicate to follow a physician's order. Resident #56 was admitted to the facility in February 2024 with diagnoses including peripheral vascular disease, anxiety and depression. Review of the Minimum Data Set assessment dated [DATE], indicated Resident #56 scored an 11 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. On 6/16/25 at 8:10 A.M. the surveyors observed Resident #56 sitting on the edge of the bed. The surveyors then observed a soiled dressing on Resident #56's right ankle covering half the open wound and exposing the other half. The surveyors also observed that the dressing was dated 6/12/25. On 6/16/25 at 12:50 P.M. the surveyor and Nurse #1 observed Resident #56 sitting on the edge of the bed with a soiled dressing on Resident #56's right ankle covering half the open wound and exposing the other half. They also observed that the dressing was dated 6/12/25 and had yellow/brown drainage. Review of the physician's orders dated June 2025 indicated an order for: Day Shift; Mupirocin External Ointment 2 % (Mupirocin) Apply to Right medial ankle topically every day shift for Wound care - Start Date - 05/14/2025 0700 - D/C Date - 06/13/2025 0938 Further review indicated an order for: Day Shift; Mupirocin External Ointment 2 % (Mupirocin) Apply to Right medial ankle topically every day shift for Wound care for 30 Days - Start Date - 06/14/2025 0700 Review of the Medication Administration Record dated June 2025, indicted that on 6/13/25, 6/14/25 and 6/15/25, nurses documented that they changed the dressing as ordered. During an interview on 6/16/25 at 12:50 P.M. Nurse #1 said that the dressing should have been changed daily. During an interview on 6/18/25 at 7:26 A.M. the Director of Nursing said that she expects the nurses to follow the physician's orders for dressing changes.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to consistently provide range of motion (ROM) care and treatment in accordance with professional standards of practice for one Resident (#11) out of a total sample of 21 residents. Specifically, the facility failed to ensure staff implemented Resident #11's, physician ordered, rolled facecloth to contracted [left] hand every shift. Findings include: Review of the facility policy titled 'Resident Mobility and Range of Motion', revised July 2017, indicated: - Residents will not experience an avoidable reduction in range of motion (ROM). - Residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. - Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless a reduction in mobility is unavoidable. Resident #11 was admitted to the facility in March 2021 with diagnoses including contracture, unspecified joint. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/25/25, indicated Resident #11 had a Brief Interview for Mental Status (BIMS) assessment, which indicated severe cognitive impairment. This MDS also indicated Resident #11 had functional limitation in range of motion in bilateral upper and lower extremities. Review of Resident #11's physician's order, initiated 4/21/24, indicated: - Cleanse left hand with water and soap and dry. Inspect skin. Notify physician (MD) if impairment is noted and document in progress notes. Place a rolled washcloth to contracted hand, every shift (QS). Review of Resident #11's plan of care related to alteration in musculoskeletal status left hand related to contracture, revised 2/16/22, indicated: - washcloth in palm to prevent further contracture deterioration. On 6/16/25 at 8:02 A.M., the surveyor observed Resident #11 lying in bed without a facecloth in his/her left hand. On 6/17/25 at 7:34 A.M., the surveyor observed Resident #11 lying in bed without a facecloth in his/her left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/25 at 10:10 A.M., Certified Nurse Assistant (CNA) #2 said she regularly works on the unit with Resident #11, and he/she usually has a facecloth in his/her left hand, but she does not know why he/she hasn't had it for the past two days. Review of Resident #11's medical record, including medication administration record (MAR), treatment administration record (TAR), and progress notes failed to indicate any rationale regarding why Resident #11 was not using a facecloth to his/her left hand. During an interview on 6/17/25 at 10:45 A.M., Nurse #1 and surveyor reviewed Resident #11's order for facecloth to left hand and then observed that he/she did not have a facecloth in his/her left hand. She said that Resident #11 usually has a facecloth in his/her left hand, and it should be there according to physician's orders. Nurse #1 and surveyor reviewed Treatment Administration Record (TAR) and observed that the order for rolled facecloth to left hand is signed off every shift as completed. On 6/17/25 at 10:50 A.M., the surveyor observed Resident #11 lying in bed without a facecloth in his/her left hand. During an interview on 6/18/25 at 7:25 A.M., the Director of Nursing (DON) said if Resident #11 had a physician's order for a facecloth to be applied to his/her left hand, it should have been in place. The DON said if it was not in place, the rationale should be documented in the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to adequately maintain the nutrition and hydration status of one Resident (#1) out of a total sample of 21 residents. Specifically, for Resident #1 the facility failed to ensure significant weigh loss was assessed and continually monitored. Findings include: Review of the facility policy titled, Weighing and Measuring the Resident, dated as revised March 2011, indicated the following: -The purposes of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height in order to determine the ideal weight of the resident. -Reporting: 1. Report significant weight loss/weight gain to the nurse supervisor. 2. The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria. a. 1 month- 5% loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months- 10% weight loss is significant; greater than 10% is severe. 3. Notify the Nurse Supervisor if the resident refuses the procedure. 