STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225199	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worcester Rehabilitation & Health Care Center	119 Providence Street Worcester, MA 01604

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that one Resident (#133) out of a total sample of 27 residents, was afforded the ability to review/sign documents pertaining to his/her medical care. Specifically, the facility failed to ensure that Resident #133, who was identified as his/her own person and was able to make his/her own decisions, was able to review and sign documentation relative to Advanced Directives (life sustaining measures that can be taken when a person's heart stops or they fail to breathe on their own), psychotropic medication, vaccination education, and ancillary services that could be provided while at the facility. Findings include: Review of the facility document titled, admission Procedure, last reviewed April 2005, indicated: -Prior to or upon admission the Admissions Coordinator will provide each resident and/or responsible party with written information regarding the resident's rights under state law to make decisions regarding his or her medical care, including the right to accept or refuse treatment and to formulate advance directives. -The advance directive status of each resident will be reviewed at their resident care conference. -In the event that the resident has not executed an advanced directive, and the Interdisciplinary Team (IDT) along with the resident's physician determine that the resident is capable of executing an advance directive (i. e. is no longer incapacitated), the social worker will provide the resident with this information. -This will be documented in the resident's medical record. Resident #133 was admitted to the facility in February 2025 with diagnoses including hemiplegia and gastrostomy (G-tube). Review of the Resident's clinical record included the following: -Request for Services Form for consent or declination for audiology (hearing services), eye care, podiatry (foot care services), dental, and Behavioral Health, which was completed, all services were requested and the consent was signed by the Resident's Representative on 2/25/25. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident admission Vaccination Education Form for the Influenza, Pneumococcal Conjugate and COVID-19 vaccines, all vaccines were declined and signed by the Resident's Representative on 2/25/25. -Informed Consent Forms for the administration of psychotropic medication were signed by the Resident's Representative on 2/24/25. -MOLST (Medial Orders for Life Sustaining Treatment) Form completed and signed by the Resident's Representative on 2/25/25. Further review of Resident #133's clinical record indicated that Resident #133's Healthcare Proxy (HCP) was not invoked (put into effect, was not dependent on a designated person to make medical and health care decisions) by the Physician/Medical Provider since his/her admission to the facility. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #133: -has a mild cognitive impairment as evidenced a Brief Interview of Mental Status (BIMS) score of 11 out of 15. -understood and does speak English as well as Spanish. Review of Resident #133's Social Service Interim Progress Note dated 3/11/25, indicated the Resident: -had a care plan conference on 3/11/25, -was seen by the facility's psychiatric team with no new recommendations, and -the HCP understood that the Resident had not been invoked. During an interview on 5/14/25 at 12:44 P.M., Social Worker (SW) #1 said that upon the Resident's admission she had confirmed with the hospital that Resident #133's HCP had not been activated and that he/she had the capacity for informed medical decision making. SW #1 also said that the MOLST Form and Consent Forms should not have been signed by the Resident's HCP on admission, but should have been signed by the Resident, but they were not signed by the Resident. During an interview on 5/14/25 at 4:51 P.M., the Assistant Director of Nursing (ADNS) said that the facility should have had Resident #133 sign all of his/her consents upon admission, but they had not done so.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, interviews, and record review, the facility failed to provide appropriate access to the call light for one Resident (#88) out of a total sample size of 27 residents. Specifically, for Resident #88, the facility staff failed to place the Resident's call light within his/her reach, putting Resident #88 at risk of falls, and being unable to request staff assistance when needed. Findings include: Review of the facility policy titled Resident's Rights, undated, indicated Residents have the right: -To have [their] personal preferences reasonably accommodated. -To have all reasonable requests responded to promptly. Review of the facility policy titled, Call Lights; Use Of, dated April 2015, indicated: -All facility resident/patients will have a call light or alternative communication device within his/her reach when unattended. -Answer all call lights, promptly