STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Rehabilitation & Health Care Center	123 South Street Plymouth, MA 02360

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, and records reviewed, the facility failed to ensure one Resident (#10), out of a total sample of 29 residents, received care and treatment to promote healing of a pressure ulcer. Specifically, for Resident #10, the facility failed to implement treatments from the wound consultant physician for a Stage 4 pressure ulcer (full-thickness loss of skin) on the left ischium/buttock.Findings include:Review of the facility's policy titled Prevention and Management of Pressure Injuries, revised 1/2025, indicated, but was not limited to, the following:-Wound treatments are done per MD order.Resident #10 was admitted to the facility in October 2025 with diagnoses including Stage 4 pressure ulcer of the left buttock.Review of Resident #10's Minimum Data Set (MDS) assessment, dated 1/2/26, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS indicated the Resident had one Stage 4 pressure ulcer present on admission to the facility and received pressure ulcer care. Review of Resident #10's Consultant Wound Care Provider's Progress Notes indicated, but was not limited to, the following:-1/2/26 follow-up visit: Stage 4 pressure ulcer located on the left ischium/buttock appears healed. Wound dressing: none. As far as the patient's moisture related dermatitis on groin and buttock areas, suggest house barrier cream daily and PRN (as needed). -1/9/26 follow-up visit: Recurrent stage 4 pressure ulcer is located on the left ischium/buttock. Surgical debridement (removal of dead or damaged tissue) to promote optimal wound healing. Post-debridement wound measurements: 6 cm (centimeters) length by 6 cm width by 0.8 cm depth. Moderate amount of serous exudate (a clear, thin, and watery fluid that is produced by the body in response to tissue damage or inflammation, playing a crucial role in the healing process), wound bed is 100% granulation (a key component of wound healing, consisting of new connective tissue and blood vessels that form in the wound bed). No signs of infection. Wound dressing: Prisma/Puracol/Dermacol (or similar collagen dressing) (collagen dressings promote healing by stimulating new tissue growth, providing structural support, and maintaining a moist environment), Alginate (a dressing that absorbs drainage and forms a gel) and foam to the left ischium/buttock wound changed daily and PRN. -1/16/26 follow-up visit: Stage 4 pressure ulcer on the left ischium/buttock. Surgical debridement to promote optimal wound healing. Post-debridement wound measurements: 4 cm length by 5.8 cm width by 0.6 cm depth. Moderate amount of serous exudate, wound bed is 100% granulation. No signs of infection. Wound dressing: Prisma/Puracol/Dermacol (or similar collagen dressing), Alginate and foam to the left ischium/buttock wound changed daily and PRN.-1/23/26 follow-up visit: Stage 4 pressure ulcer on the left ischium/buttock. Surgical debridement to promote optimal wound healing. Post-debridement wound measurements: 3 cm length by 5 cm width by 0.3 cm depth. Moderate amount of serous exudate, wound bed is 100% granulation. No signs of infection. Wound dressing: Prisma/Puracol/Dermacol (or similar collagen dressing), Alginate and foam to the left ischium/buttock wound changed daily and PRN.-1/30/26 follow-up visit: Stage 4 pressure ulcer on the left ischium/buttock. Post-debridement wound measurements: 3 cm length by 4.5 cm width by 0.3 cm depth. Moderate amount of serous exudate. Wound bed is 30% yellow necrosis (dead tissue) and 70% granulation. There is an odor associated with the wound. Mild periwound redness, no swelling. Wound dressing: Change to Vashe (or similar antibacterial wound (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleanser), Bactroban (a topical antibiotic), alginate and foam to the left ischium/buttock wound changed daily and PRN.Review of Resident #10's January 2026 Physician's Orders indicated the following:-10/14/25 through 1/2/26: Wash with wound cleanser, pay dry, apply skin prep to peri wound, collegen [sic] to wound base f/b (followed by) alginate cover with Foam dressing Location: left buttock/ischium every evening shift-1/3/26 through 1/30/26: NSW (normal saline wash), pat dry, apply alginate, cover with foam dressing, change every evening Location: Left lower buttocks-1/30/26: Wash with wound cleanser, pat dry, apply Bactroban f/b alginate, cover with DCD (dry clean dressing), change every evening Location: Left lower buttocksReview of Resident #10's Progress Notes showed a late entry note was entered for 1/2/26 at 1:00 P.M. indicating the Resident was seen on wound rounds and his/her wound was healing well and continue with the current treatment. Further review indicated that on 1/30/26, the Resident was seen by the Consultant Wound Care Provider and the Resident's left ischium wound was measuring smaller, but a new slight odor was present, and the Consultant Wound Care Provider recommended treatment with wound cleanser, Bactroban ointment, alginate and dry protective dressing. Review of Resident #10's medical record failed to indicate the facility implemented pressure ulcer treatment with a collagen dressing as recommended by the Consultant Wound Care Provider from 1/9/26 through 1/30/26 and failed to implement antibacterial wound cleanser and a foam dressing after the Consultant Wound Care Provider's visit indicated a new wound odor on 1/30/26. ˆReview of Resident #10's Physician and Nurse Practitioner Progress Notes failed to indicate the Physician or Nurse Practitioner declined any of the Consultant Wound Care Provider's treatment recommendations.During an interview on 1/29/26 at 11:10 A.M., the Infection Prevention Nurse said she usually rounded with the Consultant Wound Care Provider. The Infection Prevention Nurse said the Consultant Wound Care Provider had recommended discontinuing treatment with collagen and implementing treatment with the alginate dressing only because Resident #10's wound healing had stalled.During an interview on 1/30/26 at 2:01 P.M., the Consultant Wound Care Provider said Resident #10's left ischium treatment recommendation has always included collagen with the treatment. The Infection Prevention Nurse, present during the surveyor's interview with the Consultant Wound Care Provider, reviewed the Consultant Wound Care Provider's progress notes and confirmed the notes indicated collagen should be used. The Consultant Wound Care Provider said the Resident's wound care order should have included treatment with collagen.During an interview on 2/2/26 at 2:16 P.M., Resident #10's Attending Physician said she was not aware the facility had not been following the Consultant Wound Care Provider's recommendations. The Attending Physician said the Consultant Wound Care Provider's recommendations should have been implemented and if she were to disagree with a recommendation, she would document that in a progress note.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure medications were labeled and stored in accordance with acceptable professional standards. Specifically, the facility failed to:1. Ensure Resident #50's Prednisolone Acetate 1% and Timolol Maleate 0.5% ophthalmic drops were stored securely; 2. Ensure medication and topical treatments were securely stored and not left at the bedside on 1 out of 5 units in the facility; and3. Ensure that medications in the refrigerator were stored under the proper temperature for 1 out of 3 medication rooms.Findings include:Review of the facility's policy titled Medication Storage Room/Medication Cart Policy, dated 2/2018, indicated, but was not limited to, the following:-Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel.-Storage for other medications will be limited to a locked medication room.-Drugs requiring refrigeration are stored separately in a refrigerator, that is used exclusively for medication and medication adjuncts.-Medication refrigerators/freezers will be cleaned on a weekly basis and daily as needed. 