4. Report other information in accordance with facility policy and professional standards of practice. Resident #1 was admitted to the facility in February 2025 with diagnoses including anxiety, depression, and bipolar disorder. Review of Resident #1's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) of 12 out of a possible 15, which indicated he/she had moderate cognitive impairment. Review of Resident #1's weights indicated the following: -5/12/25 152.0 lbs. -4/1/25 157.1 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/6/25 176.5 lbs. -5/24/25 129.3 pounds (lbs.) 14.9 % decrease from 5/12/25; 17.7 % decrease from 4/1/25; 26.7 % decrease from 2/6/25. Review of the Resident's medical record failed to indicate any record of weights during the month of March 2025 and failed to record any reweights or documentation of physician being notified of significant weight loss. Review of the dietary notes indicated the following: 5/12/2025 10:50 Weight Note Note Text: he/she triggered for loss this month -10% from 2/6 176.5 Wt. Hx 2/6 176.5 4/1 157 5/12 152 -10% decrease Diet mech (mechanical) soft in dining room He/she reports UBW (usual body weight) 160. Appetite is variable, prefers sandwiches and cold cereal. He/she agreed to try the house supps (supplements) added to trays to prevent further loss. BMI is wnl [within normal limits] and insight loss x 30 days. Will cont [continue] to monitor and evaluate. [sic] 4/4/2025 12:15 Weight Note Note Text: He/she triggered for wt. loss, -10% from admission. He/she was seen in the dining room in his/her electric wheelchair with others. He/she reports his/her appetite is good and he/she prefers sandwiches. He/she declines supplements or any snacks and reports he/she gets enough to eat. He/she appears to be recorded ht/wt [height/weight] and adequately nourished. BMI is wnl [within normal limits]. Wt. HX 4/1 157 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/6 176.5 BMI 22.5 wnl Diet mechanical soft. Intakes 50-100% Since he/she declines interventions no new concerns. Will cont to monitor. [sic] During an interview on 6/17/25 at 10:45 A.M., Nurse #1 said she would report any significant weight loss to the dietitian and physician. During a follow up interview on 6/17/25 at 1:12 P.M., Nurse #1 said she would ask for Resident to be reweighed if the weight was significantly different compared to previous weight. Nurse #1 said she was unaware of Resident #1's significant weight loss, but she said that he/she recently had mighty shakes ordered. She was unaware if the physician had been notified of weight changes. During an interview on 6/17/25 at 12:52 P.M., the Registered Dietitian (RD) said she works at the facility two times per week. She said that she reviews the weight change progress report weekly to monitor for variances, attends risk meetings weekly and then writes progress notes to address any Resident's discussed. She said she would expect that nursing would identify any changes in Resident's weights or eating patterns before her and let her know so she could review and make recommendations. The RD said that if a weight was significantly different than the previous weight, she would ask for a reweight. If weight loss was still significant, she would expect the physician to be notified. She says that she does request reweights from nursing and that the need for reweights is also discussed in risk meetings but states that she does not have any documentation to support this. Review of the Medication Administration Reports (MAR) for January 2025 to June 2025 failed to indicate the Resident refused the Mighty Shake supplement. During an interview on 6/18/25 at 7:25 A.M., the Director of Nursing (DON) said she expects weights to be obtained at least monthly, reweighs to be obtained and recorded if there is a significant change and dietitian and physician to be notified if a significant weight change has occurred. The DON said she was unaware of Resident #1's weight loss and does not know why it did not get followed up on.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop a trauma informed care plan for two Residents #10 and #1 out of a total sample of 21 residents. Specifically: 1. For Resident #10, the facility failed to develop a post-traumatic stress disorder (PTSD) care plan addressing the needs of trauma by minimizing triggers and re-traumatization. 2. For Resident #1, the facility failed to develop a care plan addressing PTSD with a history of suicide attempt. Findings include: A review of the facility policy titled 'Trauma Informed Care' with no revision date indicated the following: -Trauma informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of traumas. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. -The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which retraumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. 1. Resident #10 was admitted to the facility in April 2025 with diagnoses including schizophrenia, intellectual disability and PTSD. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 indicating moderate cognitive impairment. A review of the hospital discharge record dated March, 2025 indicated the following: -Psycho-social history: History of trauma/life events impacting wellbeing: DDS (Department of Developmental Services) involvement in the childhood due to abuse and exposure to family violence. Chart review indicates there is some concern of prior sexual assault while admitted to the hospital in the past. The resident tells me he/she was raped by a stranger at age [AGE], physically assaulted by a stranger on the street as a young boy/girl. [sic] A review of Resident #10's care plan failed to indicate a person-centered PTSD care plan identifying triggers which may re-traumatize the Resident. A review of Resident #10's Trauma Informed Care Assessment with an effective date of 4/29/25 failed to indicate any identified trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 6/17/25 at 9:17 A.M., the Social Worker reviewed the hospital discharge paperwork and the Trauma Informed Care Assessment with the surveyor. The Social Worker said the Trauma Informed Care Assessment should have identified the Resident's history of trauma. The Social Worker said a person-centered PTSD care plan identifying triggers that may re-traumatize the Resident should be put in place. During an interview on 6/17/25 at 10:40 A.M., the Director of Nurses said the Resident should have a person-centered PTSD care plan identifying all his/her triggers.2. Resident #1 was admitted to the facility in February 2025 with diagnoses including anxiety, depression, bipolar disorder, and post-traumatic stress disorder (PTSD). A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 indicating moderate cognitive impairment. This MDS indicated a diagnosis of PTSD. A review of physician progress note from a previous facility, dated 12/11/24 indicated the following: -complicated psychiatric history dx of bipolar depression with anxiety, PTSD, insomnia with history of suicide attempt by jumping from 4th floor of building 5 years ago. He/she was last seen by behavioral health NP (nurse practitioner) for medication management on 11/4/24. [sic] A review of Resident #1's care plan failed to indicate a person-centered PTSD care plan identifying triggers which may re-traumatize the Resident and/or identification of history of suicide attempt. A review of Resident #1's Trauma Informed Care Assessment with an effective date of 2/7/25 failed to indicate any identified trauma. During an interview on 6/17/25 at 10:45 A.M., Nurse #1 said she would expect a care plan to be in place to address the Resident's history of suicide attempts so staff would be aware of and monitor for any signs and symptoms. During an interview on 6/17/25 at 10:40 A.M., the Director of Nurses said the Resident should have a person-centered care plan to identify his/her triggers and history of suicide attempt. During an interview and record review on 6/17/25 at 12:42 P.M., the Social Worker reviewed the progress notes and the Trauma Informed Care Assessment with the surveyor. The Social Worker said the Trauma Informed Care Assessment should have identified the Resident's history of trauma. The Social Worker said a person-centered PTSD care plan identifying triggers that may re-traumatize the Resident should be put in place and should also address his/her history of suicide attempt.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free from a medication error rate of greater than 5 percent. Specifically, one of two nurses observed made two errors in 33 opportunities resulting in a medication error rate of 6.06%. These errors impacted one Resident (#18) out of four residents observed. Findings include: Review of the facility policy titled Adverse Consequences and Medication Errors dated as revised April 2014 indicated the following: -A medication error is defined as the preparation or administration of drugs or biological's which is not in accordance with physician orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. For Resident #18 the facility failed to administer medications as ordered by the physician. Review of the current doctor's orders indicated an order for the following: 1. Lactose Fast Acting Relief Oral Tablet (Lactase) Give 2 tablets by mouth before meals for lactose intolerance. Start Date 6/13/25. 2. Saline Spray Nasal Solution (Saline) 1 spray in each nostril three times a day for dryness. Start Date 3/31/25. During a medication pass on 6/17/25, at 8:50 A.M. the surveyor observed Nurse #3 prepare and administer the following medications: 1.Lactose Fast Acting Relief Oral Tablet (Lactase) -two tablets given after the breakfast meal was consumed. The surveyor observed a staff member feeding Resident #18 just prior to the medication pass. The breakfast tray was observed on the over bed table with consumed food during the medication pass. 2. Saline Spray Nasal Solution (Saline)- two sprays were administered in each nostril. During an interview on 6/17/25 at 8:55 A.M., Nurse #3 said he should have administered the medication before the breakfast meal and said he always gives the Resident two sprays per nostril and said he should have followed the physician order for one spray.

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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 observations and interviews, the facility failed to ensure 1.) a medication cart was locked when unattended, on one of three nursing units, 2.) medications were labeled, and dated once opened, according to manufacturer's guidelines on one out of three medication carts sampled, 3.) store medications at proper temperatures and other appropriate environmental controls to preserve their integrity. Findings include: Review of the facility policy titled, Storage of Medications, dated as revised April 2007, indicated: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. -Only a person authorized to prepare and administer medications shall have access to the medication room, including keys. -Medication requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medication must be stored separately from food and must be labeled accordingly. 1.The facility failed to ensure medications were stored in locked compartments on one of three nursing units. On 6/17/25 at 8:08 A.M., the surveyor observed a medication cart left unlocked and unattended on the third-floor unit. The surveyor was able to open the medication cart and gain access to the medications. There were no staff present at or around the medication cart and residents were observed walking past the unlocked medication cart. During an interview on 6/17/25 at 8:18 A.M., Nurse #3 said the medication cart must be locked at all times and said he did not realize it was unlocked. During an interview on 6/17/25 at 3:20 P.M., the Director of Nursing (DON) said medication carts must remain locked and said no one should have access to the medications except the nursing staff who have the keys to unlock the cart and gain access to the medication stored inside. 2.The facility failed to ensure medications were labeled, and dated once opened, according to manufacturer's guidelines in one out of four medication carts sampled. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/17/25 at 8:50 A.M., the surveyor and Nurse #3 observed the following on the 3rd floor medication cart: -Artificial Tears Lubricant Eye Drops ½ FL Oz 15ml., open undated. During an interview on 6/17/25 at 8:52 A.M., Nurse #3 said medications must be dated when opened and said he is not sure when the bottle was opened. During an interview on 6/17/25 at 3:20 P.M., the Director of Nursing (DON) said the Artificial Tears should have been dated when opened and said she expects staff to document on the bottle when a medication if first opened. 