whether or not you are assigned to the resident/patient. -Answer all call lights, in a prompt, calm, courteous manner. -When providing care to residents/patients be sure to position the call light conveniently, telling/showing the resident/patient where the call light is located. -Orient all new residents/patients to the call light at the bedside as well as the call light in the bathroom, and shower/tub rooms. Resident #88 was admitted to the facility in April 2025, with diagnoses including abnormalities of gait and mobility, weakness, and Hypertension (HTN). Review of the Minimum Data Set (MDS) Assessment, dated 4/15/25, indicated Resident #88: -was cognitively intact as evidenced by a Brief Interview f or Mental Status (BIMS) score of 15 out of a possible score of 15. -was understood by others and understand others. -has adequate hearing, adequate vision, and clear speech. Review of Resident #88's Comprehensive Person-Centered Care Plan, initiated 4/11/25 and revised 5/1/25, indicated the Resident was at risk for falls with an intervention to have the call light within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 8:27 A.M., the surveyor observed Resident #88 lying in bed in his/her bedroom. The surveyor observed the call light hanging on the wall on the left side of the Resident's bed and out of reach of the Resident. the surveyor further observed Resident #88 was alone in his/her bedroom with no evidence of a roommate. During an interview on 5/14/25 at 12:32 P.M., Resident #88 said that he/she needed a call light so he/she can call for staff help if needed. The surveyor observed the Resident was alone in his/her room, with the call light hanging on the wall, out of reach of the Resident who was lying in bed. Resident #88 said he/she uses the call light to get assistance from staff when needed. Resident #88 said he/she was unable to locate the call light at this time. The surveyor and the Resident observed the call light hanging on the wall to the left of the Resident. Resident #88 said that he/she was unable to reach the call light on the wall while lying in bed, if he/she needed to call staff for assistance. On 5/14/25 from 12:30 P.M. through 12:50 P.M., the surveyor observed a staff member enter Resident #88's room and exit the room with the Resident's lunch tray in the staff member hands. The surveyor returned to the Resident's room and observed that the call light was hanging on the wall behind the head of the Resident's bed, away from the Resident, and not within the Resident's reach. On 5/14/25 at 1:15 P.M., the surveyor and Certified Nurses Aide (CNA) #1 entered Resident #88's room and reviewed the placement of Resident #88's call light in his/her bedroom which remained hanging on the wall behind the head of the Resident's bed. CNA #1 said that the call light should have been within Resident #88's reach to ensure that the Resident can use the call light to call for staff assistance. CNA #1 further said that ensuring that the call light was within the Resident 's reach was important so Resident #88 could call for assistance if needed to ensure safety. CNA #1 also said that Resident #88 was able to utilize a call light to call for staff assistance, if the call light was within the Resident's reach. During an interview on 5/14/25 at 1:43 P.M., the Director of Nursing (DON) said that the expectation for CNA's was that call lights were always placed within the Resident's reach after care and each time staff enter or leave the room to provide assistance for the residents. The DON further said that the nursing staff should ensure that all residents had access to their call lights. The DON said call lights should be within reach of the residents to ensure the residents safety and ability to access staff in order to have their needs met.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that assistive devices to maintain vision were acquired for one Resident (#118) out of a total sample of 27 residents. Specifically, for Resident #118, the facility failed to ensure that a prescription for necessary glasses was filled, as recommended by the Optometrist (Eye Doctor). Findings include: Review of the facility policy titled Consultant Services, dated April 2015, indicated: -[The facility] will identify and facilitate consultant services to meet the resident's needs, to ensure optimum care for each resident/patient through consultant services. -The charge nurse will notify the attending physician of findings and he/she can then order the specific treatments as outlined by the consultant. -A consultant's report or some form of documentation pertaining to the results will be retained in the clinical record. Resident #118 was admitted to the facility in January 2024, with diagnoses including Paranoid Schizophrenia, Type 2 Diabetes without complications, and Essential (primary) Hypertension. Review of the Resident's clinical record included evidence of the appointment of a Legal Guardian, dated 6/21/23. Further review of the Resident's clinical record included a consent for an Eye Care Consultation, signed by the Resident's