STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225201	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherrill House	135 South Huntington Avenue Boston, MA 02130

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide necessary treatment, services, or interventions to promote healing and prevent new ulcers from developing a.) ensure treatment orders were transcribed and implemented per the Wound Nurse Practitioner's recommendations and b.) accurately implement a wound intervention of an air mattress for four Residents (#152, #32 , #4, and #5) out of a total sample of 33 residents. 1.For Resident #152, the facility failed to prevent an existing ankle wound that was present on admission to the facility from worsening from a Stage 2 (partial-thickness skin loss- shallow open ulcer with a red-pink wound bed) pressure ulcer to a Stage 4 (full-thickness tissue loss- exposed bone, tendon, or muscle) pressure ulcer by not assessing and monitoring the wound and not implementing physician orders for wound treatment.2.For Resident #32, the facility failed to (a) ensure treatment orders were transcribed and implemented per the Wound Nurse Practitioner's recommendations and (b) accurately implement a wound intervention of an air mattress.3.For Resident #4, the facility failed to (a) follow wound care orders to a pressure wound as ordered by the physician, failed to assess and measure wound weekly, and (b) ensure an air mattress was at the correct setting.4.For Resident #5, the facility failed to ensure treatment was provided according to the physician's order. Findings include:Review of the facility policy titled Pressure Ulcer/Skin Breakdown - Clinical Protocol, revised April 2018, indicated, but was not limited to, the following: -The nursing staff and practitioners will assess and document an individual's significant risk factors for developing pressure ulcers. -In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. b. Pain assessment. d. Current treatments, including support surfaces. -The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. Resident #152 was admitted to the facility in March 2026 with a diagnosis of Parkinson's, Dementia, Anemia, Diabetes, and Malnutrition. Review of Resident #152's most recent Minimum Data Set (MDS) assessment, dated 3/30/26, indicated severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) (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 0686 Level of Harm - Actual harm Residents Affected - Few	score of 7 out of 15. The MDS further indicated Resident #152 was dependent for all activities of daily living, had impairment to functional limitation in range of motion to bilateral lower extremities and was assessed to be at risk for developing pressure injuries. Review of Resident #152's plan of care titled I have a potential for pressure ulcer development with a goal of Resident being free from pressure ulcers, dated as initiated 3/30/26, indicated: -Weekly skin check by licensed nurse. -I use a therapeutic mattress on my bed. -Apply barrier lotion to my bony prominences every shift as preventative measure and with incontinent care as needed. -Avoid prolonged positioning on my bony prominences. -I need assistance to turn and reposition at least every 2 hours, and more often as needed or requested. -I need moisturizer applied every shift and as needed to my skin. Do not massage bony prominences and use mild cleansers for peri-care/washing. -Inform me and my family/caregivers and MD/PA/NP of any new area of skin breakdown. -Inspect my skin while providing personal care, paying special attention to boney prominences. -Monitor and report to my MD/PA/NP any change in skin status: appearance, color, wound healing, signs of infection, wound size, stage. -Educate me and my family/caregivers as to the causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Review of Resident #152's plan of care failed to include care for a pressure ulcer. Review of Resident #152's Norton Plus Skin Risk Assessment, dated 3/27/26, indicated Resident #152 scored a four, indicating that he/she was assessed by nursing to be at high risk for skin breakdown. On 4/8/26 at 9:30 A.M., and 4/9/26 at 9:15 A.M., the surveyor observed Resident #152 sitting in his/her recliner. Resident #152's right ankle was exposed and there was a wound dressing in place. Review of Resident #152's hospital discharge paperwork, dated 3/23/26, indicated that the Resident had a Stage 2 pressure injury on his/her right ankle with a treatment of Vaseline gauze covered with an abdominal pad and wrapped with bulky gauze. Review of Resident #152's skin check, dated 3/27/26, indicated: -Right ankle wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #152's nursing progress note, dated 3/27/26 indicated he/she had a right ankle wound. Further review of Resident #152's medical record, dated 3/27/26 failed to include any further description of his/her right ankle wound. During an interview on 4/9/26 at 9:20 A.M., Unit Manager #2 said that she was Resident #152's assigned nurse and she had done his/her skin check on 3/27/26 and that he/she did have a wound on his/her right ankle with a dressing that she lifted to look at and then returned to cover the wound. Unit Manager #2 said she did not communicate Resident #152's wound to the supervisor or to the doctor and she did not get an order for treatment to the wound. During a telephone interview on 4/9/26 at 12:15 P.M., Nurse #7 (evening supervisor) said she reviewed the hospital paperwork and did not see any wound orders for Resident #152 and had not received any report about Resident #152 needing a wound treatment from Unit Manager #2. Review of Resident #152's medical record failed to indicate the physician was notified of the impairment in skin condition so a treatment could be ordered, if indicated. Review of Resident #152's March 2026 Treatment Administration Record (TAR) failed to indicate any order to monitor or treat Resident #152's wounds. Review of Resident #152's nursing skilled evaluation by Unit Manager #2, dated 3/30/26, indicated: - Rear right malleolus. Pressure ulcer/injury. Wound was present on admission. It is unknown how long the wound has been present. Review of Physician progress note dated 3/30/26, 3/31/26, and 4/1/26 failed to indicate the right ankle wound. Review of Resident #152's nursing skilled evaluation skin note and weekly skin check by Nurse #5, dated 4/3/26, indicated: - Rear right malleolus. Pressure ulcer/injury. Wound was present on admission. It is unknown how long the wound has been present. Review of Physician progress note, dated 4/3/26, indicated: -Stage 4 wound right ankle. -His/hers were documented in wound notes during hospitalization. -Honey Medi (Medi honey is used to manage dry to moderately exuding ulcers), foam dressing. -Air mattress. Review of Resident #152's physician orders, dated 4/3/26, indicated: -PU (pressure ulcer) to right later malleolus; NSW (normal saline wash), pat dry, apply therahoney gel, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	cover with foam dressing every day shift for wound care. -Low air loss mattress: Ensure air mattress is functioning properly and settings are correct. During an interview on 4/9/26 at 9:04 A.M., Physician #2 said that the first time she was made aware of Resident #152's right ankle wound was 4/3/26 when Nurse #5 was completing a skin check and asked her to assess the wound. Physician #2 said it was a stage 4 pressure injury as it was down to the bone. It was on 4/3/26 that treatment was initiated for Resident's pressure injury. Physician #2 said she had missed the documentation from the hospital paperwork about the stage 2 right ankle pressure injury that was present and had not seen the right ankle wound during physical inspection related to the Resident's contracted lower extremities making it difficult to see the area. Physician #2 said she would have expected nursing to have noticed the skin impairment during daily care and communicated it with her so that a treatment could have been put in place. Physician #2 said that the wound would have worsened without having treatment in place. On 4/9/26 at 11:44 A.M., the surveyor observed Resident #152's wounds with wound nurse consultant and Unit Manager #2. The wound nurse consultant assessed the right outer ankle as stage 4 as it was down to the bone and recommended an x-ray to rule out osteomyelitis (infection of the bone) and lab work. The wound nurse consultant described the wound as having slough and measured it as 3cm (centimeters) x 2.5cm. She recommended pressure to be off-loaded and for treatment to be changed to vashe cleanse followed by honey gel, calcium alginate (absorbent wound dressing for moderate to heavy drainage) and covered with foam. During an interview on 4/9/26 at 12:22 P.M., with the Director of Nursing she said that all new admissions have a skin assessment that includes a chart review, as well as observation. If a wound is found during the physical skin check, the appearance should be documented, and the admitting nurse should either get an order for treatment of the wound or carry over the treatment order from the hospital, if there is one, until the resident can be seen by the doctor. The Director of Nursing said that any new pressure ulcers are referred to the wound consultant and added to risk meeting. The Director of Nursing said that wounds should be looked at daily by licensed nurses and certified nursing aides should be reporting to nurses if there are any changes in residents' skin. The Director of Nursing said that she was aware that Resident #152 was admitted with a wound but was not aware that the admitting nurse did not inform the doctor or get a treatment order in place. The Director of Nursing said the risk of not getting treatment put into place timely for Resident #152's wound was that it would get worse. 