1. On 1/28/26 at 9:54 A.M. on the [NAME] Unit, the surveyor observed Nurse #9 leave Resident #50's Prednisolone Acetate 1% and Timolol Maleate 0.5% ophthalmic drops on top of the medication cart when she left the medication cart parked in the hallway against the wall across from the nurses' station and went to a resident's room down the hallway, out of view of the medication cart. Nurse #9 returned to the medication cart at 10:24 A.M. and put the medications away in the medication cart. During an interview on 1/28/26 at 11:53 A.M., Nurse #9 said she should have put the eye drops away in the medication cart before walking away. During an interview on 2/2/26 at 12:16 P.M., the Director of Nursing (DON) said it was her expectation that medications were not left unattended on top of the medication cart. 2. On 1/27/26 at 9:00 A.M., 1/28/26 at 8:30 A.M. and 1:00 P.M. the surveyor observed multiple topical treatments at the bedside in 7 of 12 resident rooms on the Mayflower South unit: -room [ROOM NUMBER]: two tubes of 2.5 oz tube of Triad Hydrophilic wound dressing Pansement hydrophile (topical zinc oxide), two bottles of Miconozole Nitrate 2% antifungal powder -room [ROOM NUMBER]: two 17.9 oz bottles of polyethylene Glycol 3350 (laxative), one 2.5 oz tube of Triad Hydrophilic wound dressing Pansement hydrophile, one bottle of Miconozole Nitrate 2% antifungal powder -room [ROOM NUMBER]: one tube of 2.5 oz tube of Triad Hydrophilic wound dressing Pansement hydrophile -room [ROOM NUMBER]: one Ventolin HFA inhaler (medication used to treat bronchospasms) -room [ROOM NUMBER]: one tube of Muscle Rub (topical analgesic) -room [ROOM NUMBER]: one Flovent HFA inhaler (corticosteroid medication used to treat asthma attacks) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER]: one bottle of fluticasone propionate nasal spray (medication used to treat allergies) During an interview on 1/28/26 at 10:00 A.M., Nurse #6 said she didn't notice the items, and they should not be left at the bedside and should be secured. During an interview on 1/28/26 at 2:13 P.M., Unit Manager #1 said these medications and treatments should be secured and not left at the bedside. 3. Review of the United States Pharmacopeia (USP) standards, dated 5/1/17 indicated, but was not limited to: -Safe medication storage includes the provision of appropriate environmental controls. Medications can be altered by exposure to improper temperature; medications should be stored and handled in accordance with manufacturer's specifications. Review of manufacturer guidelines for the following diabetic insulin vials and kwikpens indicated but was not limited to: -Unopened medications Novolog, Levemir, Lantus, Basaglar, Humalog, Humulin, Lispro, Procrit Desmopressin, and Tubersol should be stored in a refrigerator with a temperature between 36 to 46 degrees Fahrenheit. On 1/30/26 at 8:05 A.M., the surveyor, accompanied by Nurse #3, inspected the medication room on the [NAME] Unit, and observed the following: -Refrigerator was open with an internal temperature of 70 degrees. -The following medications were warm to the surveyor's touch: Novolog (treats diabetes) Lantus (treats diabetes) Basaglar (treats diabetes) Humalog (treats diabetes) Lispro (treats diabetes) Procrit (stimulates the bone marrow to produce red blood cells) Desmopressin nasal spray (treats cranial diabetes insipidus) Tubersol (used as a diagnostic agent to detect tuberculosis infection) Review of the facility Medication Refrigerator Temperature Logs from August 2025 through January 2026 failed to indicate the refrigerator temperature was checked on the following dates: 8/2/25, 8/6/25, 8/7/25, 8/12/25, 8/13/25, 8/14/25, 8/16/25, 8/20/25, 8/21/25, 8/23/25, 8/27/25, 8/28/25, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/3/25, 9/4/25, 9/6/25, 9/10/25, 9/11/25, 9/13/25, 9/18/25, 9/20/25, 9/23,25, 9/24/25, 10/8/25, 10/18/25, 11/1/25, 11/6/25, 11/20/25, 11/22/25, 11/27/25, 11/29/25, 12/6/25, 12/14/25, 12/24/25, 12/31/25, 1/3/26, 1/7/26, 1/10/26, 1/13/26, 1/14/26, 1/15/26, 1/20/26, 1/21/26, 1/31/26. During an interview on 1/30/26 at 8:05 A.M., Nurse #3 said she did not know how long the refrigerator was left open and did not know what the process was for use vs. disposal of the medications in the refrigerator that were warm to touch and would need to check with her supervisor. Nurse #3 said the 11:00 P.M. to 7:00 A.M. shift nurse is in charge of checking the medication refrigerator temperatures and did not know where the Medication Refrigerator Temperature Logs were kept on the unit. During an interview on 1/30/26 at 8:39 A.M., Unit Manager #2 said the 11:00 P.M. to 7:00 A.M. shift nurse is responsible every shift for checking and documenting the medication refrigerator temperatures. Unit Manager #2 said the medication refrigerator should be kept closed at all times and medications not within manufacturer's guidelines for storage temperature should be removed immediately. During an interview on 2/2/26 at 8:57 A.M., the DON said the medication refrigerator should be kept closed and the 11:00 P.M. to 7:00 A.M. shift nurse is responsible for checking and documenting the temperatures at least once per shift, and twice if there are vaccines stored in the refrigerator. The DON said the nurse should be checking at the beginning and end of each shift. The DON said all nurses are responsible for checking the refrigerators.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure one Resident (#33), out of a total sample of 29 residents, was treated with respect and dignity. Specifically, the facility failed for Resident #33, to ensure a Foley catheter (tube inserted into the bladder to drain urine) drainage bag was consistently covered with a privacy bag. Findings include:Resident #33 was admitted to the facility in June 2025 and had diagnoses including urinary retention (inability to completely empty the bladder leading to frequent urination or leakage of urine).Review of the Minimum Data Set (MDS) assessment, dated 12/12/25, indicated Resident #33 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had an indwelling urinary catheter.Review of Physician's Orders indicated but was not limited to:-Foley catheter size #16 French with 10 milliliter (ml) balloon (6/27/25)-Catheter to bedside drainage bag while in bed every shift (6/27/25)-Flush Foley catheter with 30 ml normal saline as needed and every shift (9/20/25)-Provide Foley catheter care every shift (6/13/25)-May use leg bag (6/13/25)-Replace Foley bag monthly the 28th of every month (8/4/25)On 1/27/26 at 9:20 A.M., the surveyor observed Resident #33 sitting upright in bed watching television. A urinary drainage bag was observed lying directly on the floor to the side of the Resident's bed. The drainage bag was visible from the doorway, contained clear/yellow urine and was not covered by a privacy bag.On 1/28/26 at 10:10 A.M., the surveyor observed Resident #33 being pushed in his/her wheelchair down the hallway. The Foley catheter bag was not covered by a privacy bag and clearly visible hanging underneath the wheelchair.On 1/28/26 at 10:50 A.M., the surveyor observed Resident #33 seated in a wheelchair at the bedside. The Foley catheter bag was not covered with a privacy bag and clearly visible from the doorway hanging underneath the wheelchair.On 1/28/26 at 1:49 P.M., the surveyor observed Resident #33 sitting in a wheelchair in his/her room watching television. The Foley catheter bag was not covered by a privacy bag, was visible from the doorway hanging underneath the wheelchair and contained clear/yellow urine.On 1/29/26 at 1:18 P.M., the surveyor observed Resident #33 ambulating in the unit hallway with therapy staff. The Foley catheter bag was not covered by a privacy bag and contained clear/yellow urine visible to anyone in the hallway.During an interview on 1/29/26 at 2:55 P.M., Nurse #7 said Resident #33 as well as all residents with catheter bags should have privacy bags to cover the catheter drainage bag.During an interview on 2/2/26 at 12:04 P.M., the Director of Nursing (DON) said Resident #33 is supposed to have had a privacy cover on his/her catheter bag and staff must have forgotten to put it on.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility failed to implement written policies and procedures for the investigation of allegations of abuse, protection of residents during investigations and reporting of allegations and investigative findings for one Resident (#18), out of a total sample of 29 residents. Specifically, the facility failed to initiate their abuse policy after an allegation of potential abuse was reported by the surveyor during the survey.Findings include:Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2/2023, indicated, but was not limited to, the following:-It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.- Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.-An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.-Written procedures for investigations include:1. Identifying staff responsible for the investigation;2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);3. Investigating different types of alleged violations;4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.-The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:a. Responding immediately to protect the alleged victim and integrity of the investigation;b. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment, if needed;c. Increased supervision of the alleged victim and residents;d. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;f. Providing emotional support and counseling to the resident during and after the investigation, as needed;g. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. -The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.-The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.-Accused employee may be placed on administrative leave while the investigation is being conducted.-The resident will be monitored for potential negative outcomes for 72-hours post-incident occurrence, and this will be documented in the clinical record.Resident #18 was admitted to the facility in August 2025 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by underlying metabolic disturbances, leading to symptoms like confusion, memory loss, and altered consciousness), dementia, and cognitive communication deficit. Review of Resident #18's Minimum Data Set (MDS) assessment, dated 1/23/26, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Further review of the MDS assessment indicated that the Resident was dependent on staff for completing activities of daily living. During an interview on (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/28/26 at 12:06 P.M., Resident #18 said there was lots of abuse in the facility and that staff think he/she is crazy. Resident #18 said he/she was not comfortable sharing anything further because he/she did not know the surveyor. Resident #18 said he/she had not shared his/her concerns with any staff at the facility but said would like to discuss it with the police. On 1/28/26 at 12:08 P.M., the surveyor notified the Director of Nursing (DON) of Resident #18's report of abuse in the facility and his/her request to speak with the police. During an interview on 1/29/26 at 11:03 A.M., the DON said she had completed a grievance form for Resident #18 on 1/28/26. The DON said when she interviewed the Resident on 1/28/26, she determined the Resident was unhappy with the Certified Nursing Assistant's (CNA) method of positioning him/her with pillows and that she had changed the CNA assignment for the Resident's comfort. The DON provided a copy of the grievance form to the surveyor. Review of a Grievance Sheet, dated 1/28/26, completed by the DON and Assistant Director of Nursing (ADON) for Resident #18 indicated the Resident did not like having pillows behind his/her back for positioning and said CNA #9 would not remove the pillows and had a bad attitude. Resident #18 said he/she prefers CNA #9 not provide his/her care going forward. Included with the Grievance Sheet was an Employee Education Report that indicated CNA #9 was educated on refusal of care/customer service/resident's rights on 1/28/26 and a written statement from CNA #9 dated 1/29/26 regarding her provision of care to Resident #18. During an interview on 1/29/26 at 12:01 P.M., the Administrator said the DON was able to complete her investigation within 2 hours after the initial report was made and, after speaking to Resident #18, the DON determined that it was more of a misunderstanding than abuse. The Administrator did not know if other staff or residents on the unit were interviewed during the course of the DON's investigation.During an interview on 1/29/26 at 12:18 P.M., the DON said when an allegation of abuse is reported, the first thing she does is talk to the resident making the allegation to find out what had occurred. The DON said if indicated, she would interview staff and anyone else that may have been witness to what the resident was reporting to determine whether abuse had occurred or not. The DON said that if she determined that abuse had occurred, she would report the allegation to the Department of Public Health within the 2-hour window as required. The DON said the ADON spoke with Resident #18's roommate on 1/28/26, but no other residents on the unit were interviewed and no other staff were interviewed beyond CNA #9, who had been caring for the Resident on 1/28/26 when the allegation was reported. During an interview on 1/29/26 at 12:35 P.M., the DON said after she spoke with Resident #18, she determined the concern was a care concern, not abuse, so she did not report it or notify the police. The DON said she had not informed the Resident's Health Care Proxy about the Resident's concern.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to report a potential allegation of abuse for one Resident (#18), out of a total sample of 29 residents. Findings include:Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2/2023, indicated, but was not limited to, the following:-It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.-Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.-The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.Resident #18 was admitted to the facility in August 2025 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by underlying metabolic disturbances, leading to symptoms like confusion, memory loss, and altered consciousness), dementia, and cognitive communication deficit. Review of Resident #18's Minimum Data Set (MDS) assessment, dated 1/23/26, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Further review of the MDS assessment indicated that the Resident was dependent on staff for completing activities of daily living. During an interview on 1/28/26 at 12:06 P.M., Resident #18 said there was lots of abuse in the facility and that staff think he/she is crazy. Resident #18 said he/she was not comfortable sharing anything further because he/she did not know the surveyor. Resident #18 said he/she had not shared his/her concerns with any staff at the facility but said he/she would like to discuss it with the police. On 1/28/26 at 12:08 P.M., the surveyor notified the facility's Director of Nursing (DON) of Resident #18's report of abuse in the facility and request to speak with the police.Review of the Health Care Facility Reporting System (HCFRS- system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 1/29/26 failed to indicate the facility submitted a report on 1/28/26 for an allegation of abuse. During an interview on 1/29/26 at 12:01 P.M., the Administrator said the DON was able to complete her investigation of the abuse allegation within two hours and determined that it was not necessarily abuse but more of an educational opportunity for the Certified Nursing Assistant (CNA) and was not reported in HCFRS. During an interview on 1/29/26 at 12:18 P.M., the DON said when an allegation of abuse is reported, the first thing she does is talk to the resident making the allegation to find out what had occurred. The DON said if indicated, she would interview staff and anyone else that may have been witness to what the resident was reporting to determine whether abuse had occurred or not. The DON said that if she determined that abuse had occurred, she would report the allegation to the Department of Public Health within the 2-hour window as required. The DON said the Assistant Director of Nursing (ADON) spoke with Resident #18's roommate on 1/28/26, but no other residents on the unit were interviewed and no other staff were interviewed beyond CNA #9, who had been caring for the Resident on 1/28/26 when the allegation was reported. During an interview on 1/29/26 at 12:35 P.M., the DON said after she spoke with Resident #18, she determined the concern was a care concern, not abuse, so she did not report the allegation in HCFRS or notify the police.