Guardian on 3/21/24. Review of the Eye Care Consultation report dated 10/17/24, indicated: -Pt (patient) reports blurry vision in the distance. -Personal Ocular History .myopia (near sightedness); Diabetes Type 2, without complications, retinopathy, hypertensive, history of wearing soft CLs (contact lenses). -Visual acuity uncorrected right 20/40, left 20/25. -No Glasses. -Assessment: >Diabetes Type 2, without complications, both eyes, >retinopathy, hypertensive, mild, both eyes, (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>Myopia, both eyes. -Recommendations: New Glasses Recommended, to be delivered upon approval. -Plan: Monitor blood sugars, Monitor Blood Pressure, New distance glasses. -Action Required by Nursing Home Staff: Glasses required, encourage part-time use for distance, New order for glasses. -The Consultation Report included a prescription for eyeglasses, dated 10/17/24 that expires on 10/17/26. Review of the Resident's Progress Notes included a Social Service Note dated 10/23/24, which indicated: -Resident is UTD (up to date) with routine eye/dental care. -Team to follow-up with recommendation for part-time glasses. Review of the most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #118: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 possible points. -did not have any eye glasses. Review of the Physician's orders for Resident #118 included: -Yearly eye examination -Reason: Diabetes Mellitus, dated 5/9/25. During an interview on 5/13/25 at 9:52 A.M., Resident #118 said that he/she needed glasses for distance, but did not have any eye glasses. During an interview on 5/19/25 at 1:33 P.M., the Director of Nursing (DON) said that the staff should have followed up on the recommendation made by the eye doctor to fill the prescription for eyeglasses last October but the staff had not done so. The DON said that it was the Unit Managers' responsibility to review the Consultants' Notes and notify the Doctor of recommendations for follow through. The DON was unable to provide evidence that any facility staff had followed through on the recommendation for Resident #118 to get the needed prescription eye glasses.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to ensure that one Resident (#103) out of a total sample of 27 residents, with limited range of motion (ROM) received appropriate care and services to maintain and/or improve their mobility function. Specifically, the facility staff failed to implement a functional mobility program to have staff walk with Resident #103 as recommended by PT (Physical Therapy) upon discharge from skilled services, which resulted in an avoidable reduction in ROM and mobility for the Resident. Findings include: Resident #103 was admitted to the facility in January 2025 with diagnoses including Type II Diabetes with diabetic neuropathy, Myasthenia Gravis without acute exacerbation, and difficulty walking. Review of the Minimum Data Set (MDS) assessment, dated 4/10/25, indicated Resident #103: -was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of a possible 15. -had lower extremity impairments on both sides, utilized a wheelchair, and walking had not been attempted due to medical condition or safety concerns during the lookback period. -received Physical and Occupational Therapies during the assessment period. On 5/13/25 at 11:26 A.M., the surveyor observed Resident #103 in bed and dressed for the day. During an interview at the time, Resident #103 said that he/she was having some swelling to his/her legs and that staff were supposed to walk with him/her daily. Resident #103 further said that he/she had been discharged from rehabilitation services about two weeks prior with the plan for staff to walk with him/her daily. On 5/14/25 at 10:30 A.M., the surveyor observed Resident #103 reclining in bed with the head of the bed elevated. During an interview at the time, Resident #103 said that he/she witnessed a conversation while he/she was on services with Physical Therapy, between a Physical Therapist (PT) and a Certified Nurses Aide (CNA) where the PT staff educated the CNA about walking with the Resident daily. Resident #103 said that he/she did not walk to the bathroom at this time, he/she utilized a brief instead of the toilet, and that staff do not walk with him/her to the bathroom. Resident #103 said that no staff have walked with him/her since he/she was discharged from rehabilitation services. Review of Resident #103's Order Summary Report Active Orders as of 4/1/25, indicated the following Physician's orders: -PT Physical Therapy 3x/wk for 4 weeks for LE (lower extremity) therex (therapeutic exercise), theract (therapeutic activity), gait, NMR (neuromuscular re-education), Pt/staff education and safety, initiated 2/20/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's Physical Therapy Treatment Encounter Notes indicated the following: -4/24/25: Gait training on unit with Contact Guard Assist/Stand By Assist, 300 feet. Inservice on ambulation on unit with 1st shift CNA's with rollator. -4/28/25: Completed functional mobility training with Contact Guard Assist, sit