2. Review of the facility policy titled 'Pressure Ulcers/Skin Breakdown – Clinical Protocol', dated April 2018, indicated but was not limited to: -The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents. Resident #32 was admitted to the facility in January 2023 with diagnoses including Alzheimer's disease, stroke, and functional quadriplegia. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/4/26, indicated that Resident #32 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of a possible 15, and required assistance with activities of daily living including (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	bed mobility. The MDS further indicated that Resident #32 was at risk for developing pressure ulcers/injuries and had a pressure-reducing device for bed. Review of Resident #32's medical record indicated he/she was admitted to hospice services on 1/28/26. Review of the Norton Assessment completed on 2/5/26 indicated Resident #32 had a score of 5, indicating he/she is at a very high risk of skin breakdown. Resident #32 was unable to be interviewed due to his/her cognitive status. During an interview on 4/9/26 at 8:02 A.M., Resident #32's activated Health Care Proxy (HCP) said Resident #32's has wounds, which have been worsening over the last month. Review of Resident #32's wound management care plan, revised 3/3/26, indicated the following interventions: -Provide wound care per treatment order, initiated on 3/2/26. a) Review of the nursing skin assessment, dated 2/2/26, indicated Resident #32 developed new facility-acquired Moisture-Associated Skin Damage (MASD- inflammation or erosion of the skin caused by prolonged exposure to moisture, such as urine, stool, sweat, or wound exudate) on his/her bilateral buttocks. Review of the Wound NP note, dated 3/19/26, indicated Resident #32 had a worsening stage 2 pressure injury to his/her left buttock that had increased in size, with a measurement of 6 cm x 3 cm x 0.1 cm, a calculated area of 18 sq cm, no odor, and a moderate amount of serosanguineous (a common wound drainage that is thin, watery, and light red or pink, combining blood and serum) exudate. The Wound NP note indicated the following updated treatment recommendation: -Cleanse with normal saline. -Apply calcium alginate (a highly absorbent wound dressing) to the base of the wound. -Secure with bordered foam. -Change PRN (as needed) for soiling, saturation, or accidental removal, daily. Review of the Treatment Administration Record (TAR) for March 2026 failed to indicate this recommendation was put into place. Review of the nursing progress notes acknowledged the updated treatment order but failed to indicate the physician was notified to transcribe and implement the recommendation. Review of the nursing skin assessment, dated 3/23/26, indicated overall wound has declined. No measurements were taken. Review of the Wound NP note dated 3/26/26 indicated Resident #32 had a worsening stage 2 pressure injury to his/her left buttock, with a measurement of 8 cm x 5.5 cm x 0.1 cm and a calculated area of 44 sq cm, which is an overall increase of 43.25 sq cm in one month. The note indicated the worsening stage 2 pressure injury had no odor and a moderate amount of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	serosanguineous exudate. The Wound NP note indicated the following treatment recommendation: -Cleanse with normal saline. -Apply calcium alginate to the base of the wound. -Secure with bordered foam. -Change PRN for soiling, saturation, or accidental removal, daily. Review of the TAR for March 2026, nursing notes, and physician notes failed to indicate this recommendation was put into place. Review of the nursing skin assessment, dated 3/26/26, indicated Resident #32 had a worsening stage 2 pressure wound to his/her buttocks that measured 8.5 cm x 5.5 cm x 0 cm with a treatment to cleanse with normal saline, apply calcium alginate, and cover with bordered foam. Although the skin assessment includes the Wound NP recommendation, the nursing staff failed to implement this recommendation as an order. Review of the nursing skin assessment, dated 3/30/26, indicated Resident #32 had a deteriorating pressure wound to his/her buttocks with foul odor. No measurements were taken and the wound was not staged. Review of the most recent Wound NP note, dated 4/2/26, indicated Resident #32 had a worsening unstageable (a full-thickness wound where the base is obscured by necrotic tissue) pressure wound to his/her left buttock, with a measurement of 5 cm x 5 cm x 0 cm, a calculated area of 25 sq cm, mild odor, and a moderate amount of serosanguineous exudate. The Wound NP note indicated the following treatment recommendation: -Cleanse with Vashe (a professional-grade, sterile wound cleanser containing hypochlorous acid to cleanse, irrigate, and moisten acute and chronic wounds). -Apply 1/4 strength Dakin's moist gauze (a wound care dressing soaked in Dakin's solution, or sodium hypochlorite, that is used to clean, disinfect, and debride wounds) to the base of the wound. -Secure with bordered foam. -Change PRN (as needed) for soiling, saturation, or accidental removal, twice a day. Review of the nursing skin assessment dated [DATE] indicated Resident #32 had an unstageable wound to his/her left buttock, with a measurement of 5 cm x 5 cm and a treatment to cleanse with Vashe, apply 1/4 strength Dakin's moist gauze then cover with bordered foam twice daily and PRN for soilage or accidental removal. During an interview on 4/8/26 at 1:29 P.M., Unit Manager #1 said the Wound Nurse Practitioner (NP) comes in weekly to assess residents with wounds and provides written recommendations, and the nurse is responsible for transcribing and implementing wound care recommendations once they are approved by the physician. Unit Manager #1 said Resident #32 has facility-acquired wounds to his/her bilateral buttocks, and the left buttock wound has been worsening over the last few weeks. Unit (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Manager #1 said the Wound NP recommended calcium alginate on 3/19/26 and 3/26/26. Unit Manager #1 said the purpose of calcium alginate is to dry out the wound to help with drainage and odor, but the Wound NP's recommendations were never transcribed into an order because they must have been missed. Unit Manager #1 said the wound then developed more odor and drainage resulting in the Wound NP recommending a stronger treatment on 4/2/26. During an interview on 4/8/26 at 2:06 P.M., the Director of Nursing (DON) said she was aware Resident #32 had a pressure injury on his/her left buttock. The DON said she was unaware that the Wound NP's treatment recommendations on 3/19/26 and 3/26/26 for Resident #32 were never transcribed or implemented which could contribute to worsening wounds. The DON said the purpose of calcium alginate is to dry out the wound, and the risk of not implementing calcium alginate as recommended is that the wound will not heal properly. The DON said it was possible the physician declined the Wound NP's recommendations or the recommendations were missed. During an interview on 4/9/26 at 8:21 A.M., Hospice Staff #1 said she was aware Resident #32 had a wound to his/her left buttock. Hospice Staff #1 said she would expect the Wound NP treatment recommendations to be followed and was unaware that the Wound NP's treatment recommendations on 3/19/26 and 3/26/26 were never transcribed or implemented. Hospice Staff #1 said calcium alginate helps to manage wound drainage and has antimicrobial properties, and the risk of not implementing calcium alginate as recommended is the wound would have maceration or not improve. Hospice Staff #1 said she cannot recall a situation where hospice has declined treatment recommendations made by the Wound NP. During an interview on 4/9/26 at 10:09 A.M., Physician #1 said Resident #32 has had a worsening wound to his/her left buttock. Physician #1 said she was unaware that the Wound NP's treatment recommendations on 3/19/26 and 3/26/26 were never transcribed or implemented which could contribute to worsening wounds; she said she cannot recall declining any treatment recommendations the Wound NP made for Resident #32. Physician #1 said the purpose of calcium alginate is to absorb some of the wound exudate, and the risk of not implementing calcium alginate as recommended is the wound could deteriorate. During an interview on 4/9/26 at 10:39 A.M., the Wound NP said she communicates wound treatment recommendations the same day she sees the resident, and the unit manager is responsible for transcribing the order once approved by the physician. The Wound NP said Resident #32 has a worsening pressure wound