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	225207	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Rehabilitation & Health Care Center	123 South Street Plymouth, MA 02360

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure staff thoroughly investigated an allegation of abuse for one Resident (#18), out of a total sample of 29 residents. Findings include:Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2/2023, indicated, but was not limited to, the following:-It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.- Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.-An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.-Written procedures for investigations include:1. Identifying staff responsible for the investigation;2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);3. Investigating different types of alleged violations;4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.-The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:a. Responding immediately to protect the alleged victim and integrity of the investigation;b. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment, if needed;c. Increased supervision of the alleged victim and residents;d. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;f. Providing emotional support and counseling to the resident during and after the investigation, as needed;g. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. -The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.-The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.-Accused employee may be placed on administrative leave while the investigation is being conducted.-The resident will be monitored for potential negative outcomes for 72-hours post-incident occurrence and this will be documented in the clinical record.Resident #18 was admitted to the facility in August 2025 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by underlying metabolic disturbances, leading to symptoms like confusion, memory loss, and altered consciousness), dementia, and cognitive communication deficit. Review of Resident #18's Minimum Data Set (MDS) assessment, dated 1/23/26, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Further review of the MDS assessment indicated that the Resident was dependent on staff for completing activities of daily living. During an interview on 1/28/26 at 12:06 P.M., Resident #18 said there was lots of abuse in the facility and that staff think he/she is crazy. Resident #18 said he/she was not comfortable sharing anything further because he/she did not know the surveyor. Resident #18 said he/she had not shared his/her concerns with (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any staff at the facility but said he/she would like to discuss it with the police. On 1/28/26 at 12:08 P.M., the surveyor notified the facility's Director of Nursing (DON) of Resident #18's report of abuse in the facility and request to speak with police. During an interview on 1/29/26 at 11:03 A.M., the DON said she had completed a grievance form for Resident #18 on 1/28/26. The DON said when she interviewed the Resident on 1/28/26, she determined the Resident was unhappy with the Certified Nursing Assistant's (CNA) method of positioning him/her with pillows and that she had changed the CNA assignment for the Resident's comfort and the CNA was provided reeducation. CNA #9 was not placed on administrative leave during the DON's investigation. The DON provided a copy of the grievance form she had completed to the surveyor. Review of a Grievance Sheet, dated 1/28/26, completed by the DON and Assistant Director of Nursing (ADON) for Resident #18 indicated the Resident did not like having pillows behind his/her back for positioning and said CNA #9 would not remove the pillows and had a bad attitude. Resident #18 said he/she prefers CNA #9 not provide his/her care going forward. Included with the Grievance Sheet was an Employee Education Report that indicated CNA #9 was educated on refusal of care/customer service/resident's rights on 1/28/26 and a written statement from CNA #9 dated 1/29/26 regarding her provision of care to Resident #18. The grievance form did not include any information the surveyor had reported to the DON on 1/28/26.As of the survey exit on 2/2/26, review of the Health Care Facility Reporting System (HCFRS) failed to indicate the facility had reported any allegations of abuse involving Resident #18 and their investigation findings.During an interview on 1/29/26 at 12:01 P.M., the Administrator said the DON was able to complete her investigation within 2 hours after the initial report was made and, after speaking to Resident #18, the DON determined that it was more of a misunderstanding than abuse. The Administrator did not know if other staff or residents on the unit were interviewed during the course of the DON's investigation.During an interview on 1/29/26 at 12:18 P.M., the DON said when an allegation of abuse is reported, the first thing she does is talk to the resident making the allegation to find out what had occurred. The DON said if indicated, she would interview staff and anyone else that may have been witness to what the resident was reporting to determine whether abuse had occurred or not. The DON said that if she determined that abuse had occurred, she would report the allegation to the Department of Public Health within the 2-hour window as required. The DON said the ADON spoke with Resident #18's roommate on 1/28/26, but no other residents on the unit were interviewed and no other staff were interviewed beyond CNA #9, who had been caring for the Resident on 1/28/26 when the allegation was reported. During a subsequent interview on 1/29/26 at 12:35 P.M., the DON said after she spoke with Resident #18, she determined the concern was a care concern, not abuse, so she did not report it or notify the police. The DON said she had not informed the Resident's Health Care Proxy about the Resident's concern.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff implemented care and services consistent with professional standards of practice for four Residents (#12, #1, #145, and #5), out of 29 sampled residents. Specifically, the facility failed:1. For Resident #12, to administer an antihypertensive medication as ordered on days the Resident left the facility to go to dialysis;2. For Resident #1, to monitor that Certified Nursing Assistants (CNA) were not working out of their scope of practice by adjusting liter flow on oxygen tanks;3. For Resident #145, to administer Ativan according to physician's orders; and4. For Resident #5, to ensure a physician's order was in place for self-administration of Muscle Rub (topical analgesic treatment).Findings include:Review of [NAME], Manual of Nursing Practice 11ed, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. 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 prescriber 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. Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of Registered Nurse and Practical Nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered Nurse and Practical Nurse respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate into the plan of care and implement prescribed medical regimens. The Rules and Regulations 9.03 define Standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. 