to stand and transfers with rollator use. Contact Guard Assist for gait training on the unit. Staff in-service completed. [Resident] is communicated on Discharge, in agreement. Review of Resident #103's Physical Therapy Discharge summary, dated [DATE], indicated the following: -Dates of service: 2/17/25 - 4/28/25 -[Resident] was seen for skilled PT to address strength, balance, and mobility deficits. -[Resident] requires Contact Guard Assist/Stand By Assist for safe sit to stand, transfers, and gait training with rollator use. -Staff in-service completed on ambulation. -[Resident] and Caregiver training: safe transfers and gait. -Prognosis to Maintain Current Level of Function = good with staff follow through. -Discharge Recommendations: Out of Bed and ambulation. Review of the Inservice Training document, dated 4/24/25, indicated: -Rehabilitation Services presented education for Resident #103's walking on the unit. -[Resident] to walk on unit with rollator with gait belt 300 feet or as tolerated holding onto belt or standby assist for safety with verbal cues for upright posture. -4 CNA's and one unidentified staff, including CNA #2, signed and dated the education form on 4/24/25. Review of Resident #103's CNA Care Card dated 4/1/25, indicated Not Applicable relative to the Resident's transfer needs or walking any distance. Review of Resident #103's CNA Documentation Survey Report for April 2025 and May 2025 failed to indicate that the Resident was transferred to the toilet, walked on any uneven surfaces, or walked a specific distance from 4/28/25 through 5/14/25. Review of Resident #103's Nursing Progress Notes failed to indicate any documentation of the Resident being offered to walk with staff or that a plan of care was updated for staff to walk with the Resident. (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 5/14/25 at 10:57 A.M., CNA #2 said that she knew Resident #103 well and that the Resident was not safe to walk with her at this time. CNA #2 said that the Resident is not able to walk to the bathroom now. CNA #2 said that typically therapy staff make recommendations so that a Resident can walk with staff and if CNA #2 had questions, she would feel comfortable speaking with the Rehabilitation Staff for clarification. CNA #2 said that if staff walk with a resident, such as if a resident walked to the toilet, it would be documented in the resident's record. CNA #2 said that she did not recall participating in any in-service or education relative to Resident #103 walking recently, but she had in the past. During an interview on 5/14/25 at 2:13 P.M., Rehabilitation Staff Member #1 said that when a resident is discharged from Rehabilitation Services with a walking plan, it would be considered a functional mobility plan. Rehabilitation Staff Member #1 further said rehab staff would do caregiver education to staff about the resident's level of functioning and maximum ability to perform tasks. The surveyor and Rehabilitation Staff Member #1 reviewed the In-Service Form dated 4/24/25, and Rehabilitation Staff Member #1 said the form was evidence of education provided to staff for Resident #103's functional mobility program. During an interview on 5/14/25 at 3:13 P.M., Rehabilitation Staff Member #2 said that she was the Physical Therapist who worked with Resident #103 and completed his/her discharge from rehabilitation services. Rehabilitation Staff #2 said that at the time of discharge on [DATE], Resident #103 was able to transfer and was walking at a Contact Guard level. Rehabilitation Staff #2 said that an in-service and education was provided to nursing staff. Rehabilitation Staff #2 said the Resident needed encouragement, was able to make his/her needs known, expressed understanding of the rehabilitation plan, and he/she had been able to ambulate with a rollator and walk between 150 - 300 feet at time of discharge. The surveyor and Rehabilitation Staff #2 reviewed the In-Service documentation and Rehabilitation Staff #2 said that a Physical Therapy Assistant (PTA) had provided the education to nursing staff on 4/24/25, and the form was how that education was documented. During an interview on 5/15/25 at 1:29 P.M., the Director of Nursing (DON) said that a resident's Care Card is how a resident's level of functioning and care plan is communicated to the nursing staff and would indicate if a resident walked with assistance by staff. The DON further said that when staff education was provided on 4/24/25, Resident #103's Care Card should have been updated so that the Resident could have walked with staff assistance as recommended by Physical Therapy, but the Resident had not been walked as recommended.