3.The facility failed to ensure storage of medications at proper temperatures and other appropriate environmental controls to preserve their integrity. On 6/17/25 at 12:18 P.M., the surveyor made the following observations on the 1st floor unit: -One Medication refrigerator was located inside of the medication storage room. There was no thermometer located inside of the refrigerator and the inside of the refrigerator felt cool not cold. Condensation was observed on the medications located inside of the refrigerator. -There was one digital thermometer located on the outside of the refrigerator that was not operatable and had a blank screen. -One April 2025 Temperature Log containing 12 documented temperatures out of 30 days. The following medications were observed inside of the refrigerator: -One box of Latanoprost Ophthalmic Solution 0.005% Store unopened bottle in refrigeration at 2 degrees Celsius to 8 degrees Celsius (2°C to 46°C) /36 degrees Fahrenheit to 46 degrees Fahrenheit. (36°F to 46°F) -Six Vitals of Humalog CAR 100 Units. Store in a refrigerator at approximately 36°F to 46°F. -15 Insulin Injection Pens. Store in a refrigerator at approximately 36°F to 46°F -1 Box Repatha (evolocumab) Prefilled Syringe Injection - Store in a refrigerator at approximately 36°F to 46°F. -1 Box Risperdal Consta Risperidone Long-Acting Injection Single Use Dose Pack - Store in refrigerator at approximately 36°F to 46°F. During an interview on 6/17/25 at 12:24 P.M., Nurse #2 said the refrigerator should have daily temperature logs and said the overnight staff are responsible for maintaining the logs. Nurse #2 said the Assistant Director of Nursing took the thermometer out this morning because it was not working. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 6/17/25 at 1:04 P.M., the Assistant Director of Nursing (ADON) said the temperature of the refrigerator was too high and said he took the thermometer out this morning and did not place a new thermometer inside of the refrigerator. The surveyor along with the ADON observed the refrigerator and observed condensation, melting frost and water on the inside of the refrigerator that contained medications. The bottles and bags were wet to the touch. The ADON said the overnight nurse reported to him that the refrigerator was not working and that it was warm. The ADON said the medications must be within parameters and said all he knows is that the temps were high according to the overnight nurse, but he does not know what the temperature was and does not know how long the refrigerator was warm. The ADON then said he does not have any temperature logs and said the staff should be documenting the temperature every night. During an interview on 6/17/25 at 2:37 P.M., the Director of Nursing said it is her expectation that the temperature of the refrigerators are checked each night and monitored for safety within the appropriate temperatures. The DON said she was not aware of the warm refrigerator and said the medications must be thrown away because they do not know how long they have been warm. During an interview on 6/18/25 at 10:38 A.M., the Medical Director said it is his expectation that medications are stored according to the manufactures guidelines and said he expects staff to monitor temperature controls and remove medications that have been compromised.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on records reviewed and interviews, the facility failed to ensure it provided appropriate administrative oversight in a manner that enabled the facility to use its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility administration failed to ensure pre-employment health requirements and dementia training was provided to all staff to provide competent, safe, and effective resident care as well as ensuring the governance and leadership members sustain a sufficient Quality Assurance Performance Improvement (QAPI) program during transitions in leadership and staffing. Specifically, the facility administration failed to: 1. Ensure effective systems were in place for education, and training for licensed staff to ensure competent, and safe practice. 2. Establish and maintain an IPCP (Infection Prevention Control Program) designed to provide a safe, sanitary, and comfortable environment and to help prevent development and transmission of disease and infection. 3. Develop an Antibiotic Stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. Findings include: During the survey process it was identified that the Administration's failure to orient and educate staff on policies and procedures specifically related to dementia care. During the survey process, it was also identified that the Administration's failure to implement an infection control program for identifying, tracking, and monitoring, including the failure to develop and implement an Antibiotic Stewardship Program. During an interview on 6/18/25 at 9:39 A.M., the Administrator said it is his expectation that the clinical staff are trained appropriately and have the required completed clinical competencies on file. The Administrator said he was not aware that 3 out of the 5 new hire employee records reviewed were lacking proof of dementia training. He then said that he could provide no documentation of clinical concerns brought to the QAPI meetings including infection control measures, antibiotic stewardship or dementia education. During a phone interview on 6/18/25 at 10:40 A.M., the Medical Director said he started as the facility's medical director in April 2025, and he is aware that there is no Infection Control Program in place. He said it is something they are working on and will address through the Quality Assurance and Performance Improvement (QAPI) program. He said he would expect the facility to be monitoring and tracking infections, including antibiotic stewardship and the vaccinating of residents and staff when appropriate, data collecting and recording and calculating infection rates so this information can be brought to the QAPI committee, and they can be involved in interpretation of the data. During an interview on 06/18/25 11:10 A.M., the Administrator said that he had not informed the [NAME] president of Operations or the governing body of the lack of QAPI in the facility prior to February. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/18/25 at 11:23 A.M., the [NAME] President of Operations said he was not made aware of the lack of QAPI being performed in the building from September 2024 through February 2025. He then said that he expects the Administrator is ensuring QAPI and infection control programs are in place. I expect them to follow the system and QAPI programs. I do not review the QAPI minutes to make sure that the administration is following the QAPI program. Refer to F837, F880 and F881

