STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225208	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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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 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 observation, interview, and record review, the facility failed to ensure the physician was notified of changes to a wound for one Resident (#27), out of a total sample of 19 residents. Specifically, for Resident #27, the facility failed to notify the physician of changes to a wound on the right lower extremity from a superficial wound (minor injury that affects only the outermost layer of skin) to a wound with slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) in the wound bed. Findings include: Review of the facility's policy titled Wound Care, dated October 2010, indicated the following was to be documented in the medical record during wound care treatments: all assessment data including wound bed color, size, drainage obtained when inspecting the wound; if the resident refused the treatment and the reasons why. Resident #27 was admitted to the facility in April 2025 with diagnoses of diabetes, a history of a left transmetatarsal amputation (TMA- a surgical procedure where the forefoot (including the toes and part of the foot bones is removed to preserve the remaining part of the foot and ankle), and history of right foot first, second and third toe amputations. Review of the Minimum Data Set (MDS) assessment, dated 5/13/25, indicated Resident #27 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Review of the medical record indicated Resident #27 was admitted with multiple wounds to the bilateral lower extremities including pressure ulcers to the bilateral heels, vascular wounds to the top of the right foot, and scattered open areas to the lower portions of the lower extremities. Review of the re-admission hospital paperwork, dated 5/25/25, indicated Resident #27 had bilateral shin wounds with a treatment of a wet to dry dressing (type of wound dressing where moist gauze is applied to a wound and allowed to dry, creating a mechanical debridement (removing dead tissue and debris). The discharge summary indicated the right anterior lower tibial wound bed was red, fragile, pink with a pink peri-wound on 5/25/25. Review of the May 2025 Treatment Administration Record (TAR) indicated the same treatment order from prior to the hospitalization of wound care: right leg and heel superficial wounds, normal saline cleanse and bacitracin with Mepore dressing was re-instated on 5/26/25. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's document, Admission/readmission assessment, dated 5/25/25, indicated Resident #27 had a superficial wound to the right lower leg. The comment section on the assessment indicated the bilateral shins were to be cleansed with normal saline, apply gauze dressing daily. There was no indication the treatment was now a wet to dry dressing as indicated in the hospital discharge summary. On 5/30/25 at 10:40 A.M., the Director of Nurses (DON), the facility Wound Nurse and the surveyor observed the lower extremity wounds of Resident #27. After removing the gauze, a Mepore dressing was observed on the right lower lateral leg. The DON removed the adhesive bandage and said the wound bed was 100% slough. During an interview on 5/30/25 at 11:45 A.M., Nurse #4 said she had been the nurse providing care to Resident #27 on 5/29/25. She said on 5/29/25 she put bacitracin and the Mepore dressing on the wound to the right lower leg. She said the wound was not superficial and had slough on 5/29/25. She said she could not be sure if the wound had changed. She said she had not documented that the wound had slough on 5/29/25 and had not notified anyone. Review of the Interim Skin Assessment completed 5/30/25 indicated Resident #27 had a vascular wound to the right lower leg with 100% slough measuring 4.7 centimeters (cm) in length by 2.5 cm in width by 0.3 cm in depth. During an interview on 5/30/25 at 12:50 P.M., the Physician said she was aware Resident #27 had wounds to the bilateral lower extremities. She said she was not notified of changes to the wound on the right lower leg and was unaware the wound had slough. During an interview on 5/30/25 at 1:30 P.M., the DON said the physician had not been notified of changes until the wound was observed on 5/30/25 with the surveyor. Refer to F684