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, record review, and interview, the facility failed to provide peripherally inserted central catheter (PICC: flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV]) care and services in accordance with professional standards of practice and plan of care for one Resident (#137) of two applicable residents receiving IV treatment via PICC, out of a total sample of 27 residents. Specifically, for Resident #137, the facility staff failed to measure the external length of the PICC weekly, as ordered by the Physician to prevent the risk of inadvertent PICC migration and catheter related complications. Findings include: Review of the Lippincott Manual of Nursing Practice, 11th Edition, dated 2021, included the following for documentation relative to PICC line migration and dressing changes: -Use a sterile measuring tape or incremental markings on the catheter to measure the external length of the catheter from hub to skin entry to make sure that the catheter has not migrated. -Measure upper arm circumference when clinically indicated to assess for the presence of edema and deep vein thrombosis (DVT: blood clot in a deep vein), take the measurement four inches (10 centimeters) above the antecubital fossa (area of transition between the forearm and upper arm) and compare this measurement to the baseline. Review of the facility policy, titled Midline/Extended Dwell Catheter Needleless Connector Change, effective January 2022, indicated: -Needleless connector will be changed according to the IV therapy order: upon admission, at least every seven days and as needed for any complications. Review of the facility policy for Midline/Extended Dwell Catheter Dressing Change, dated January 2022, indicated: -To provide specific intervals and technique for midline or extended dwell catheter dressing changes. -The IV therapy order for care and maintenance is required - dressing changes will occur according to the intravenous (IV) Order Form -If the catheter migrates out during the dressing change DO NOT re-insert the migrated catheter. -With each assessment of the Vascular Access Devices (VAD), presence of the following at a minimum should be included: >External catheter length. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ProCare Infusion Therapy Order Forms, dated 3/25/25 and 4/24/25, for a vascular PICC indicated the following considerations for catheter care: -Document catheter length and external catheter length. -Document baseline arm circumference and as needed. -Document external catheter length weekly with dressing change and as needed. Resident #137 was admitted to the facility in March 2025 with diagnoses including acute and subacute endocarditis and severe sepsis with septic shock. Review of Resident #137's Comprehensive Care Plan, last revised 4/17/25, indicated: -receiving IV therapy for endocarditis and was receiving antibiotics. -An intervention to change IV tubing per policy and as needed. -IV as ordered. Review of the Minimum Data Set (MDS) assessment, dated 4/25/25, indicated Resident #137: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 points. -was receiving IV antibiotic medication. -had a central line in place. Review of Resident #137's May 2025 Physician's orders indicated: -measure external catheter length on admission, weekly with dressing change and as needed, every day shift every Wednesday for maintenance, dated 4/24/25. Review of Resident #137's April 2025 and May 2025 Treatment Administration Records (TARs) indicated the Resident's PICC line dressing was changed but the external length of the catheter was not documented on: -4/3/25 -5/7/25 -5/14/25 Further review of the April 2025 and May 2025 TARs indicated that the PICC line dressing had not been changed, nor the external length of the catheter measured on 4/30/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/25 at 8:59 A.M., Resident #137 said that his/her PICC line dressing had only been changed once since he/she was admitted to the facility in March 2025. During an interview on 5/15/25 at 11:13 A.M., the Director of Nursing (DON) said that for Resident #137, the weekly measurements for the PICC line were not being done but they should have been. The DON also said that it is important to check the measurements weekly to ensure that the PICC line did not migrate and cause medical complications to the Resident.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review, and interview, the facility failed to provide the necessary Behavioral Health care and services to attain or maintain the highest practicable mental, and psychosocial well-being for one Resident (#30) out of a total sample of 27 residents. Specifically, the facility failed to ensure that Resident #30 received follow-up Behavioral Health Services after recommendations for continued psychiatric follow-up visits were made by the Provider for a Resident with known mental illness, who demonstrated behaviors, was prescribed psychotropic medications, and who required emergency mental health evaluation for suicidal ideation (SI). Findings include: Review of the facility policy titled Consultant Services, dated April 2015, indicated: -The facility routinely uses their own consultants in the following specialty areas - psychiatry, dental, optometry, and podiatry. -Once the consultant is identified by the Physician . the staff will call the consultant to notify him/her of the request and document response in the medical record. -A consultant's report or some form of documentation