to his/her left buttocks and she was unaware that her recommendations from 3/19/26 and 3/26/26 were not transcribed or implemented; she said she cannot recall the physician declining these recommendations. The Wound NP said she recommended calcium alginate for Resident #32 to absorb the wound's increased drainage while keeping the wound moist to promote healing and not implementing calcium alginate as recommended could cause deteriorating of the wound regardless of whether the resident is on hospice. The Wound NP said Resident #32's left buttock wound continued to deteriorate as evidenced by increased drainage and odor, which resulted in her recommending a stronger treatment on 4/2/26. During an interview on 4/9/26 at 12:57 P.M., the Clinical Director of Operations said it is possible that Resident #32's wound worsened from not transcribing and implementing the Wound NP's treatment recommendations regardless of hospice status. b) On 4/7/26 at 7:39 A.M. and 10:43 A.M. and 4/8/26 at 6:40 A.M., 9:11 A.M., and 1:20 P.M., the surveyor observed Resident #32 lying in bed on an air mattress that was set to 350 or more pounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Resident was non-interviewable and unable to answer any questions about his/her air mattress and whether or not it was comfortable. Review of Resident #32's physician orders indicated the following: -Air flow mattress with bumper pads, monitor functioning and setting according to my weight and alternating every shift, every shift for offload spine, initiated on 5/6/25. Review of Resident #32's vitals summary report indicated his/her most recent weight was 157.8 pounds on 1/1/26. Review of Resident #32's skin integrity care plan, revised 3/3/26, indicated the following interventions: -Air mattress, initiated on 4/21/25. Review of Resident #32's Kardex (a form indicating the level of care a resident requires) instructions indicated the following: -Air flow mattress, monitor functioning and setting every shift. Set according to my weight (close to 157 pounds) and alternating to off-load spine. During an interview on 4/8/26 at 1:22 P.M., Certified Nursing Assistant (CNA) #3 said Resident #32 has a wound on his/her buttock and uses an air mattress as an intervention. CNA #3 said the nurse is responsible for monitoring the air mattress; she said she is unaware of how to check for the proper air mattress setting and does not adjust the setting. CNA #3 said if wound-related interventions are not implemented properly, the wound could get worse. During an interview on 4/8/26 at 1:29 P.M., Unit Manager #1 said Resident #32 has a facility-acquired wound to his/her left bilateral buttock that has been worsening over the last few weeks. Unit Manager #1 said the Resident has an air mattress that is supposed to be set to his/her weight. Unit Manager #1 said if an air mattress is on too firm of a setting it could cause wounds to worsen because Resident #32 has a pressure ulcer and a mattress that is too firm adds more pressure to the wound. Unit Manager #1 said nursing is responsible for checking the air mattress is at the correct setting every shift. On 4/8/26 at 1:55 P.M., Unit Manager #1 and the surveyor went to check Resident #32's air mattress which was set to 350 or more pounds; she said it must have been an accident and changed the air mattress to the correct setting. During an interview on 4/8/26 at 2:06 P.M., the Director of Nursing (DON) said the nurses and unit managers are responsible for checking air mattress settings every shift per the physician's order and if an air mattress is on too firm of a setting it could cause wounds to worsen because a firmer mattress adds more pressure and the etiology of Resident #32's wound is pressure-related. During an interview on 4/9/26 at 8:21 A.M., Hospice Staff #1 said she would expect air mattress settings to be implemented per physician orders. The facility is responsible for ensuring the air mattress is on the correct setting; she said if an air mattress is on too firm of a setting it could cause wounds to worsen. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/9/26 at 10:09 A.M., Physician #1 said she would expect air mattress orders specified to the Resident #32's weight to be followed. During an interview on 4/9/26 at 10:39 A.M., the Wound Nurse Practitioner (NP) said Resident #32 has an air mattress that is supposed to be set to his/her weight. The Wound NP said if an air mattress is on too firm of a setting it could cause wounds to worsen because a firmer mattress adds more pressure and the etiology of Resident #32's wound is pressure-related. During an interview on 4/9/26 at 12:57 P.M., the Clinical Director of Operations said if an air mattress is on too firm of a setting it could cause wounds to worsen because a firmer mattress adds more pressure and the etiology of Resident #32's wound is pressure-related. 3.For Resident #4 the facility failed to (a) follow wound care orders to a pressure wound as ordered by the physician, failed to assess and measure wound weekly, and (b) ensure an air mattress was at the correct setting. a) Resident #4 was admitted to the facility in March 2026 with diagnoses including pressure ulcer of the sacrum. Review of the Minimum Data Set (MDS) assessment, dated 3/27/26, indicated the Resident scored 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS further indicated that the Resident had a stage 3 pressure ulcer to the sacrum. -On 4/8/26 at 11:00 A.M., the surveyor observed Nurse #5 perform a wound dressing change to Resident #4's sacrum. The Resident had a quarter size open area with some granulating tissue and slough in the wound bed. Nurse #5 cleansed the wound bed with normal saline solution, applied calcium alginate and covered with border gauze dressing. Nurse #5 said the wound Nurse Practitioner measures the wounds weekly on Thursdays. Review of the April physician's orders indicated the following: - Gluteal cleft/coccyx wound- Vashe soak/cleansing prior to triad dressing, saturate gauze with vashe wound solution and apply directly to the wound bed. Soak wound bed for with vashe saturated gauze for 3-5 minutes. Remove saturated gauze from wound bed and discard. Gently pat dry wound bed, apply calcium alginate and cover with border dressing every day shift. Review of the pressure ulcer care plan date initiated 3/23/26 indicated the following interventions: -Administer my treatments as ordered and monitor for effectiveness. Notify my MD/PA slash NP as needed for signs of infection, wound worsening, or other abnormality that may impede the healing process. -Access my wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound parameter, wound bed and healing progress. Report abnormal or negative outcomes to my MD slash NP as needed. -I use a therapeutic mattress on my bed. Review of Resident #4's treatment administration record for April indicated the following physician's (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	order: - Gluteal cleft/coccyx wound- Vashe soak/cleansing prior to triad dressing, saturate gauze with vashe wound solution and apply directly to the wound bed. Soak wound bed for with vashe saturated gauze for 3-5 minutes. Remove saturated gauze from wound bed and discard. Gently pat dry wound bed, apply calcium alginate and cover with border dressing every day shift. Review of the medical record failed to indicate the pressure ulcer had been measured weekly. During an interview on 4/8/26 at 11:24 A.M., Nurse #5 said the order should have been modified since last Thursday as the wound nurse practitioner gave him a verbal order to change the wound treatment orders. When asked why he did not implement those orders when he got the verbal order Nurse #5 said he should have. During an interview on 4/8/26 at 11:37 A.M., Nurse Practitioner (NP) #2 said she knows the wound NP comes into the facility every Thursday and follows all the wounds. She said wound orders should be followed as ordered and if any changes should be implemented immediately. During an interview on 4/8/26 at 11:41 A.M., Unit Manager #2 said she does wound rounds with the wound NP, she said the wound NP did not see Resident #4 the previous week. UM #2 said wound orders are to be followed as per the physician's orders and any changes should go into the electronic medical record as an order. UM #2 said wounds should be measured weekly. During an interview on 4/8/26 at 2:26 P.M., the Director of Nursing said wound orders should be followed as ordered and if any changes it should be reflected in the electronic medical record. She also said wounds are to be measured once a week. During an interview on 4/9/26 at 10:47 A.M., Wound Nurse Practitioner #3 said she never gave any verbal orders to Nurse #5 for Resident #4's coccyx/sacrum wound. She further said all her communications are either faxed or emailed to the facility. She said she saw Resident #4 on the 3/29/26 and only saw his/her toes and not the coccyx/sacrum. b) On 4/8/26 at 8:14 A.M., 10:53 A.M., 11:12 A.M., 1:46 P.M., and 1:56 P.M., the surveyor observed Resident #4's lying on an air mattress, the dial on the pump was set to above 175 pounds (lbs). Review of the Resident most current weight documented on 4/1/26 indicated the Resident weighed 143.4 lbs. Review of the current physician's order indicated the following: -Low air loss mattress: Ensure air mattress is functioning properly and settings are correct. Firmness setting must correlate with patient weight margin of manufacture intervals every shift for skin integrity. During an interview on 4/8/26 at 8:14 A.M., Resident #4 said the mattress was uncomfortable because it was too firm. The Resident further said he/she has a wound on his/her buttocks that hurts sometimes. During an interview on 4/8/26 at 1:53 P.M., Certified Nursing Assistant #1 said she never changes the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	settings on the air mattress that if the mattress malfunctioned, she would notify the nurse. During an interview on 4/8/26 at 1:56 P.M., Nurse #5 said the air mattress should be set according to the resident's weight, he said if the mattress is too firm it could impede the wound healing. During an interview on 4/8/26 at 2:12 P.M., Unit Manager #2 said residents' air mattresses are set to their weights. During an interview on 4/8/26 at 2:26 P.M., the Director of Nursing said air mattress should be set according to the resident's weight following the manufactures guidelines. 