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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 interview, the facility failed to ensure nursing staff provided the resident and/or representative with a summary of the baseline care plan for one Resident (#126), out of a total sample of 19 residents. Findings include: Resident #126 was admitted to the facility in May 2025 with diagnoses including interstitial pulmonary disease, chronic respiratory failure with hypoxia, chronic respiratory with hypercapnia and neurocognitive disorder with Lewy Bodies. Review of the medical record failed to indicate the Resident and/or representative were provided with a written summary of his/her baseline care plan within 48 hours of admission which included initial goals for the resident, current medications and dietary instructions, and services and treatments to be administered by the facility and personnel acting on behalf of the facility. During an interview on 5/28/25 at 10:42 A.M., Resident #126 said they had not had a care plan meeting yet and he/she'd been at the facility a few weeks. Resident #126 said he/she was their own person, and the facility did not review or provide a summary of a baseline care plan to him/her within 48 hours of admission. During an interview on 5/29/25 at 11:30 A.M., Nurse #2 said the baseline care plan was not developed within 48 hours of admission. During an interview on 5/30/25 at 12:13 P.M., the Administrator said during the morning meeting new admissions are discussed, and it is a team effort to gather the information to complete the baseline care plan within 48 hours. She said the team should have completed the baseline care plan and a summary of it should have been provided to the Resident and/or representative.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop, implement and individualize a comprehensive care plan for one Resident (#58), out of a total sample of 19 residents. Specifically, the facility failed to ensure a comprehensive care was developed and implemented related to Resident #58's smoking status and preferences. Findings include: Review of the facility's policy titled Smoking Policy - Residents, dated 2024, indicated but was not limited to the following: - The facility shall establish and maintain safe resident smoking practices. - A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. - Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated March 2022, indicated but was not limited to: - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. - The interdisciplinary team reviews and updates the care plan: (d) at least quarterly, in conjunction with the required quarterly MDS (Minimum Data Set) assessment. Resident #58 was admitted to the facility in April 2023 with diagnoses including quadriplegia and muscle weakness. Review of Resident #58's Minimum Data Set (MDS) assessment, dated 4/11/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Furthermore, the MDS indicated Resident #58 required assistance from staff for activities of daily living and currently used tobacco. Review of the list of smokers provided by the facility upon entrance indicated Resident #58 was a smoker residing in the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #58's Nursing Assessment, dated 4/9/25, indicated but was not limited to the following: - Resident requires a smoking apron. - Resident requires one to one assistance when smoking. - Resident smokes one to two times per day in evening. - Resident requires a staff person or family member present while utilizing the e-cigarette, vapor or any nicotine related device. Review of Resident #58's comprehensive care plans failed to indicate a smoking care plan was developed or implemented. During an interview on 5/29/25 at 2:42 P.M., Nurse #4 said she was uncertain of Resident #58's smoking status. Nurse #4 initially checked the electronic medical record to determine Resident #58's smoking status, but said she would have to check with the Certified Nursing Assistants (CNA). After discussion with a CNA, Nurse #4 said Resident #58 does smoke but mostly goes out in the evening with family. Nurse #4 said Resident #58 needs assistance with smoking tasks and family and/or staff would assist as needed. Nurse #4 said Resident #58's smoking preferences and needs should be identified in a care plan. Nurse #4 said she was unsure if a smoking care plan had been developed for Resident #58. Nurse #4 said any nurse or supervisor can update a care plan to reflect a resident's status, needs or preferences. During an interview on 5/29/25 at 3:47 P.M., the Director of Nursing (DON) said any resident in the facility who smokes should have a care plan developed and implemented related to his/her smoking status. The DON said she would expect any preference, assistance level and/or protective devices required during smoking to be listed in a resident's care plan. The DON said Resident #58 should have a care plan related to smoking.