pertaining to results will be retained in the clinical record. Resident #30 was admitted to the facility in April 2025 with diagnoses including Post Traumatic Stress Disorder (PTSD), Schizoaffective Disorder, bi-polar type, Borderline Personality Disorder, Depressive Disorder, and Generalized Anxiety Disorder. Review of Resident #30's Progress Notes included a Clinician Progress Note dated 4/17/25, which indicated: -The Resident was recently admitted to the hospital for suicidal ideation and exacerbation of bi-polar symptoms. -Plans include ongoing psychiatric management. -Will benefit from psychiatric follow-up in house. Review of the most recent Minimum Data Set (MDS) Assessment, dated 4/23/25, indicated Resident #30: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 points. -reported he/she had little interest or pleasure in doing things and feeling down or depressed for two to six days during the MDS two-week look back period. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had verbal behaviors, other behavioral symptoms and rejected care for one to three days during the MDS seven-day look back period. -received antipsychotic and antidepressant medication. Review of Resident #30's clinical record indicated: -Request for Service Form signed by the Resident on 4/17/25, for Behavioral Health Services. -A Nursing Progress Note dated 4/19/25, that indicated the Resident discharged from the facility Against Medical Advice (AMA) and called his/her own ambulance for pick up (Director of Nursing [DON] and Nurse Practitioner[NP] notified). -A Nursing Progress Note dated 4/20/25, that indicated the Resident had returned to the facility from the hospital after evaluation for suicidal ideation. -Physician's order for psychiatric consultation and treatment as indicated, order date 4/20/25. -Care plan for Alteration in Mood exhibited by signs and symptoms of depression and anxiety with an intervention to refer to psychiatric services as needed. -Care plan for a History of Trauma with the potential for re-traumatization by triggers that include talking about his/her past history, with an intervention to refer the Resident for psychiatric services for added support as needed. During an interview on 5/13/25 at 9:06 A.M., Resident #30 said that he/she wanted to see a Specialist from the Psychiatric Consultant Team and that he/she had not seen one since he/she has been in the facility. Review of Resident #30's clinical record failed to indicate that the Resident had been seen by the facility's Consultant Psychiatric Services to date. During an interview on 5/14/25 at 12:37 P.M., Social Worker (SW) #1 said that Resident #30 should have been referred to the Consultant Psychiatric Team, but the Resident had not been referred. During an interview on 5/14/25 at 12:57 P.M., the Medical Records Staff said that all new residents should be referred to for Behavioral Health Services upon admission to the facility. The Medical Records Staff also said that Resident #30 should have been referred for Behavioral Health follow up, but had not been referred.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, and interviews, the facility failed to maintain accurate records of controlled substances (drugs or chemicals that the government regulates for its manufacture, possession, and use, that are classified into schedules based on their potential for abuse) for one Unit (5th Floor) out of four units reviewed. Specifically, for the 5th Floor Unit, the facility staff failed to maintain accurate documentation in the Controlled Substance Register (Narcotic Book), relative to the recording of prescription numbers and receipt dates being recorded on the individual pages when a new controlled medication was entered into the Register or the information for a medication was transferred from one page to another. Findings include: Review of the facility policy titled Narcotics (Massachusetts & Rhode Island), dated April 2015, included: -Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling and record keeping in the facility, in accordance with Federal and State laws and regulations and require narcotic book documentation as follows. -Pages: <Head top of each page - Use blue/black ink. <Prescription number and date of prescription. <Indicate if medication is new, from e-Kit, or transferred on right upper page. <Prescription number needed to be check[ed] each time [a new] card [was] received. Update as needed. This number changes periodically after a certain number of refills, for non C-II narcotics. -Transfer from one page to another: <At top right of new page, indicate page transferred from . <Head new page completely. -Receiving Narcotics: <Log in Narcotic Book. <If new, head top of page completely . <If previous order, check prescription number and update if needed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Auditing <The Narcotic Book should be audited on a consistent basis. On 5/14/25 at 10:33 A.M., the surveyor and Nurse #1 reviewed the Controlled Substance Log on the 5th Floor Unit. Review of the Controlled Substance Log failed to provide evidence