4.For Resident #5 the facility failed to ensure treatment was provided according to the physician's order. Resident #5 was admitted to the facility in February 2026 with diagnoses including non- pressure chronic ulcer right foot and a deep tissue pressure injury (DTI) to right heel. Review of Resident #5's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored 14 out of total 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS further indicated unhealed DTI and infection to the right foot. On 4/8/26 at 2:00 P.M., the surveyor and Nurse #5 observed a wound dressing on Resident #5's right heel and ankle dated 4/7/26 with initials. The Resident said the dressing had been done late morning the previous day. Review of the current physician's order indicated the following: -Right heel DTI: cleanse with vashe, apply 1/4 strength dakins (a dilute sodium hypochlorite solution used as an antiseptic to clean skin, treat infected wounds, and reduce bacteria preventing infection) moist gauze, apply abdominal pad and rolled gauze every day and evening shift for wound care. Review of the pressure ulcer care plan date initiated 2/2/26 indicated the following: -Administer my treatment was ordered and monitored for effectiveness. Notify my MD/PA /NP as needed for signs of infection, wound worsening, or other abnormality that may impede the heali

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, interviews, and record reviews, the facility failed to ensure that effective pain management that was consistent with professional standards of practice was provided for one Resident (#4) out of a total sample of 33 residents. Specifically, the facility failed to provide interventions for pain management during wound care treatment, resulting in the Resident experiencing pain during the wound care.Findings include: Review of the facility policy titled ?Pain-Clinical Protocol' dated March 2018, indicated the following but not limited to:-The physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain, for example degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology, and post-stroke syndromes.-The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated, for example, wound care, ambulation, or repositioning.-The physician will help identify causes of pain, for example, by examining the resident directly, reviewing the resident's history, and via discussion with the resident and staff. Resident #4 was admitted to the facility in March 2026 with diagnoses including peripheral vascular disease, type 2 diabetes and gangrene. Review of the Minimum Data Set (MDS) assessment, dated 3/27/26, indicated the Resident scored 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS further indicated the Resident was receiving scheduled pain medication regimen, reported pain occasionally, at a level of 4 out of 10 and had diabetic foot ulcers. Review of the pain care plan, initiated 3/23/26, indicated Resident #4 had the following interventions:-Anticipate my need for pain relief and respond immediately to any complaint of pain.-Monitor and report to my nurse any signs of non-verbal pain: Changes in breathing, vocalizations grunting, grimacing. Review of Resident #4's Wound Care Specialist note dated 3/26/26, indicated the following but not limited to:-Left 4th toe appeared necrotic eschar covered. Left 2nd toe eschar covered and left great toe eschar covered. No drainage present. Patient reports pain to left foot. Would recommend pain management, painting eschar areas with betadine, monitor for pain, and follow up with vascular surgeon. Review of Resident #4's April Physician orders indicated:-Acetaminophen tablet 325 milligrams (mg), give 2 tablets via G-tube every 4 hours as needed for pain.-Hydromorphone oral tablet 2mg, give one tablet via G-tube every 4 hours as needed for moderate pain.-Left 1st, 2nd and 4th toes: apply betadine and leave open to air, every day shift.Review of the Medication Administration Record failed to indicate Resident #4 had been medicated prior to the wound care treatment.On 4/8/26 at 11 A.M., the surveyor observed Nurse #5 perform wound care treatment to Resident #4's left foot. Resident #4 retracted his/her foot and groaned, indicating discomfort. Nurse #5 asked the Resident if he/she was in pain, the Resident said yes, the nurse told the Resident that he was going to medicate him/her after he was done performing wound care treatment.-At 11:12 A.M., Nurse #5 completed performing wound care and asked the Resident to rate his/her pain on a scale of (1-10), the Resident rated his/her pain at a 7 indicating severe pain. Nurse #5 exited the room.During an interview on 4/8/26 at 11:14 A.M., Resident #4 said the nurses do not offer him/her pain medication prior to wound care treatment. Resident #4 said he/she always experiences pain with wound care treatment and would like to have pain medication prior to the procedures.During an interview on 4/8/26 at 11:30 A.M., Nurse #5 said Resident #4 is on acetaminophen for pain management, he further said prior to wound care he should have assessed the Resident for pain and premedicated him/her. He also said during the wound care treatment when the Resident verbalized being in pain he should have stopped the procedure, medicated the Resident then continued with wound care treatment. Nurse #5 said he did medicate the Resident with hydromorphone after the wound care.During an interview on 4/8/26 at 11:37 A.M., Nurse Practitioner #2 said Resident #4 has multiple wounds and he/she should be assessed and medicated prior to wound care if they report they have pain.During an interview on 4/8/26 at 2:26 P.M., the Director of (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Nursing said Residents with wounds should be assessed and be premedicated prior to wound care. She further said if a resident reports pain during wound care the nurse should stop the treatment, medicate the resident then continue with wound care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to ensure that services provided met professional standards for 3 Residents (#146, #42, and #134), out of 33 total sampled residents. Specifically,1.) For Resident #146, the facility failed to notify the provider and obtain and implement Bumex (a diuretic medication) for a weight gain as ordered by the physician.2.) For Resident #42, the facility failed to (2a.) implement a functioning air mattress physician's order, (2b.) complete a wound treatment and dressing documentation in the Treatment Administration Record (TAR).3.) For Resident #134, the facility failed to ensure daily weights were obtained according to the physician's orders. Findings include: 1.Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - 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 error. Resident #146 was admitted to the facility in June 2023 with diagnoses including congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/19/26, indicated Resident #146 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. On 4/8/26 at 10:42 A.M., the surveyor observed Resident #146 sitting up in his/her wheelchair wearing compression stockings (used for managing lower extremity swelling). Resident #146 was unable to answer questions about recent swelling or increased weight. Review of Resident #146's physician's order, initiated 1/23/26, indicated: - Obtain weight 3 times a week, weight goal is 142-147, if weight goes above 147 lbs. Give 2mg Bumex in PM (evening) and Notify NP/MD. Review of Resident #146's weight summary log, dated 4/6/26, indicated a weight of 148.4. Review of Resident #146's medication administration record (MAR), dated 4/6/26, indicated the physician order to Obtain Weight 3 times a week, weight goal is 142-147, if weight goes above 147 lbs. Give 2mg Bumex in PM and Notify NP/MD, scheduled for 7:30 A.M., was documented as a weight of 148.4 pounds by Unit Manager #1. The MAR failed to indicate any P.M. dose of Bumex was administered. Review of Resident #146's medical record, including nursing progress notes, dated 4/6/26, failed to indicate a provider was notified of an elevated