1. Resident #12 was admitted to the facility in November 2025 with diagnoses including end stage renal disease (ESRD) and hypertension urgency (a severe elevation of blood pressure generally over 180/120 mmHg, without new or progressive target organ damage). Review of the Minimum Data Set (MDS) assessment, dated 11/21/25, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review of the MDS indicated Resident #12 had received dialysis. Review of Resident #12's current Physician's Orders indicated but was not limited to: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dialysis: Tuesday, Thursday and Saturday 11:30 AM chair- dated 1/23/26 -Labetalol HCL oral tablet 300 milligrams (MG) give one tablet by mouth every eight hours related to hypertensive urgency. Hold for systolic blood pressure (SBP) less than 130-dated 1/23/26 Further review of the Medication Administration Record (MAR) indicated that the Labetalol HCL was scheduled to be given at 6:00 A.M., 2:00 P.M., and 10:00 P.M. The following as ordered 2:00 P.M. doses were marked as not given on dialysis days: 11/18/25, 11/20/25, 11/22/25, 11/29/25, 12/2/25, 12/4/25, 12/6/25, 12/9/25, 12/11/25, 12/22/25, 12/27/25, 12/29/25, 12/31/25, 1/6/26, 1/8/26, 1/10/26, 1/24/26 and 1/27/26 To note Resident #12's dialysis schedule was modified from 12/22/25 through 12/31/25 to accommodate the holidays. Further review of Resident #12's medical record failed to indicate the Physician or Nurse Practitioner (NP) were notified of the missing doses of the Labetalol HCL. During an interview on 1/29/26 at 1:53 P.M., Nurse #2 said she holds the scheduled dose of Labetalol when Resident #12 is at dialysis. Nurse #2 said she does not send any medications to dialysis. Nurse #2 said she does not inform the physician or NP of the missing doses. During an interview on 1/30/26 at 10:15 A.M., Nurse #1 said she does not send any medications with the resident to dialysis. Nurse #1 said she would document the scheduled 2:00 P.M. dose of Labetalol as not given. Nurse #1 said she does not inform the physician or NP of the missing doses. During an interview on 1/30/26 at 11:12 A.M., the surveyor and Unit Manager (UM) #1 reviewed the times that the Labetalol was not given as Resident #12 was out of the facility. UM #1 said the Labetalol should have been scheduled for times that the Resident was in the facility. During an interview on 1/30/26 at 1:14 P.M., the Director of Nurses (DON) said medications should be scheduled around the times Resident #12 was out of the facility at dialysis. The DON said several missed doses of medication should be relayed to the physician or NP. On 1/30/26 at 1:30 P.M. and 2/4/26 at 11:57 A.M., the surveyor attempted to contact the NP but was unsuccessful. 2. Review of the National Institutes of Health (NIH) (.gov) https://www.ncbi.nlm.nih.gov>books>NBK593208, indicated but was not limited to: Oxygen is considered a medication and, therefore, requires a prescription and continuous monitoring by the nurse to ensure its safe and effective use. Review of the facility's policy titled Oxygen Administration Nasal Cannula, dated revised November 2020, indicated but was not limited to: -Policy Statement to deliver low flow oxygen, per the physician's order (generally 1-6 liters per minute (LPM) and 24%-45% concentration) via nasal cannula. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Set the oxygen liter flow to the prescribed liters flow per minute -Verify oxygen is flowing through tips of the cannula -Document flow rate and resident's condition and response in the medical record as indicated Resident #1 was admitted to the facility in December 2025 with diagnoses including chronic obstructive pulmonary disease (COPD) and chronic respiratory failure. Review of the MDS assessment, dated 1/9/26, indicated Resident #1 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS indicated Resident #1 had received Oxygen. Review of Resident #1's current Physician's Orders indicated but was not limited to: -Evaluate and document respiratory status for change in condition every shift-dated 12/17/25 -Monitor shortness of breath (SOB) q shift: Does the resident with COPD/Asthma/Interstitial lung disease have SOB while lying flat and request or need to have head of bed elevated for respiratory support-dated 12/17/25 -Oxygen as needed via NC at 2 LPM for SOB. May titrate between 1-4 LPM as needed for comfort or to maintain O2 saturation greater than 90%-dated 1/19/26 On 1/29/26 at 1:15 P.M., the surveyor observed Resident #1 tell CNA #1 that he/she was not getting any oxygen through his/her portable oxygen tank. CNA #1 said she would boost it up to six and took her hand and manipulated the setting on the oxygen tank. During an interview on 1/29/26 at 1:16 P.M., CNA #1 said she was able to fill the portable oxygen tanks and turn on the tank for the residents. CNA #1 said on a good day Resident #1 would be on four liters. CNA #1 said when he/she was huffing and puffing, he/she was on five liters. CNA #1 said, if she did not know what setting to use, she would ask the nurse. During an interview on 1/29/26 at 1:37 P.M., Nurse #2 said CNAs were allowed to fill portable oxygen tanks but were not allowed to manipulate the liter flow on the oxygen tanks. The surveyor and Nurse #2 observed the liter flow on Resident #1's portable oxygen tank. Nurse #2 said the liter flow was five liters. Nurse #2 said the liter flow was set at two liters this morning and decreased the flow to two liters. During an interview and observation on 1/30/26 at 10:20 A.M., Resident #1 returned from his/her cigarette break. CNA #2 placed a portable oxygen tank on the back of Resident #1's wheelchair and turned on the oxygen. The surveyor and CNA #2 observed the setting which was set at two liters. CNA #2 said she was allowed to fill the oxygen tanks and turn on the oxygen. During an interview on 1/30/26 at 10:57 A.M., Nurse #1 said CNAs are allowed to fill oxygen tanks and adjust the liter flow. Nurse #1 said if they do not know the liter flow to set the oxygen tank they would ask the nurse. During an interview on 1/30/26 at 11:20 A.M., the Staff Development Coordinator (SDC) said we (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	educate and do competencies with licensed nurses on oxygen delivery. The SDC said CNAs are educated and go through a competency to fill the portable oxygen tanks. The SDC said oxygen is considered a medication and only licensed nurses can administer and manipulate the liter flow with a physician's order. During an interview on 1/30/26 at 12:22 P.M. the DON said all CNAs are educated during orientation on filling a portable oxygen tank. The DON said CNAs should not be adjusting or turning on oxygen tanks. 3. Resident #145 was admitted to the facility in February 2024 with diagnoses including anxiety disorder. Review of Resident #145's MDS assessment, dated 11/14/25, indicated the Resident was cognitively impaired, as evidenced by a BIMS score of 12 out of 15. Further review of the MDS assessment indicated that the Resident had a psychiatric mood disorder of anxiety and received antianxiety medications. Review of Resident #145's Physician's Orders indicated, but was not limited to, the following: -Lorazepam (a medication used to treat anxiety) Oral tablet 1 MG. Give one tablet by mouth three times a day for increased anxiety (order date 8/27/24), at scheduled times of 9:00 A.M., 5:00 P.M., and 10:00 P.M. Review of Resident #145's MAR indicated Nurse #4 administered Lorazepam 1 MG as prescribed on 1/29/26 at 9:00 A.M. On 1/29/26 at 3:18 P.M., the surveyor, with Nurse #4 present, reviewed the narcotic log count and actual medication count for Resident #145's Lorazepam 1 MG. Nurse #4 counted 66 tablets of Lorazepam 1 MG remaining. The narcotic log indicated 65 tablets of Lorazepam 1 MG should have been remaining, a discrepancy of one tablet of Lorazepam 1 MG. During an interview on 1/29/26 at 3:18 P.M., Nurse #4 said she was certain she gave Resident #145 his/her 9:00 A.M. dose of Lorazepam 1 MG and did not know why the narcotic count was incorrect. Nurse #4 said the count was correct earlier and she signed out the 9:00 A.M. dose. Nurse #4 said based on the number of tablets remaining she was unsure if she gave Resident #145 his/her ordered Lorazepam 1 MG. Review of Resident #145's incident report indicated Nurse #4 made a medication error. The report indicated Nurse #4 signed one tablet of Lorazepam 1 MG out of the narcotic log for Resident #145 without giving the medication and the Resident was unaware. During an interview on 2/2/26 at 8:57 A.M., the DON said Resident #145 should have received their medication as ordered. 