that the headings of each page were completed with prescription numbers, fill dates, and transfer page numbers. Nurse #1 said that when there was a change of page for a medication in the Controlled Substance Log, the Nurse must fill out the heading on the new page with the page number the medication was transferred from, the prescription number, and the filled on date. The surveyor and Nurse #1 reviewed the Control Log pages where a transfer to another page had occurred and none of the headings reviewed had been filled out for prescription number, and date that the prescription had been filled. Nurse #1 said that the headings should have been completely filled in with prescription numbers, filled on dates, and pages numbers but they had not been completed. During an interview on 5/14/25 at 2:11 P.M., the Director of Nursing (DON) said when controlled medications were received from the pharmacy the prescription number and date filled were logged into the Controlled Medication Log. The DON said that when the page number was changed in the Controlled Medication Log, the prescription number and date filled must be transferred to the new page. The DON said that the headings of each page in the Controlled Medication Log should be complete to include the prescription number and date the prescription was filled.

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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 interviews, and record reviews, the facility failed to maintain a complete and accurate clinical record for one Resident (#133) out of a total sample of 27 residents. Specifically, for Resident #133, the facility failed to accurately document the daily total amount of administered enteral feeding. Findings include: Review of the facility policy titled Enteral Feeding, dated April 2015, indicated: -Check physician order for formula, rate and water flushes. -Document procedure in the resident's medical record. -Record intake, flush and free water volume administered. Review of the facility policy titled Nursing Documentation, dated February 2016, indicated: -The licensed nursing personnel documents information related to the resident's condition and care provided in the resident's medical record. -Notes should be clear, concise, and not subject to misinterpretation. -Treatments: the type and resident/patient response. Resident #133 was admitted to the facility in February 2025 with diagnoses including hemiplegia and gastrostomy. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #133: -has a mild cognitive impairment as evidenced a Brief Interview of Mental Status (BIMS) score of 11 out of 15. -has a gastrostomy. Review of Resident #133's Care Plans, last revised 3/19/25, indicated that the Resident had a gastric feeding tube because of a diagnosis of Cerebrovascular Accident (CVA). Review of the May 2025 Physician's orders indicated: -Enteral feed order two times a day for nutrition, Administer Glucerna 1.5 calorie at 100 milliliters (ml) an hour for 14 hours (6:00 P.M. to 8:00 A.M.) via feed pump. Flush with 30 ml free water before and after cycle, start date 2/25/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Change G-Tube (gastrostomy tube) feeding system every 24 hours (bag, tubing and syringe), start date 2/25/25. Review of the Medication Administration Records (MARs) and Treatment Administration Records (TARs) for April 2025 and May 2025 failed to indicate the total amount of enteral formula that Resident #133 was administered daily. During an interview on 5/15/25 at 11:27 A.M., the Dietician said that the facility staff should have documented Resident #133's enteral fluid intake so that she knows how much the Resident was consuming daily but the staff had not accurately documented the enteral fluid intake. During an interview on 5/15/25 at 11:53 A.M., the Assistant Director of Nursing (ADNS) said that the facility staff had not been documenting Resident #133's total enteral fluid intake but they should have been. The ADNS was also unable to locate evidence that the Resident's daily intake was being documented elsewhere in the Resident's clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, and interviews, the facility failed to maintain appropriate hygiene practices while serving meals in the dining room, on one Unit (1st Floor) out of four Units observed. Specifically, the facility failed to ensure that staff distributing food during the lunch meal on the 1st Floor dining room performed appropriate hand hygiene during the meal service to prevent contamination and the spread of foodborne illnesses. Findings include: Review of the facility policy titled Hand Hygiene, April 2015, indicated: -To protect residents/patient from health care associated infections. >Equipment: -Soap. -Warm running water. -Paper towels. >Hand Sanitizing: -Alcohol-based hand rub. Dining Service Staff Training, Revised May 2015, indicated but was not limited to: >Poor personal hygiene and cross contamination. >The key to serving safe food is to handle it safely. Remember that hand washing is the single most important measure to prevent food