weight above 147 or that the P.M. dose of Bumex was administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/26 at 10:50 A.M., Unit Manager #1 said she documented the weight of 148.4 for Resident #146. Unit Manager #1 said she did not realize the Resident had an increased weight and did not request a reweight. Unit Manager #1 reviewed all locations and paperwork where additional weights would be recorded and said there was no re-weight obtained and she believed the weight of 148.4 was accurate. Unit Manager #1 said she did not realize the weight required the physician to be notified and the Bumex 2mg to be implemented, so neither was done but should have been. Unit Manager #1 said when Resident #146 requires a P.M. dose of Bumex, they must call the provider to obtain an order and time for the Bumex to be given. During an interview on 4/8/26 at 10:53 A.M., Nurse Practitioner (NP) #1 said if Resident #146 has a weight above 147 pounds the nurse must notify them to obtain an order for Bumex 2mg, and she was not aware of the facility notifying them of the 148.4 weight on 4/6/26. NP #1 said the facility did not notify them of a weight of 148.4 pounds on 4/6/26 but should have. During an interview on 4/8/26 at 11:41 A.M., the Director of Nursing (DON) said if Resident #146 had a weight increase to 148.4 she would have expected the nurse to obtain a reweight to validate the weight increase. The DON said if the weight was documented as 148.4 pounds, based on the physician's order, the nurse should have notified the provider and obtained an order to implement Bumex 2mg in the P.M. but did not. 2. A review of the facility policy titled 'Pressure Ulcers/Skin Breakdown-Clinical Protocol' with a revision date of April 2018 indicated the following: -The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer (s). -The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. -The physician will order pertinent wound treatments, including pressure reducing surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. -The physician will help identify medical interventions related to wound management, for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc. Review of the facility policy titled 'Support Surface Guidelines' with a revision date September 2013 indicated the following: -The purpose for this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. -Redistributing support surfaces are to promote comfort for all bed-or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. -Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, static air, alternating air, gel or air loss device, when lying in bed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the 'Supra Air Low Air Loss Alternating Pressure Mattress and Pump-User's Manual' indicated the following: The functions of the Supra Air Loss Alternating Pressure Mattress and Pump control unit are described below. Power Switch (1)-Turn on/off the power switch, the control unit will start/stop operation. Resident #42 was admitted to the facility in June 2024 with diagnoses including type 2 diabetes mellitus with peripheral angiopathy and venous insufficiency. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 indicating intact cognition. 2a. A review of Resident #42's April 2026 physician's orders indicated the following: -Low air loss mattress: ensure air mattress is functioning properly and settings are correct. Firmness setting must correlate with the patient's weight within margin of manufacturers intervals, every shift for skin integrity issues. Pressure settings do not vary significantly between intervals and should be set to the best ability of the user never exceeding the weight interval margins. Review policy if needed. Start Date:11/15/24. On 4/7/26 at 7:56 A.M., the Surveyor observed Resident #42 lying in bed on an air mattress. The air mattress was turned off. On 4/7/26 at 9:34 A.M., the Surveyor observed Nurse #1 leave the Resident's room with a medication cart. Nurse #1 told the Surveyor she had finished attending to both residents in the room and was moving on to the next room. On 4/7/26 at 9:35 A.M., the Surveyor observed the Resident in bed lying on an air mattress. The air mattress was turned off. During interviews and an observation on 4/7/26 at 9:53 A.M., Unit Manager #3 and the Surveyor observed the Resident in bed, lying on an air mattress. The air mattress was turned off and partially inflated. The Unit Manager said the air mattress was off because it was not plugged into the power outlet. The Unit Manager plugged the air mattress into the outlet. The Resident's air mattress visibly started to inflate. The Resident said he/she could feel the air mattress inflating. The Unit Manager said this particular air mattress starts to deflate in an hour if it is not turned on. The Unit Manager said the Resident currently has a venous ulcer on his/her left lower extremity and is a high risk for pressure ulcers, therefore the air mattress should always be on while he/she is in bed and set according to his/her weight. The Unit Manager said the Resident's physician's orders should be followed. During an interview on 4/8/26 at 8:36 A.M., the Assistant Director of Nurses said the Resident's air mattress should always be turned on, set according to the Resident's weight while he/she is in bed as per the physician's orders. During an interview on 4/8/26 at 1:02 P.M., the Director of Nurses said Resident #42 is a high risk for pressure ulcers and currently has a venous ulcer on the lower left extremity. The DON said his/her air (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mattress should always be turned on and set according to his/her weight while in bed. 2b. A review of the March 2026 Treatment Administration Record (TAR) indicated the following: Bilateral lower legs: clean with wound cleanse or normal saline, pat dry with gauze over open wound bed, cover with ABD (Abdominal/Army Battle Dressing). Change daily every day shift for wound care. Start Date: 2/20/26. Further review of the TAR indicated holes (gaps in the medical record) dated 3/2/26 and 3/16/26. Review of the Nurse's progress notes failed to indicate documentation for the gaps in the TAR. Further review of Resident #42's census failed to indicate that the Resident was on a medical leave of absence on 3/2/26 and 3/16/26. During an interview on 4/10/26 at 7:15 A.M., the Assistant Director of Nurses said the Resident had two lower extremity venous ulcers, on the right and left lower extremities, but the right lower extremity ulcer resolved on 3/20/26. During an interview and medical record review on 4/9/26 at 9:36 A.M., Nurse #8 and the Director of Nurses said gaps in the TAR indicated that the treatment and dressing were not done as ordered. The Director of Nurses said Nurses should code in the TAR or write a progress note to explain why there were gaps in the medical record. During an interview on 4/9/26 at 1:14 P.M., the Director of Clinical Operations said the Resident does have a history of refusing wound care. The Director of Clinical Operations said the Nurses should document in the medical record if the Resident refuses care or document the correct code in the TAR. The Director of Clinical Operations was requested by the Surveyor to provide any documentation that would indicate why there were gaps in the Resident's TAR, no documentation was provided during the survey. 3.For Resident #134, the facility failed to ensure daily weights were obtained according to the physician's orders. Resident #134 was admitted to the facility in March 2026 with diagnosis including diastolic congestive heart failure. Review of Resident #134's Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS further indicated the Resident required supervision to complete activities of daily living (ADLS). Review of Resident #134's current physician orders dated 3/28/26 indicated the following: -Daily body weight. Notify MD/NP if weight gain 2 pounds in one day or 5 pounds in one week in the morning [sic] Review of the Medication Administration Record (MAR) for March and April indicated the clinical nursing staff signed off as weights being obtained. Review of weights and vitals summary failed to indicate weights were obtained and documented on (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following dates: -3/29/26, 3/30/26, 3/31/26, 4/1/26, 4/3/26 and 4/5/26. Review of Resident #134's care plan failed to indicate a care plan for congestive heart failure was developed. During an interview on 4/8/26 at 12:05 P.M., Nurse #5 said if there is an order for daily weights the certified nursing assistant (CNA) would obtain the weights and either document in the weight's binder and/or inform the nurse who would document in the electronic medical record. He further said the Resident does not refuse care and the daily weights are for monitoring fluid overload due to congestive heart failure. During an interview on 4/8/26 at 12:13 P.M., Unit Manager #2 said the CNA's will obtain the weights and document on paper then give to the nurses who then input in the electronic medical records. She said the Resident is being monitored for fluid overload. During an interview on 4/8/26 at 12:50 P.M., the Director of Nursing said physician orders should be completed as ordered.