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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. Based on interview and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for two Residents (#38, #19), out of a total sample of 19 residents. Specifically, the facility failed, for Residents #38 and #19, to ensure pain medication was administered in accordance with the pain scale indicated in the Physician's order. Findings include: Review of the facility's policy titled Administering Medications, revised April 2019, indicated but was not limited to: - Medications are administered in a safe and timely manner, and as prescribed. - Medications are administered in accordance with prescriber orders, including any required time frame. Standard of Practice Reference: 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. A nurse licensed by the Board shall not administer any prescription drug or non-prescription drug to any person in the course of nursing practice except as directed by an authorized prescriber. A nurse licensed by the Board shall document the handling, administration, and destruction of controlled substances in accordance with all federal and state laws and regulations and in a manner consistent with accepted standards of practice. 1. Resident #38 was admitted to the facility in September 2021 with diagnoses including osteoporosis and muscle weakness. Review of Resident #38's Minimum Data Set (MDS) assessment, dated 4/23/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Furthermore, the MDS assessment indicated Resident #38 had occasional pain, as well as received scheduled and as needed (PRN) pain medication. Review of Resident #38's Physician's Orders indicated but were not limited to: - 2/26/25: Oxycodone HCl (hydrochloride) (narcotic pain medication) Oral Tablet 5 MG (milligrams); give one tablet by mouth every eight hours as needed for pain 4-6. Review of Resident #38's Medication Administration Record (MAR) for March 2025 indicated but was not limited to the following: - Oxycodone 5 MG Tablet was given 15 times for a pain level score of less than four. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #38's MAR for April 2025 indicated but was not limited to the following: - Oxycodone 5 MG Tablet was given eight times for a pain score of less than four. Review of Resident #38's MAR for May 2025 indicated but was not limited to the following: - Oxycodone 5 MG Tablet was given 17 times for a pain score of less than four. Further review of Resident #38's medical record failed to indicate nursing documentation related to the reason for medication administration for pain scale rating of less than four. During an interview on 5/29/25 at 2:45 P.M., Nurse #1 said Resident #38's PRN Oxycodone order is written so he/she will receive the medication when they report a pain scale between 4 to 6 out of 10. Nurse #1 said based on how the order is written the pain medication was administered outside of physician's orders when given for a pain scale rating of less than 4 out of 10. 2. Resident #19 was admitted to the facility in October 2024 with diagnoses including: spinal stenosis (narrowing of the spaces inside the spine) and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Review of the MDS assessment, dated 5/8/25, indicated the Resident was taking opioid (narcotic) pain medication and was cognitively intact with a BIMS score of 15 out of 15. Review of the Physician's Orders for Resident #19 indicated but were not limited to the following: -2/26/25: Tylenol tablet 325 MG, give two tablets (650 MG) by mouth every 12 hours as needed (PRN) for pain scale of 1-3. -2/26/25: Oxycodone 5 MG, give one tablet (5 MG) as needed (PRN) every six hours (Q6H) for pain scale of 3-6. During an interview on 5/28/25 at 11:09 A.M., Resident #19 said he/she asks for pain medication sometimes to manage breakthrough back pain. Resident #19 said when he/she requests the medication, the staff does not ask his/her pain level. Resident #19 said the nurse provides him/her with Oxycodone when he/she says they have pain. The nurses have never offered him/her Tylenol for pain. Review of the Numeric Pain Rating Scale indicated the following: - Rating of 0 indicates (=) no pain - Rating of 1-3 = mild pain, often described as annoying or distracting, but not significantly impacting daily activities. - Rating of 4-6 = moderate pain, which can interfere with daily activities and require some effort to manage. - Rating of 7-10 = severe pain, which significantly limits daily activities and can be debilitating (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MAR for both April 2025 and May 1st -29th, 2025 indicated, but was not limited to the following for Resident #6: April 2025: - Tylenol tablet 325 MG, give two tablets (650 MG) by mouth every 12 hours PRN, for pain scale of 1-3. > Not administered - Oxycodone 5 MG tablet (5 MG) Q6H PRN for pain (rating of 3 - 6) was administered outside of the ordered parameters 5 out of 9 times it was provided: > Twice for a rating of 0, > Once for a rating of 7, > Twice for a rating of 8. May 2025: - Tylenol tablet 325 MG, give two tablets (650 MG) by mouth every 12 hours PRN, for pain scale of 1-3. > Not administered - Oxycodone 5 MG one-tab Q6H PRN for pain (rating 3-6) was administered outside of the ordered parameters 13 of the 28 times it was provided. > Four for a rating of 0, > Four for a rating of 2, > Three for a rating of 7, > Once for a rating of 8, > Once for a