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview and record review, the facility failed to ensure that the governing body provided oversight and accountability for: 1. The maintenance of an effective QAPI program. 2. The provision of an infection control/antibiotic stewardship program. Findings include: Review of the facility policy titled, Quality assurance Performance Improvement Plan, dated January 2025, indicated that the Administrator has responsibility and is accountable to the governing body for ensuring that QAPI is implemented throughout our facility. QAPI activities and discussion will be a standing item on our governing body board meeting agendas. During the survey period the surveyor requested the infection control program information for tracking infections, including line listings, reporting data and antibiotic stewardship. The facility failed to have any documented information related to tracking and reporting of infections or antibiotic stewardship in the facility. Review of the QAPI program failed to indicate that a QAPI had been initiated for the implementation of the infection control/antibiotic stewardship programs. During an interview on 6/18/25 at 10:50 A.M., the Administrator said that the QAPI program had not been implemented since ownership changed hands in June 2024 until February 2025. The Administrator said that he could not find any QAPI meeting minutes or projects June 2024 through February 2025. The Administrator said that he was not aware that the infection control and antibiotic stewardship programs were not being implemented. The Administrator said that it is his expectation that the facility follows an infection prevention and control program that includes a system for appropriate infection surveillance. The Administrator also said that he would expect that the facility is implementing an antibiotic stewardship program. The Administrator said that the lack of complete infection control and antibiotic stewardship programs would warrant the inclusion in QAPI. During an interview on 6/18/25 at 10:56 A.M., the [NAME] President of Operations/owner said that he was not aware of who the Governing Body representative was for the facility. During an interview on 06/18/25 at 11:10 A.M., the Administrator said that he had not informed the governing body of the lack of QAPI in the facility prior to February. During an interview on 6/18/25 at 11:23 A.M., the [NAME] President of Operations/owner said he was not made aware of the lack of QAPI being performed in the building from September 2024 through February 2025. He then said that he expects the facility to follow the system and QAPI programs. Refer to F880 and F881

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to accurately document in the medical record for one Resident (#56) out of a total sample of 21 residents. Specifically, for Resident #56 the facility documented a dressing change was completed for three days when it was not. Findings include: Resident #56 was admitted to the facility in February 2024 with diagnoses including peripheral vascular disease, anxiety and depression. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #56 scored an 11 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. On 6/16/25 at 8:10 A.M. two surveyors observed Resident #56 sitting on the edge of the bed. The surveyors then observed a soiled dressing on Resident #56's right ankle covering half the open wound and exposing the other half. The surveyors also observed that the dressing was dated 6/12/25. On 6/16/25 at 12:50 P.M. the surveyor and Nurse #1 observed Resident #56 sitting on the edge of the bed with a soiled dressing on Resident #56's right ankle covering half the open wound and exposing the other half. They also observed that the dressing was dated 6/12/25 and had yellow/brown drainage. Review of the physician's orders dated June 2025 indicated an order for: Day Shift: Mupirocin External Ointment 2 % (Mupirocin) Apply to Right medial ankle topically everyday shift for Wound care. Start Date 5/14/25 7:00 A.M., D/C (discontinued) Date 6/13/25 at 9:38 A.M. Further review indicated an order for: Day Shift: Mupirocin External Ointment 2 % (Mupirocin) Apply to Right medial ankle topically everyday shift for Wound care for 30 Days. Start Date: 6/14/25 at 7:00 A.M. Review of the Medication Administration Record (MAR) dated June 2025, indicated that on 6/13/25, 6/14/25 and 6/15/25, nurses documented that they changed the dressing as ordered. During an interview on 6/16/25 at 1:45 P.M., Nurses #1 and the surveyor observed Resident #56 sitting on the edge of the bed with a dressing on the right ankle dated 6/12/25. The surveyor and Nurse #1 then observed the MAR and Nurse #1 said that nurses should not be documenting they changed the dressing when they did not. During an interview on 6/18/25 at 7:23 A.M., the Director of Nursing (DON) said she expects nurses to document accurately in the medical record. The DON then said that she cannot locate a facility policy regarding accurate documentation in the medical record.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to implement and maintain a Quality Assurance and Performance Improvement (QAPI) program which addressed the full range of care and services, was comprehensive and data-driven, and focused on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility developed QAPI plans related to staff education and infection control once these concerns were identified by the Administrator. Findings include: Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, dated January 2025, indicated the following: -Purpose: To ensure the delivery of the highest standard of care and services to our residents. Our QAPI program is designed to monitor, assess, and continuously improve all aspects of care and operations, addressing areas for improvement proactively, and ensuring that quality outcomes are consistently achieved. - Program Overview: The QAPI program is comprehensive, facility-wide, data-driven approach aimed at identifying and addressing quality gaps in clinical care, resident safety, patient