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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 staff stored drugs and biologicals in accordance with State and Federal requirements in two out of four medication carts observed. Specifically,1.) The facility failed to ensure medications with shortened expiry dates were dated once opened, according to manufacturer's guidelines.2.) The facility failed to ensure medications were stored in the original, labeled containers. Findings include:Review of the facility policy titled 'Medication Storage', revised April 2019, indicated:- Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received.- The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.- Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.- Schedule II-V controlled medications are stored in a separately locked, permanently affixed compartments. 1a.) On 4/7/26 at 12:50 P.M., the surveyor and Nurse #2 observed the following in the fourth-floor team one medication cart:- one incruse ellipta inhaler, open and undated. The label indicated to discard six weeks after opening.- one fluticasone propionate and salmeterol inhaler, open undated. The label indicated to discard one month after opening.- one anoro ellipta inhaler, open and undated. The label indicated to discard six weeks after opening.- one budesonide fumarate inhaler, open and undated. The label indicated to discard three months after opening.- one advair inhaler, open and undated.- one bottle of latanoprost eye drops, open and undated.- one fluticasone propionate and salmeterol inhaler, open, undated, and not labeled with resident name. This stored not in a box, directly in drawer. During an interview on 4/7/26 at 12:52 P.M., Nurse #2 said the eye drops and inhalers observed and listed above in the fourth-floor team one medication cart were open and not dated. Nurse #2 said these are medications with shortened expiry date and should have been dated once opened but were not. Nurse #2 further said the fluticasone propionate and salmeterol inhaler (which was not labeled with any resident's name) should have been stored in its original box and labeled with the resident's name. 1b.) On 4/7/26 at 12:43 P.M., the surveyor and Nurse #1 observed the following in the third-floor team two medication cart:- One bottle of prosource (liquid protein), open and undated. The label indicated to discard three months after opening. During an interview on 4/7/26 at 12:45 P.M., Nurse #1 said the prosource should have been dated upon opening but was not. During an interview on 4/8/26 at 8:59 A.M., the Director of Nursing (DON) said she would expect eye drops, inhalers, and liquid protein should be dated once opened because they have shortened expiry dates. 2.) On 4/7/26 at 12:43 P.M., the surveyor observed Nurse #1 sitting behind the nurses' station using the computer, not actively administering medications. The surveyor requested to observe her medication cart. The surveyor and Nurse #1 observed the following in the third-floor team two medication cart:- one clear, unlabeled medication cup containing one round white pill.- another clear, unlabeled medication containing two oval white pills. During an interview on 4/7/26 at 12:45 P.M., Nurse #1 said the white round pill was oxycodone (a scheduled II controlled medication) that was scheduled for 9:00 A.M. Nurse #1 said she tried administering it earlier, but the Resident was asleep and was unable to. Nurse #1 said controlled substances should be locked in a separate controlled substance box, but it was not. Nurse #1 said she also pre-poured the two white oval pills, which were Tylenol, but had not administered them yet. Nurse #1 said she stored these medications in her medication cart, unlabeled, because she was going to go back and administer them later. During an interview on 4/8/26 at 8:59 A.M., the Director of Nursing (DON) said medications should be prepared when the resident is ready to take medication and should be discarded if unable to be administered within a reasonable amount of time. The DON said controlled medications, such as oxycodone, should be stored in a separately locked container. The DON said medications should always be labeled with the resident's name.