4. Resident #5 was admitted to the facility in July 2025 and had diagnoses including right upper quadrant pain, osteoarthritis of the right hip and muscle weakness. Review of the MDS assessment, dated 1/14/26, indicated that Resident #5 was cognitively intact as evidence by a BIMS score of 15 out of 15, experienced constant pain over the past five days, and had (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited range of motion on one side of his/her lower extremity. On 1/27/26 at 9:31 A.M., the surveyor observed a tube of Muscle Rub (topical analgesic) on the bedside table in full view. During interviews with observation on 1/28/26 at 8:37 A.M. and 10:06 A.M., the surveyor observed Resident #5 seated in a wheelchair at the bedside applying Muscle Rub to his/her legs. The Resident said staff used to leave him/her a small cup of the cream to apply, but it wasn't enough, so they leave the entire tube for him/her to apply on his/her own. Review of Physician's orders failed to indicate Resident #5 had an order to self-administer Muscle Rub and/or to keep the treatment at the bedside. Review of the medical record indicated Self-Administration of Medication assessments, dated 7/25/25, 10/3/25, 12/26/25 and 1/3/26. All the assessments indicated Resident #5 did not want to self-administer any medications and was not assessed to self-administer. Review of comprehensive care plans failed to indicate a care plan for self-administration of medication. During an interview on 1/28/26 at 2:13 P.M., Unit Manager #1 said she said she was not aware Resident #5 had been self-administering and keeping Muscle Rub cream at the bedside. She said treatments should not be left at the bedside and not self-administered without an assessment and Physician's order is obtained to do so. During an interview on 2/2/26 at 12:04 P.M., the DON said Resident #5 should have had an evaluation to self-administer the treatment and a Physician's order to apply the treatment independently and store it at the bedside but did not.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, records reviewed, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when one of one nurses observed during a medication pass made two errors out of 32 opportunities, resulting in a medication error rate of 6.25%. Those errors impacted two Residents (#50 and #56), out of three residents observed.Findings include:Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to the following:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers. 1. Review of Resident #50's Physician's Orders indicated, but was not limited to, the following:-Prednisolone Acetate Ophthalmic Suspension 1% - Instill 1 drop in both eyes two times a day (order date 10/4/24)On 1/28/26 at 10:24 A.M., the surveyor observed Nurse #9 prepare and administer Resident #50's morning medications. Nurse #9 returned to the medication cart, put the Resident's eye drops away, and began preparing medications for another resident. Nurse #9 failed to administer the Resident's prescribed Prednisolone Acetate Ophthalmic Suspension (a steroid medicine used to treat eye inflammation) to both eyes as ordered.During an interview on 1/28/26 at 10:26 A.M., Nurse #9 said she failed to administer Resident #50's Prednisolone eye drops because she must have gotten distracted after administering the Resident's inhaler and forgot.2. Review of Resident #56's Physician's Orders indicated, but was not limited to, the following:-Buprenorphine HCl-Naloxone HCl (a combination medication used primarily to treat opioid use disorder) Sublingual Tablet 8-2 MG- Give 1 tablet sublingually three times a day (order date 6/26/25)On 1/28/26 at 9:48 A.M., the surveyor observed Nurse #9 prepare and administer Resident #56's morning medications. Nurse #9 prepared and administered the sublingual film form of Buprenorphine HCl-Naloxone HC to the Resident. During an interview on 1/28/26 at 10:38 A.M., Nurse #9 said the form of Buprenorphine HCl-Naloxone HCl supplied by the pharmacy for Resident #56 was films, not tabs, as indicated in the Resident's Physician's Orders.During an interview on 2/2/26 at 12:16 P.M., the Director of Nursing said it was her expectation that medications were administered as indicated by the physician's orders.

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	225207	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Rehabilitation & Health Care Center	123 South Street Plymouth, MA 02360

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential for foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Properly label and date food and beverage products as well as maintain safe and clean equipment in three of four nourishment kitchenettes; and2. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another).Findings include: Review of the facility's policy titled Personal Food Policy, dated 11/2016, indicated but was not limited to the following: - Families and visitors of residents are permitted to bring food into the facility for resident use. - The staff person receiving the personal food shall label the container with the date it was brought into the facility and the name of the resident receiving it. - Dietary aides are responsible for checking nourishment refrigerators daily and discarding any unused refrigerated food after 3 days. - Frozen food should be discarded after 3 months. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: - 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under 2-301.12. (B) Except when washing fruits and vegetables as specified under 3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. - 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 1. On 1/28/26 at 10:19 A.M., the surveyor made the following observations of the Hopkins Unit nourishment kitchenette: - Brown/orange food splatter/residue was noted to the top inside portion of the microwave. - One Lean Cuisine Protein Kick Ricotta Cheese and Spinach Ravioli frozen dinner was in the freezer with a manufacturer expiration date of August 2026 but had no resident identification. On 1/28/26 at 3:56 P.M., the surveyor made the following observations of the Mayflower Unit nourishment kitchenette: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Brown/orange food splatter/residue was noted to the top inside portion of the microwave. - One 2-liter (L) bottle of Diet Coca Cola was on the door of the refrigerator, opened with no resident identification. - One 20-ounce bottle of [NAME] Dry Ginger Ale was on the door of the refrigerator with no resident identification. - A white takeaway container with illegible resident name and a date of 12/2025 containing mashed potatoes with gravy and ground meat with gravy and crust. The inside of the container was noted to have water droplets on the inside of the container. On 1/29/26 at 8:45 A.M., the surveyor made the following observations of the [NAME] Unit nourishment kitchenette: - Brown/orange food splatter/residue was noted to the top and sides of the inner portion of the microwave. The white inner plastic component of microwave was peeling with exposure of the metal components on top and bottom. - An opened Vanilla Med Pass 2.0+ Fortified Nutritional Shake was undated on the door of the refrigerator. The manufacturer label on the bottle indicated to discard four days after opening if properly refrigerated. - An opened [NAME] Spicy Chicken Broth container with no resident identification was on the top shelf of the refrigerator. The container was undated. - Two whole milk individual milk cartons with manufacturer expiration date of 1/26/26 located on the top shelf of the refrigerator. - Two whole milk individual milk cartons with manufacturer expiration date of 1/28/26 located on the top shelf of the refrigerator. - Six fat-free individual milk cartons with manufacturer expiration date of 1/28/26 located on the top shelf of the refrigerator. - Two Cosmic Stardust [NAME] Nu Energy Drink cans with no resident identification on the door of the refrigerator. - [NAME] residue observed underneath the bottom drawers of the refrigerator. Residue was sticky and had hair residue on the bottom of the refrigerator. On 1/29/26 at 10:01 A.M., the surveyor made the following observations of the Hopkins Unit nourishment kitchenette: - Brown/orange food splatter/residue was noted to the top inside portion of the microwave. - One Lean Cuisine Protein Kick Ricotta Cheese and Spinach Ravioli frozen dinner was in the freezer with a manufacturer expiration date of August 2026 but had no resident identification. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/26 at 10:08 A.M., the surveyor made the following observations of the Mayflower Unit nourishment kitchenette: - Brown/orange food splatter/residue was noted to the top inside portion of the microwave. - One 2-liter (L) bottle of Diet Coca Cola was on the door of the refrigerator, opened with no resident identification. - One 20-ounce bottle of [NAME] Dry Ginger Ale was on the door of the refrigerator with no resident identification. On 1/29/26 at 1:00 P.M., the surveyor made the following observations of the [NAME] Unit nourishment kitchenette: - Brown/orange food splatter/residue was noted to the top and sides of the inner portion of the microwave. The white inner plastic component of microwave was peeling with exposure of the metal components on top and bottom. - An opened Vanilla Med Pass 2.0+ Fortified Nutritional Shake was undated on the door of the refrigerator. The manufacturer label on the bottle indicated to discard four days after opening if properly refrigerated. - An opened [NAME] Spicy Chicken Broth container with no resident identification was on the top shelf of the refrigerator. - Two whole milk individual milk cartons with manufacturer expiration date of 1/26/26 located on the top shelf of the refrigerator. - Two whole milk individual milk cartons with manufacturer expiration date of 1/28/26 located on the top shelf of the refrigerator. - Six fat-free individual milk cartons with manufacturer expiration date of 1/28/26 located on the top shelf of the refrigerator. - Two Cosmic Stardust [NAME] Nu Energy Drink cans with no resident identification on the door of the refrigerator. - [NAME] residue observed underneath the bottom drawers of the refrigerator. Residue was sticky and had hair residue on the bottom of the refrigerator. During an interview on 1/30/26 at 9:39 A.M., the Food Service Director (FSD) said dietary staff are responsible for stocking and cleaning nourishment kitchenettes. The FSD said this includes cleaning refrigerators and microwaves, as well as disposing of any expired food products or unlabeled products. The FSD and the surveyor reviewed the observations made throughout the survey. The FSD said the [NAME] Unit microwave should be cleaned and not have plastic and/or metal exposure. The FSD said the [NAME] Unit refrigerator should be clean and free of spills and food residue. The FSD said all food and drink products should be appropriately labeled with resident identification and open dates. The FSD said expired milk products should have been removed from the refrigerators. The FSD said the Med Pass Fortified Drink is opened by nursing staff and should be dated and discarded after (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	four days by the nursing staff. During an interview on 1/30/26 at 10:12 A.M., the Administrator and the surveyor reviewed the observations of the nourishment kitchenettes. The Administrator said all food and beverage products should be appropriately labeled and dated or otherwise discarded. The Administrator said all equipment should be clean, safe and in a sanitary condition. 2. On 1/30/26 between 11:20 A.M. and 12:15 P.M., the surveyor made the following observations during the lunch line service: -11:21 A.M. the FSD washed his hands in the handwashing sink next to the food service line and dried his hands with a paper towel. -11:22 A.M. the FSD began taking temperatures of meat sauce, pasta, puree meat and gravy from the service line. The FSD wiped the thermometer down with the paper towel he used to dry his hands with after washing. - 11:26 A.M., the FSD began putting breaded fish from the oven into a pan on the service line. The FSD had a dirty/stained potholder on one hand that was observed to touch the fish as it was placed into the pan on the food service line. -11:30 A.M., the FSD began pouring broccoli into a pan on the service line. The FSD touched the broccoli with his ungloved left hand and took the temperature without cleaning the thermometer. -11:31 A.M., the FSD used his gloved hands to wipe down the counter next to the service line with the paper towel he previously used to dry his hands. The FSD threw the paper towel away but did not change his gloves or perform hand hygiene. -11:32 A.M., a dietary staff member asked the FSD for keys, the FSD placed his gloved right hand and bare left hand into his pants pocket and did not perform hand hygiene. -11:33 A.M., the FSD touched his gloved hands to his face/nose and did not perform hand hygiene or change his gloves. -11:38 A.M., the FSD checked the temperature of baked fish without cleaning the thermometer. - 11:43 A.M., the FSD checked the temperature of two soups located on the stove top. The FSD didinot clean the thermometer between checking the temperature of each soup. The FSD placed the thermometer on a tray next to the service line without cleaning it. - 11:47 A.M., the FSD took the temperature of potatoes from the oven using the thermometer without cleaning it. - 11:50 A.M., the FSD removed his gloves and put on a new pair of gloves without performing hand hygiene. - 11:52 A.M., the FSD left the service line to review a form on the table next to the service line. The FSD touched the piece of paper with his gloved hands and did not change his gloves or perform hand hygiene prior to returning to the line to plate food items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11:52 A.M., the FSD left the service line to review a form on the table next to the service line. The FSD touched the piece of paper with his gloved hands and did not change his gloves or perform hand hygiene prior to returning to the line to plate food items. -11:53 A.M., the FSD touched his gloved hands to the front of his apron without changing his gloves and continued to plate food items on the service line. -11:54 A.M., the FSD used his gloved hand to serve ready-to-eat bread to a resident's food plate. - 12:00 P.M., the FSD touched his gloved hands to the side of his apron/pants, turned to the stove to place more pasta into a pot of boiling water and then returned to the service line without changing his gloves or performing hand hygiene. - 12:05 P.M., the FSD touched his gloved hands to his face/nose and continued to plate food items on the service line without performing hand hygiene or changing his gloves. - 12:06 P.M., the FSD touched his gloved hands to his face and continued to plate food items on the service line without performing hand hygiene or changing his gloves. -12:10 P.M., the FSD left the service line and turned to the stove to stir pasta in a pot of boiling water and returned to the service line without changing his gloves or performing hand hygiene. During an interview on 1/30/26 at 2:27 P.M., the FSD said the thermometer should be cleaned using thermometer probe wipes after performing temperature checks on each food item to prevent cross contamination. The FSD said gloves should be changed when moving from one area of the kitchen to another, changing tasks, performing new tasks, or when touching clothing or aprons indirectly occurs. The FSD said he did not use a utensil to serve ready-to-eat food items, and all food items should have a serving utensil on the serving line. During an interview on 1/30/26 at 2:30 P.M., the Administrator said the thermometer should be cleaned correctly between each use with the designated cleaning wipes. The Administrator said the FSD should have changed his gloves and performed hand hygiene as needed.