satisfaction, operational efficiency, and regulatory compliance. Our program aligns with the Centers for Medicare & Medicaid Services (CMS) QAPI standards and promotes a culture of continuous improvement. -The 2025 QAPI program will focus on person-centered care, infection prevention, staff development, resident safety, and regulatory compliance while utilizing ongoing data collection and feedback to guide improvements. -Further review indicated that the QAPI committee will meet monthly and include representatives from key departments. Review of 5 out of 9 new employee records, hired in the past four months, indicated the following: -3 had no dementia training. -3 had no Certified Nurse Aide (CNA) registry check before their hire date. - The Director of Nursing did not have a license check. -1 did not have a preemployment physical. -2 did not have a tuberculin test prior to employment. -1 did not have any indication of a COVID vaccine or declination. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/18/25 at 10:50 A.M., the Administrator said that he had been at the facility for only a couple of months. He said that the Director of Nurses was responsible for the Infection Control and Prevention Program before his arrival at the facility and she was in the process of training the Assistant Director of Nurses to manage the program. The Administrator said that the QAPI program had not been implemented since ownership changed hands in June 2024 until February 2025. The Administrator said that he could not find any QAPI meeting minutes or projects June 2024 through February 2025. The Administrator said that he was not aware that the Infection Control and Antibiotic Stewardship programs were not being implemented. The Administrator said that it is his expectation that the facility follows an infection prevention and control program that includes a system for appropriate infection surveillance. The Administrator also said that he would expect that the facility is implementing an Antibiotic Stewardship Program. The Administrator said that the lack of complete Infection Control and Antibiotic Stewardship programs would warrant the inclusion in QAPI. During an interview on 6/18/25 at 10:50 A.M., the Director of Nursing said that the expectation is that an Infection Control and Antibiotic Stewardship Program is maintained and followed in the facility. She said she does not know how the facility was following antibiotic use prior to her arrival four months ago at the facility but said that currently she is training the Assistant Director of Nursing on the program. During a phone interview on 6/18/25 at 10:40 A.M., the Medical Director said he started as the facility's medical director in April 2025, and he is aware that there is no Infection Control Program in place. He said it is something they are working on and will address through the Quality Assurance and Performance Improvement (QAPI) program. He said he would expect the facility to be monitoring and tracking infections, including antibiotic stewardship and the vaccinating of residents and staff when appropriate, data collecting and recording and calculating infection rates so this information can be brought to the QAPI committee, and they can be involved in interpretation of the data.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, review of the Quality Assurance Performance Improvement (QAPI) plan, and interview, the facility failed to ensure that the Quality Assurance Committee met quarterly, identified quality deficient areas to develop and implement an appropriate corrective action plan, to ensure satisfactory outcomes. Findings Include: Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, dated January 2025, indicated the following: -Purpose: To ensure the delivery of the highest standard of care and services to our residents. Our QAPI program is designed to monitor, assess, and continuously improve all aspects of care and operations, addressing areas for improvement proactively, and ensuring that quality outcomes are consistently achieved. - Program Overview: The QAPI program is comprehensive, facility-wide, data-driven approach aimed at identifying and addressing quality gaps in clinical care, resident safety, patient satisfaction, operational efficiency, and regulatory compliance. Our program aligns with the Centers for Medicare & Medicaid Services (CMS) QAPI standards and promotes a culture of continuous improvement. The 2025 QAPI program will focus on person-centered care, infection prevention, staff development, resident safety, and regulatory compliance while utilizing ongoing data collection and feedback to guide improvements. Further review indicated that the QAPI committee will meet monthly and include representatives from key departments. During a phone interview on 6/18/25 at 10:40 A.M., the Medical Director said he started as the facility's medical director in April 2025, and he is aware that there is no Infection Control Program in place. He said it is something they are working on and will address through the Quality Assurance and Performance Improvement (QAPI) program. He said he would expect the facility to be monitoring and tracking infections, including antibiotic stewardship and the vaccinating of residents and staff when appropriate, data collecting and recording and calculating infection rates so this information can be brought to the QAPI committee, and they can be involved in interpretation of the data. During an interview on 6/18/25, at 10:50 A.M., the Administrator said that the QAPI program had not been implemented since ownership changed hands in June 2024 until February 2025. The Administrator said that he could not find any QAPI meeting minutes or projects June 2024 through February 2025.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting of infections, communicable diseases and outbreaks among residents and staff. Findings include: Review of the facility policy titled 'Surveillance for Infections', dated as revised September 2017, indicated the following: -The infection preventionist (IP) will conduct ongoing surveillance for healthcare-associated infections (HAI's) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAI's, to guide appropriate interventions, and to prevent future infections. 2. The criteria for such infections are based on current standard definitions of infections. 5. Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible. 6. If a communicable disease outbreak is suspected, this information will be communicated to the charge nurse and Infection Preventionist immediately. 7. When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures. 8. The charge nurse will notify the attending physician and the IP of suspected infections. 9. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infections, the IP will collect data to help determine the effectiveness of such measures. 10. When transmission of HAI's continues despite documented efforts to implement infection control and prevention measures, the appropriate state agency and/or specialist in infections control and epidemiology will be consulted for further recommendations. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The IP or designated infection control personnel are responsible for gathering and interpreting surveillance data and calculating infection rates. The infection control committee and/or QAPI committee may be involved in interpretation of the data. Review of the Facility assessment dated [DATE], indicated the following: Diseases /conditions, physical and cognitive disabilities. -Infectious Diseases: COVID-19, Skin and Soft Tissue Infections, Respiratory Infections, Urinary Tract Infections, Infections with Multi-Drug-Resistant Organisms (MDRO), Septicemia, Viral Hepatitis, Clostridium difficile, Influenza. -Infection prevention and control: Identification and containment of infections, prevention of infections -Management of Medical Conditions: Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), gastroenteritis, infectious such as UTI (Urinary Tract Infection) and gastroenteritis, pneumonia, hypothyroidism, Hospice/Palliative Care. -Staff training/education and competencies: Infection control training is provided to staff upon hire, annually, and as needed. -Evaluation of Infection Prevention and Control Program: facility conducts monthly/quarterly QAPI meetings, and review infection control trends. Surveillance rounds are completed; clinical rounds are done daily to discuss residents who are on antibiotics and who have active infections. During the survey period the surveyor requested the infection control program information for tracking infections, including line listings and reporting data. The facility failed to have any documented information related to tracking and reporting of infections in the facility. Further review indicated the facility failed to have any documented information for the months of August 2024, September 2024, October 2024, November 2024, December 2024, January 2025, February 2025, March 2025, April 2025, May 2025, June 2025. During the course of the survey the facility was unable to provide surveillance data and documentation of follow-up activity in response to the active antibiotic use in the facility. Review of the electronic Antibiotic Order Listing report dated 6/18/25, indicated the following prescribed antibiotics for the following infections: June 2025 Antibiotics for cystitis. May 2025 Antibiotics for toe infection, wound infection, Urinary Tract Infection (UTI), positive sputum culture. April 2025 Antibiotics oral infection, periodontal infection and UTI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	March 2025 Antibiotics for sinus infection, bacterial infections, UTI's, pyelonephritis, cellulitis, respiratory infection and C-diff. February 2025 Antibiotics for sinus infection, bacterial infection, wound infection, and UTI. January 2025 Antibiotics for bacterial infection, respiratory infection, and UTI's. December 2024 Antibiotics for osteomyelitis and bacterial infection. November 2024 Antibiotics for bacterial infection and cellulitis. October 2024 Antibiotics for UTI and skin Infections. August 2024 Antibiotics for bacterial infection and UTI's. During an interview on 6/17/25 at 11:37 A.M. the Director of Nurses (DON) said infections and surveillance of infections should be tracked, monitored, documented and reported. The DON said she does not know the rate of infections and said she has no data available and relies on what is reported to her by nursing staff. The DON said she is unaware of the infections and has no information available regarding tracking, surveillance or outbreak information available. During an interview on 6/17/25 at 11:44 A.M. the Infection Preventionist was not able to provide evidence of any infection prevention program in place in the facility including line listing, antibiotic stewardship, tracking and trending of signs of symptoms of infections, vaccination program for staff and employees, and surveillance criteria. During an interview on 6/18/25 at 8:04 A.M., the Administrator said the Infection Control program should be implemented and followed and said he is not aware of the infections in the building and said he hires staff specialized in clinical areas to manage those issues and expects the requirements to be followed. During a phone interview on 6/18/25 at 10:40 A.M., the Medical Director said he started as the facility's medical director in April 2025, and he is aware that there is no Infection Control Program in place. He said it is something they are working on and will address through the Quality Assurance and Performance Improvement (QAPI) program. He said he would expect the facility to be monitoring and tracking infections, including antibiotic stewardship and vaccinating residents and staff when appropriate, data collecting and recording and calculating infection rates so this information can be brought to the QAPI committee, and they can be involved in interpretation of the data.