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Sherrill House	135 South Huntington Avenue Boston, MA 02130

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observations, interviews, and record review the the facility failed to notify the physician of a significant change in the resident's physical status for two Residents (#152 and #146), out of 33 total sampled residents. Specifically,1. For Resident #152, the facility failed to notify the provider of an admission with a right ankle pressure injury resulting in delayed treatment and monitoring of the Resident, deterioration of the wound and management of worsening wound condition. 2. For Resident #146, the facility failed to notify the provider of need to implement Bumex (a diuretic medication) for weight gain, which could potentially indicate the clinical complication of fluid overload. Findings include: 1.) Review of the facility policy titled 'Change in a Resident's Condition or Status', revised May 2017, indicated: Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status. -The nurse will notify the resident's Attending Physician or physician on call when there has been: b. discovery of injuries of an unknown source. d. significant change in the resident's physical/emotional/mental condition. -The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Resident #152 was admitted to the facility in March 2026 with a diagnoses of Parkinson's disease, Dementia, Anemia, Diabetes, and Malnutrition. Review of Resident #152's most recent Minimum Data Set (MDS) assessment, dated 3/30/26, indicated severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. The MDS further indicated Resident #152 was dependent for all activities of daily living, had impairment to functional limitation in range of motion to bilateral lower extremities and was assessed to be at risk for developing pressure injuries. On 4/8/26 at 9:30 A.M., and 4/9/26 at 9:15 A.M., the surveyor observed Resident #152 sitting in his/her recliner. Resident #152's right ankle was exposed and there was a wound dressing in place. Review of Resident #152's hospital discharge paperwork, dated 3/23/26, indicated that the Resident had a Stage 2 pressure injury on his/her right ankle with a treatment of Vaseline gauze covered with an abdominal pad and wrapped with bulky gauze. During an interview on 4/9/26 at 9:20 A.M., Unit Manager #2 said that she was Resident #152's assigned nurse and she had done his/her skin check on 3/27/26 and that he/she did have a wound on his/her right ankle with a dressing that she had lifted to look and then returned to cover the wound. Unit Manager #2 said she did not communicate Resident #152's wound to the supervisor or to the doctor and she did not get an order for treatment to the wound. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/9/26 at 12:15 P.M., Nurse #7 (evening supervisor) said she reviewed the hospital paperwork and did not see any wound orders for Resident #152 and had not received any report about Resident #152 needing a wound treatment from Unit Manager #2. Review of Resident #152's medical record failed to indicate the physician was notified of the impairment in skin condition so a treatment could be ordered if indicated. Review of Resident #152's March 2026 Treatment Administration Record (TAR) failed to indicate any order to monitor or treat Resident #152's wounds. During an interview on 4/9/26 at 9:04 A.M., Physician #2 said that the first time she was made aware of Resident #152's right ankle wound was 4/3/26 when Nurse #5 was completing a skin check and asked her to assess. Physician #2 said it was a stage 4 pressure injury as it was down to the bone. It was on 4/3/26 that treatment was initiated for Resident's pressure injury. Physician #2 said that the wound would have worsened without having treatment in place. During an interview on 4/9/26 at 12:22 P.M., the Director of Nursing said that all new admissions have a skin assessment that includes a chart review, as well as observation. If a wound is found during the physical skin check, the appearance should be documented, and the admitting nurse should either get an order for treatment of the wound or carry over the treatment order from the hospital, if there is one, until the resident can be seen by the doctor. The Director of Nursing said the risk of not getting treatment put into place timely for Resident #152's wound was that it would get worse. 2.) Review of the facility policy titled 'Weight and Measuring the Resident', revised March 2011, indicated: -Report significant weight loss/weight gain to the nurse supervisor. -Report other information in accordance with facility policy and professional standards of practice. Resident #146 was admitted to the facility in June 2023 with diagnoses including congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/19/26, indicated Resident #146 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. On 4/8/26 at 10:42 A.M., the surveyor observed Resident #146 sitting up in his/her wheelchair wearing compression stockings (used for managing lower extremity swelling). Resident #146 was unable to answer questions about recent swelling or increased weight. Review of Resident #146's physician's order, initiated 1/23/26, indicated: - Obtain Weight 3 times a week, weight goal is 142-147, if weight goes above 147 lbs. Give 2mg Bumex in PM and Notify NP/MD. Review of Resident #146's weight summary log, dated 4/6/26, indicated a weight of 148.4. Review of Resident #146's medication administration record (MAR), dated 4/6/26, indicated the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician order to Obtain Weight 3 times a week, weight goal is 142-147, if weight goes above 147 lbs. Give 2mg Bumex in PM and Notify NP/MD, scheduled for 7:30 A.M., was documented as a weight of 148.4 pounds by Unit Manager #1. Review of Resident #146's medical record, including nursing progress notes, dated 4/6/26, failed to indicate a provider was notified of an elevated weight above 147. During an interview on 4/8/26 at 10:50 A.M., Unit Manager #1 said she documented the weight of 148.4 for Resident #146. Unit Manager #1 said she did not realize the Resident had an increased weight and did not request a reweight. Unit Manager #1 reviewed all locations and paperwork where additional weights would be recorded and said there was no re-weight obtained and she believed the weight of 148.4 was accurate. Unit Manager #1 said she did not realize the weight required the physician to be notified of the weight increase and need for bumex, so she did not notify the provider of either. During an interview on 4/8/26 at 10:53 A.M., Nurse Practitioner (NP) #1 said if Resident #146 has a weight above 147 pounds the nurse must notify them to obtain an order for bumex 2mg. NP #1 said the facility did not notify them of a weight of 148.4 pounds on 4/6/26 but should have. During an interview on 4/8/26 at 11:41 A.M., the Director of Nursing (DON) said if Resident #146 had a weight increase to 148.4 she would have expected the nurse to obtain a reweight to validate the weight increase. The DON said if the weight was documented as 148.4 pounds, based on the physician's order, the nurse should have notified the provider and obtained an order to implement bumex 2mg in the P.M. but did not.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interviews, the facility failed to ensure that, within 48 hours of admission, nursing developed and implemented baseline care plan with interventions, treatments, goals, and outcomes that addressed the residents' overall immediate care needs for one Resident (#152), out of a sample of 33 Residents. Specifically, the facility failed to initiate a baseline care plan to address a right ankle Stage 2 (partial-thickness skin loss- shallow open ulcer with a red-pink wound bed, or an intact/ruptured serum-filled blister) pressure injury resulting in the development of a right ankle Stage 4 (full-thickness tissue loss- exposed bone, tendon, or muscle, often with undermining and tunnelling) pressure injury. Findings include: Review of the facility's policy titled, Care Plans-Baseline, undated, indicated:-A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.-The interdisciplinary team will review the healthcare practitioner's orders (dietary, medications, routine treatments) and implement baseline care plan to meet the resident's immediate care needs including but not limited to: -Initial goals based on admission orders. -Physician orders. -Dietary orders. -Therapy services. -Social services. -PASARR recommendation, if applicable.-The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. Resident #152 was admitted to the facility in March 2026 and had diagnoses including Parkinson's, Dementia, and Diabetes. Review of the Minimum Data Set (MDS) assessment, dated 3/30/26, indicated Resident #152 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 7 of a possible 15. This MDS also indicated that Resident #152 was dependent for all activities of daily living. Review of Resident #152's hospital discharge paperwork, dated 3/23/26, indicated that the Resident had a stage 2 pressure injury on his/her right ankle. Review of Resident #152's clinical admission assessment skin check, dated 3/27/26, indicated:-Right ankle wound, bruising to right forearm, red, fragile buttocks/sacrum. Review of the medical record failed to indicate a baseline or comprehensive care plan for the care of a pressure injury was developed within 48 hours of Resident #152's admission. During an interview on 4/9/26 at 9:20 A.M., Unit Manager #2 said she did the skin check and she was aware that Resident #152 had a wound on his/her right ankle. Unit Manager #2 said that it is the Unit Manager's responsibility to initiate the baseline care plan and that she has 72 hours to do that. Unit Manager #2 said that she should have initiated a wound care plan even if she did not know if it was a wound caused by pressure, but she did not. During an interview on 4/9/26 at 12:22 P.M., the Director of Nursing said the admitting nurse should initiate the baseline care plan and it should include anything that nursing would need to know how to care for the patient.