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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 observation, interviews, and record review, 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 potential transmission of communicable diseases and infections for two Residents (#13, #33), out of a total of five residents. Specifically, the facility failed:1. For Resident #13, to ensure his/her indwelling Foley catheter (tube inserted into the bladder to drain urine into a collection bag outside of the body) drainage bag was maintained in a sanitary manner through implementation of infection control practices for resident care; and2. For Resident #33, to ensure his/her indwelling Foley catheter drainage bag was maintained in a sanitary manner. Findings Include:Review of the Centers for Disease Control and Prevention (CDC) Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated 2009, updated 6/6/19, page 13, section III, Proper Techniques for Urinary Catheter Maintenance, indicated but was not limited to the following criteria: - Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. 1. Resident #13 was admitted to the facility in October 2022. In October 2025, he/she had new diagnoses including urinary retention (bladder does not empty completely during urination) and urinary tract infection. Review of the Minimum Data Set (MDS) assessment, dated 10/3/25, indicated Resident #13 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15. Further review of MDS assessments indicated a significant change assessment was completed on 11/14/25 for new diagnoses of urinary tract infection, urinary retention, and indwelling Foley catheter use. Review of Resident #13's Physician's Orders indicated but was not limited to: -Foley catheter care every shift and at night [PM] (12/1/25) -Enhanced Barrier Precautions (prevent spread of infection) for Foley catheter (11/18/25) -May have indwelling catheter in place until follow up urology appt (10/31/25) -Insert Foley catheter #16 French with 10milliliter (ml) balloon (10/30/25) -Call physician if Foley catheter does not drain after replacement (10/29/25) -Irrigate Foley catheter as needed with 30 mL normal saline if not draining as needed (10/29/25) -Replace Foley bag monthly the 29th every month (10/29/25) -Replace Foley catheter as needed if still not draining after irrigation (10/29/25) On 1/27/26 at 10:23 A.M., the surveyor observed Resident #13 holding his/her Foley catheter by the drainage bag in their hand while walking down the hallway with no protective barrier. On 1/27/26 at 10:35 A.M., the surveyor observed Resident #13 sitting on his/her bed. The indwelling (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Foley catheter bag was not secured to the bedframe, and the bag was lying directly on the floor with no protective barrier. On 1/27/26 at 10:38 A.M., the surveyor observed Resident #13 stand up from his/her bed holding the indwelling Foley catheter by the side of the bag allowing urine to flow back up the urinary collection tube. Resident #13 then sat back on his/her bed placing the indwelling Foley catheter back onto the floor with no protective barrier in place. On 1/29/26 at 8:28 A.M., the surveyor observed Resident #13 lying in bed with the indwelling Foley catheter bag in front of the bedside table on the floor with no protective barrier in place. On 1/29/26 at 9:06A.M., the surveyor observed Resident #13 lying in bed watching television. The indwelling Foley catheter bag was not secured to the bedframe, and the bag was lying directly on the floor with no protective barrier. On 01/30/26 at 7:54 A.M., the surveyor observed Resident #13 holding the indwelling Foley catheter bag by the urinary drainage tube at the top of the bag while walking to the bathroom. During an interview on 1/29/26 at 9:07 A.M., Nurse #3 said sometimes Resident #13 puts the indwelling Foley catheter on the bedside table or floor and when he/she walks around they pick up the indwelling Foley catheter bag and carry it. The surveyor, accompanied by Nurse #3, observed Resident #13 lying in bed with the indwelling Foley catheter on the floor next to the Resident's bed with no protective barrier. During an interview on 1/29/26 at 9:28 A.M. Certified Nursing Assistant (CNA) #6 said Resident #13 handles his/her indwelling Foley catheter and he/she picks the catheter up and puts it down on their own. During an interview on 1/30/26 at 2:54 P.M., Unit Manager (UM) #2 said Resident #13 requires constant reminding to keep the indwelling Foley catheter off the floor. UM #2 said the indwelling Foley catheter should not be on the floor, a table, or on the Resident's lap to prevent infection. During an interview on 1/30/26 at 3:15 P.M., the Infection Control Nurse said indwelling Foley catheter bags should not be on the floor at any time. During an interview on 2/2/26 at 8:53 A.M., the Director of Nursing (DON) said indwelling Foley catheter bags should not be on the floor or a table, the indwelling Foley catheter bag should be below the level of the bladder and secured properly to the bed frame or Resident should use a secured leg bag if tolerated. 2. Resident #33 was admitted to the facility in June 2025 and had diagnoses including urinary retention (bladder does not empty completely or at all when urinating). Review of the MDS assessment, dated 12/12/25, indicated Resident #33 was cognitively intact as evidenced by a BIMS score of 15 out of 15 and had an indwelling urinary catheter. Review of Physician's Orders indicated but was not limited to: -Foley catheter size #16 French with 10 milliliter (ml) balloon (6/27/25) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Catheter to bedside drainage bag while in bed every shift (6/27/25) -Flush Foley catheter with 30 ml normal saline as needed and every shift (9/20/25) -Provide Foley catheter care every shift (6/13/25) -May use leg bag (6/13/25) -Replace Foley bag monthly the 28th of every month (8/4/25) On 1/27/26 at 9:20 A.M., the surveyor observed Resident #33 sitting upright in bed watching television. The indwelling Foley catheter tube was not secured to the bedframe, and the bag was lying directly on the floor with no protective barrier. On 1/28/26 at 10:10 A.M., the surveyor observed Resident #33 being pushed in his/her wheelchair down the hallway. The Foley catheter bag was clearly visible hanging underneath the wheelchair and dragging on the floor with no protective barrier. On 1/28/26 at 10:50 A.M., the surveyor observed Resident #33 sitting in a wheelchair at the bedside. The indwelling Foley catheter bag was hanging down from the wheelchair and lying directly on the floor with no protective barrier. On 1/28/26 at 1:49 P.M., the surveyor observed Resident #33 sitting in a wheelchair in his/her room watching television. The indwelling Foley catheter bag was hanging down from the wheelchair and lying directly on the floor with no protective barrier. During an interview on 1/29/26 at 2:55 P.M., Nurse #7 said Resident #33's catheter bag should have been secured to the bedframe or wheelchair and not lying on the floor. During an interview on 2/2/26 at 12:04 P.M., the DON said Resident #33's catheter bag is supposed to be secured and not allowed to lie directly on the floor.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interviews, the facility failed to ensure residents and/or staff properly disposed of cigarette butts in designated smoking receptacles. Findings include:Review of the Centers for Medicare & Medicaid Services (CMS) circular letter, dated November 10, 2011, titled Smoking Safety in Long Term Care Facilities indicated but was not limited to the following:-The Life Safety Code (NFPA 101, 2000 ed., 19.7.4) requires each smoking area be provided with ashtrays made of noncombustible material and safe design.-Metal containers with self-closing covers into which ashtrays can be emptied must be readily available.Review of the facility's policy titled Smoking, dated revised November 2020, indicated but was not limited to:-Purpose to afford residents the privilege of smoking while maintaining a safe and clean environment within the policy of this facility, that is also respectful to the non-smoker.On 1/28/26 at 6:55 A.M., the surveyor observed the temporary designated smoking area and identified a tall black receptacle for cigarette butts with numerous cigarette butts scattered across the pavement. The surveyor also observed cigarette butts protruding from the adjacent snowbank. Seven chairs were positioned along the outer perimeter of the smoking area, each with several cigarette butts accumulated underneath.On 1/28/26 at 5:03 P.M., the surveyor conducted a subsequent observation of the designated smoking area and identified the same conditions.On 1/30/26 at 6:56 A.M., the surveyor observed the designated smoking area and identified numerous cigarette butts scattered across the pavement.During an interview on 1/30/26 at 7:59 A.M., Certified Nursing Assistant (CNA) #2 said the smoking assistant would clean the area after each smoke but we do not have one now. CNA #2 said sometimes the maintenance staff would clean up the area. CNA #2 said she would ask the residents to use the black ash can for their cigarettes after they are finished smoking, but they often would just throw them on the ground. CNA #2 said she was not assigned to clean up the area. During an interview on 1/30/26 at 12:13 P.M., the Maintenance Director said the smoking attendant would clean the area, but we have been without one for three weeks. The Maintenance Director said he did not have a cleaning schedule, or anyone assigned to maintain the area in the absence of the smoking attendant. On 2/2/26 at 9:14 A.M., the surveyor and CNA #2 observed the smoking area and noted several cigarette butts littered on the ground. There was also a snow-covered table with a few cigarette butts embedded in the snow.During an interview on 2/2/26 at 2:05 P.M., the Administrator said the usual smoking area was located in the rear of the building but had been moved to the front temporarily due to snow. The Administrator said maintenance and housekeeping would usually maintain the area. The smoking attendants would also empty ashtrays and clean up the area, but they were down a full-time smoking attendant right now. The Administrator said she was not sure why the area had not been maintained.