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interviews, the facility failed to implement an Antibiotic Stewardship Program to promote and monitor the appropriate use of antibiotics. Findings include: Review of the facility policy titled Antibiotic Stewardship, undated, indicated the following: -Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. -The purpose of our Antibiotics Stewardship Program is to monitor the use of antibiotics in our residents. -Orientation, training and education of staff will emphasize the importance of Antibiotic Stewardship and will include how appropriate use of antibiotics affects individual residents and the overall community. -Training and education will include emphasis on the relationship between antibiotic use and: a. Gastrointestinal disorders. b. Opportunistic infections (e.g., C. difficile, candida albicans, etc.). c. Medication interactions; and d. The evolution of drug-resistant pathogens. During the survey period the surveyor requested infection control line listings and antibiotic stewardship information. The facility failed to have any documented information related to tracking, follow up or review with the physician or nurse practitioner following the initiation of the antibiotics for 3 out of 3 active physician antibiotic orders prescribed. Further review indicated the facility failed to have any documented information for the months of August 2024, September 2024, October 2024, November 2024, December 2024, January 2025, February 2025, March 2025, April 2025, May 2025, June 2025. During an interview on 6/17/25 at 11:37 A.M. the Director of Nurses (DON) said infections and surveillance of infections should be tracked, monitored, documented and reported. The DON said she does not know the rate of infections and said she has no data available and relies on what is reported to her by nursing staff. The DON said she is unaware of the infections and has no information available regarding tracking, surveillance or outbreak information available. During an interview on 6/17/25 at 11:44 A.M. the Infection Preventionist was not able to provide evidence of any infection prevention program in place in the facility including line listing, antibiotic stewardship, tracking and trending of signs of symptoms of infections, vaccination program for staff and employees, and surveillance criteria. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/18/25 at 8:04 A.M., the Administrator said the Infection Control program/Antibiotic Stewardship program should be implemented and followed. He then said he is not aware of the infections in the building and said he hires staff specialized in clinical areas to manage those issues and expects the requirements to be followed. During a phone interview on 6/18/25 at 10:40 A.M., the Medical Director said he started as the facility's medical director in April 2025, and he is aware that there is no Infection Control Program in place. He said it is something they are working on and will address through the Quality Assurance and Performance Improvement (QAPI) program. He said he would expect the facility to be monitoring and tracking infections, including antibiotic stewardship and vaccinating residents and staff when appropriate, data collecting and recording and calculating infection rates so this information can be brought to the QAPI committee, and they can be involved in interpretation of the data.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interviews, the facility failed to offer the Influenza vaccine during influenza season to one Resident out of a sample of five residents reviewed. Specifically, the facility failed to offer Influenza vaccination on admission to the facility or during their stay at the facility. Findings include: Review of the facility policy, titled 'Influenza Vaccine', undated, indicated the following: -All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. -Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. A review of five resident medical records indicated one out of the five residents had not been vaccinated for Influenza. During an interview on 6/17/25 at 11:37 A.M. the Director of Nurses (DON) said she does not track vaccinations in the building but expects the Infection Preventionist to be tracking the vaccinations. During an interview on 6/17/25 at 11:44 A.M. the Infection Preventionist said he has only been working in the facility for the past month and did not have any information on the vaccination program. During an interview on 6/18/25 at 8:04 A.M., the Administrator said the Vaccination program should be implemented and followed and said he is not aware of the status of vaccinations in the building at this time. He said he hires staff specialized in clinical areas to manage those issues and expects the requirements to be met. During a phone interview on 6/18/25 at 10:40 A.M., the Medical Director said he started as the facility's Medical Director in April 2025. He said he would expect Residents' vaccination status to be obtained upon admission and for them to be offered the Influenza vaccine if admitted during Influenza season.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interviews, the facility failed to offer the COVID-19 (Coronavirus disease) vaccine to one out of five sampled residents. Specifically, the facility failed to offer a COVID-19 vaccination to a resident on admission to the facility or during their stay at the facility. Findings include: Review of the facility policy, titled 'Coronavirus Prevention and Control', dated as revised January 2023, indicated the following: -Facility leadership and clinical staff are responsible to take reasonable measures to protect the health and safety of residents and staff during the current outbreak of coronavirus disease (COVID-19). A review of five resident medical records indicated one out of the five residents had not been vaccinated for COVID-19. During an interview on 6/17/25 at 11:37 A.M. the Director of Nurses (DON) said she does not track vaccinations in the building but expects the Infection Preventionist to be tracking the vaccinations. During an interview on 6/17/25 at 11:44 A.M. the Infection Preventionist said he has only been working in the facility for the past month and did not have any information on the vaccination program. During an interview on 6/18/25 at 8:04 A.M., the Administrator said the Vaccination program should be implemented and followed and said he is not aware of the status of vaccinations in the building at this time. He said he hires staff specialized in clinical areas to manage those issues and expects the requirements to be met. During a phone interview on 6/18/25 at 10:40 A.M., the Medical Director said he started as the facility's Medical Director in April 2025, and he has heard that residents have not been receiving Covid vaccines. He said he would expect residents' vaccination status to be obtained upon admission and for them to be offered the Covid vaccine in the facility if they had not received prior to being admitted .