borne illness. Review of the facility Dietary Department Guidelines, undated, included but was not limited to: -The facility must distribute food under sanitary conditions. -Dietary employees will comply with all basic personal health requirements. -All dietary department workers must observe good personal hygiene. -Handwashing sinks will be available, and all employees will be required to wash hands on entering the dietary department and as frequently as needed between tasks. On 5/15/25 at 12:18 P.M., during a dining observation in the 1st Floor Unit dining room, the surveyor observed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9 Staff members were in the dining room assisting with meal service. Staff observed included -1 Medical Record personnel (MR), 3 Activity Assistants (AA), 5 Dietary Aides. -A drink station including coffee, pitchers of juices, water, sealed juices, carbonated beverages, coffee mugs, and glasses stored in a metal container on top of ice. -The beverage cart was observed positioned next to the exit door in the dining room. -Two alcohol-based hand hygiene dispensers were observed fixed on the wall, a sink with soap, paper towels, and a trash container were located at the back of the dining room. -Resident meals were plated from the steam table by the cook onto resident plates at the back of the dining room. The cook was observed wearing gloves and a hair restraint. -2 Dietary Aides were at the steam table placing meals, meal tickets, and utensils on resident meal trays. -3 additional Dietary Aides were observed standing in the dining room. - AA#1, AA#2, AA#3, and 1 Medical Record Personnel were serving meal trays to residents seated at the tables. -Drinks were being served to the residents from the drink station by AA #1, AA #2, and AA #3 in between serving residents with meals. -AA #1 and AA #2 were observed to clear the used utensils, plates, and cups on two tables, wiped the tables with a paper towel, and placed the dirty plates, cups, and tableware in the dirty bins positioned on the right side of the dining room with ungloved hands and did not perform hand hygiene after handling the dirty dishware. -AA#1 and AA #2 were observed to return to the steam table and continued serving other residents meal items with no hand hygiene performed after the tables were cleaned and dirty dishware handled with ungloved hands. -AA#1, AA#2, and AA#3 were observed pouring and serving beverages, clearing plates, cups, and other dirty utensils from the tables with no hand hygiene performed between serving beverages to the residents and handling dirty dishware. -1 Dietary Aide entered the dining room and placed a container on the table positioned next to the steam table with individual ice cream covered in the container with ice underneath the ice cream. -The surveyor observed AA #1, AA #2, and AA #3 approach the container with the ice cream, open the container, removed ice creams and served residents the ice creams without performing hand hygiene first. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 12:50 P.M., Medical Record Personnel (MR) #1 said that she had been educating all the Activity Assistants during lunch services that it was important for all staff to perform hand hygiene during dining service. MR #1 further said that all the Activity Assistant staff members were aware of the importance of sanitizing their hands in between serving residents. Medical Record #1 also said that all the Activity Assistants were educated not to clean dirty tables or handle any dirty plates from residents while dining service was in process, until the meals service was completed. During an interview on 5/15/25 at 1:40 P.M., the Director of Nursing (DON) said that the expectation for all staff, including nursing and activity assistants, during dining services was that all staff are to sanitize their hands in between serving the meals to residents. The DON said that the dining room on the 1st Floor has alcohol base hand sanitizer on the wall and a sink with soap and paper towels for staff use. The DON also said that when staff remove dirty plates and tables in the dining room during meal service, staff should use gloves, clean the table, then remove the gloves, and perform hand hygiene after removing their gloves. The DON further said that performing hand hygiene during meals was important to prevent infection control and spreading germs to residents. During an interview on 5/16/25 at 8:20 A.M., the Infection Preventionist (IP) said that all staff members regardless of their discipline and/or department within the facility were trained on hand hygiene upon hire. The IP also said there was an ongoing education on hand hygiene and all staff were trained again during the annual training. The IP further said that all three Activity Assistant staff members in the dining room during the lunch meal services were new hires who had been trained in hand hygiene during meals and coffee activities upon hire. The IP said that performing hand hygiene in between serving residents is important to prevent the spread of germs to other residents.