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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 record review and interviews, the facility failed to identify and implement interventions for a significant weight loss for one Resident (#141) out of a total sample of 33 residents. Findings include:Review of the policy titled, Weighing and Measuring the Resident, dated March 2011, indicated the following:-Report significant weight loss/gain to the nurse supervisor. -The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria: 1 month - 5% weight loss is significant; greater than 5% is severe. -Notify the Nurse Supervisor if the resident refuses the procedure. -Report the information in accordance with the facility policy and professional standards of practice. Resident #141 was admitted to the facility in January 2024 with diagnoses including Alzheimer's Disease, leukemia and dementia. Review of Resident #141's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #141 is dependent on staff for all self-care and mobility tasks. Review of Resident #141's weight log indicated that on 3/2/26, the Resident weighed 164.8 lbs. (pounds) and on 4/1/26, the Resident weighed 156.4 lbs, which is a 5.1% significant weight loss. Review of Resident #141's physician orders failed to indicate the Resident had any nutritional interventions implemented at the time of the weight loss. Review of Resident #141's nutritional care plan last revised on 2/4/26, indicated the following interventions:-Monitor and report to my dietitian/MD/PA (physician's assistant) / NP (Nurse Practitioner) and signs of malnutrition, emaciation(cachexia), muscle wasting, significant weight loss : 3 lb (pounds) in 1 week, over 5% in 1 month, over 7/5% in 3 months, over 10% in 6 months. -Dietitian to evaluate and make diet changes recommendations, provide carb (carbohydrate) controlled diet. Review of Resident #141's medical record failed to indicate that nursing, the Dietitian, or the Physician was aware of the significant weight loss. Resident #141 was unable to be interviewed about his/her weight secondary to cognitive status. During an interview on 4/8/26 at 9:22 A.M., Unit Manager #1 said weights are entered into the medical record by nurses or the Dietitian and that at the time of weight entry, the staff should identify if a significant weight loss has occurred. Unit Manager #1 said if a weight loss has occurred, the Dietitian, Physician and family should be notified and a nutritional intervention should be implemented immediately. Unit Manager #1 said she was unaware of Resident #141's significant weight loss but said the Dietitian was aware. During an interview on 4/8/26 at 9:32 A.M., the Dietitian said a significant weight loss would be a loss of 5% in a month, 7.5% in 3 months and 10% in 6 months. The Dietitian said if a resident were to have a significant weight loss, he would implement an intervention immediately, within 24 hours. The Dietitian then reviewed Resident #141's weights and said he entered the Resident's most recent weight into the medical record but that when he entered the weight, he failed to look at the previous weight and identify this significant weight loss. The Dietitian said if he had identified the weight loss, he would have started Resident #141 on a nutritional supplement to address the weight loss and prevent further loss. During an interview on 4/8/26 at 12:41 P.M., the Director of Nursing said resident weights are entered into the medical record by the nurses or Dietitian and when weights are entered the previous weight should be looked at to identify if a weight loss has occurred. The Director of Nursing said a significant weight loss would be a loss of 5% in a month, 7.5% in 3 months and 10% in 6 months. She said a nutritional intervention should be implemented as soon as possible if a weight loss is identified. The Director of Nursing said she was unaware Resident #141 had a significant weight loss and the Dietitian should have assessed the Resident and implemented an intervention immediately and did not.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record review, the facility failed to accurately document in the medical record for one Resident (#32) out of a total sample of 33 residents. Specifically, for Resident #32, the nurses inaccurately documented checking air mattress settings according to the Resident's weight per the physician's order. Findings include:Review of the facility policy titled ?Charting and Documentation', dated July 2017, indicated the following:-Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Resident #32 was admitted to the facility in January 2023 with diagnoses including Alzheimer's disease, stroke, and functional quadriplegia. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/4/26, indicated that Resident #32 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of a possible 15, and required assistance with activities of daily living including bed mobility. The MDS further indicated that Resident #32 had a pressure-reducing device for bed. On 4/7/26 at 7:39 A.M. and 10:43 A.M. and 4/8/26 at 6:40 A.M., 9:11 A.M., and 1:20 P.M., the surveyor observed Resident #32 lying in bed on an air mattress that was set to 350 or more pounds. The Resident was non-interviewable and unable to answer any questions about the air mattress setting. Review of Resident #32's physician orders indicated the following:-Air flow mattress with bumper pads, monitor functioning and setting according to weight and alternating every shift, and every shift to offload spine, initiated on 5/6/25. Review of Resident #32's vitals summary report indicated his/her most recent weight was 157.8 pounds on 1/1/26. Review of Resident #32's Treatment Administration Record (TAR) for April 2026 indicated the following:-On 4/7/26, the nurses documented monitoring the air mattress function and setting according to the Resident's weight for day shift. -On 4/8/26, the nurses documented monitoring the air mattress function and setting according to the Resident's weight for day shift. On 4/8/26 at 1:55 P.M., Unit Manager #1 and the surveyor went to check Resident #32's air mattress which was set to 350 or more pounds; she said it must have been an accident and changed the air mattress to the correct setting. Unit Manager #1 said she inaccurately documented in the TAR that the air mattress was set to the Resident's weight when it was not. During an interview on 4/8/26 at 2:06 P.M., the Director of Nursing (DON) said the nurse or unit manager is responsible for checking air mattress settings every shift and it should be documented accurately in the medical record. The DON said nursing should not be checking off orders as completed if they are not completed.

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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, 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 for one Residents (#4) out of a total sample of 33 Residents. Specifically,1.For Resident #4 the facility failed to implement hand hygiene during a wound dressing treatment.2.The facility failed to adhere to contact precautions for Resident #4.Findings include:Review of facility policy titled ?Handwashing/Hand Hygiene', dated August 2019, indicated the following:-All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.-The use of gloves does not replace hand washing /hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Review of facility policy titled ?Isolation- Categories of Transmission-Based Precautions', dated October 2018, indicated the following:-Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the residents' environment.-Staff and visitors will wear gloves (clean, non-sterile) when entering the room.-Staff and visitors will wear disposable gowns entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. 1. Resident #4 was admitted to the facility in March 2026 with diagnoses including peripheral vascular disease, type 2 diabetes and gangrene. Review of the Minimum Data Set (MDS) assessment, dated 3/27/26, indicated the Resident scored 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS indicated the Resident had diabetic wounds and a pressure ulcer. Review of Resident #4's Physician's orders indicated the following:-Gluteal cleft/coccyx wound pressure ulcer.-Wounds to left foot toes 1,2 and 4.-A G-tube site wound.During a wound dressing observations on 4/8/26 at 11:00 A.M., Nurse #5 sanitized his hands donned a gown and gloves and entered Resident #4's room. Nurse #5 removed a dressing from Resident #4's G-tube site. Nurse #5 then removed his gloves and without performing hand hygiene donned a new pair of gloves. He then cleansed the site with normal saline then applied a clean dressing. Nurse #5 removed his gloves and again without performing hand hygiene, donned a new pair of gloves and cleansed Resident #4's left foot toes then applied betadine. Nurse #5 then removed his gloves and without performing hand hygiene he donned a new pair of gloves; he then removed the dressing from Resident #4's sacrum. He then removed his gloves and without performing hand hygiene he donned a new pair of gloves. Nurse #5 then applied new gloves and completed the treatment to the sacrum. He then removed his gloves and sanitized his hands. During an interview on 4/8/26 at 11:22 A.M., Nurse #5 said he should sanitize his hands every time he removed his gloves before applying a new pair of gloves.During an interview on 4/8/26 at 2:26 P.M., the Director of Nursing said her expectation is that hand hygiene should be performed in between glove changes. 2. During an observation on 4/8/26 at 8:30 A.M., Certified Nursing Assistant (CNA) #1 entered Resident #4's room who is on contact precautions only wearing gloves, she did not wear a gown.During an interview on 4/8/26 at 8:36 A.M., CNA #1 said she thought she only needed to wear a gown if she needed to empty a foley catheter. She further said that she only wore gloves because she was not giving direct care.During an observation on 4/8/26 at 8:33 A.M., CNA #2 entered Resident #4's room who is on contact precautions, only wearing a mask, she did not have gloves and a gown on. She came out with a tray cover.During an interview on 4/8/26 at 1:43 P.M., CNA #2 said she should have worn a gown and gloves before entering the contact precaution room. During an interview on 4/8/26 at 2:26 P.M., the Director of Nursing said staff should wear the right personal protective equipment before entering a precaution room.