rating of 10. During an interview on 5/29/25 at 3:42 P.M., Nurse #6 said when a resident requests PRN pain medication she asks them about their pain on a scale of 0-10. She said she administers the medication based on the pain scale the physician ordered. Nurse #6 said after the pain medication is administered, she follows up with the resident to ensure it was effective. Nurse #6 reviewed the April and May 2025 MAR for Resident #19 and said the pain medication was given outside of the physician's order, and it should not have been. She said when the pain scale is in between 1-3 Tylenol should have been administered, not Oxycodone. (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 5/29/25 at 3:55 P.M., the Director of Nursing (DON) said as needed pain medications generally have a pain scale attached to them for medication administration. The DON said nurses should follow physician's orders when administering medications. The DON said pain medication should only be administered within the prescribed pain scale rating attached to the order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record review, the facility failed to ensure activity of daily living (ADL) care was provided to maintain good personal grooming for one Resident (#66), out of a total sample of 19 residents. Specifically, the facility failed to ensure nail care was performed for Resident #66. Findings include: Review of the facility's policy titled Fingernails/Toenails, Care of, revised February 2018, indicated but was not limited to: - The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection. - Nail care includes daily cleaning and regular trimming. - If the resident refused the treatment, the reason(s) why and the intervention taken. - Notify the supervisor if the resident refuses the care. - Report other information in accordance with facility policy and professional standards of practice. Resident #66 was admitted to the facility in June 2024 with diagnoses including osteoarthritis and depression. Review of Resident #66's Minimum Data Set (MDS) assessment, dated 3/28/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Furthermore, the MDS assessment indicated Resident #66 was dependent for ADLs and mobility. During an interview with observation on 5/27/25 at 9:55 A.M., Resident #66 said their nails were long and he/she prefers them to be shorter. Resident #66 said staff do not ask him/her if they would like nail care to be performed. Resident #66 was observed by the surveyor to have long, jagged fingernails on both hands with a brown/red substance noted on the top and underneath his/her fingernails. During the following days and times, the surveyor made the following observations: - 5/28/25 at 10:06 A.M. and 12:35 P.M.: nails were long and jagged with a brown/red substance noted on the top and underneath his/her fingernails. - 5/29/25 at 9:55 P.M.: nails were long and jagged with a brown/red substance noted on the top and underneath his/her fingernails. Review of Resident #66's ADL self-care comprehensive care plan indicated but was not limited to the following: - The Resident has an ADL self-care performance deficit related to deconditioning, Parkinsonism. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Intervention: Check nail length and trim and clean on bath day and as necessary; report any changes to the nurse. (revised 6/20/24) Review of Resident #66's Certified Nursing Assistant (CNA) Kardex for bathing indicated to check nail length and trim and clean on bath day and as necessary. The CNA Kardex for bathing also indicated to report any changes to the nurse. Review of Resident #66's nursing progress notes failed to indicate he/she had refused nail care by staff. During an interview on 5/29/25 at 8:38 A.M., CNA #1 said nail care is performed on bath days for all residents in the building. CNA #1 said if a resident was noted to have longer or dirty nails they would be cared for before their next shower day. During an interview on 5/29/25 at 9:55 A.M., Resident #66 said no one has cared for his/her nails since he/she last spoke with the surveyor. Resident #66 said he/she did not know when his/her last shower was or what day he/she was assigned to have a shower. During an interview on 5/29/25 at 11:41 A.M., Nurse #2 said nail care can be done at any time when staff notice nails are long or dirty. Nurse #2 said some residents do not like their nail care to be completed. Nurse #2 was unsure where it would be documented if residents refused nail care. During an interview on 5/29/25 at 12:08 P.M., the Director of Nursing (DON) said her expectation was for nail care, including trimming and cleaning, to be a part of daily ADL care. The DON said a CNA should notify the nurse or supervisors if a resident is refusing or combative with ADL care, including nail care. The DON said nail care should be completed, and it should be documented in the medical record when it is not done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure one Resident (#27) received treatment of a wound in accordance with professional standards for quality care, out of a total sample of 19 residents. Specifically, for Resident #27, the facility failed to provide wound treatments as ordered and failed to assess (including wound description, shape, measurements and condition) a wound to the right lower extremity for changes and identify that the wound changed from a superficial wound (minor injury that affects only the outermost layer of skin) to a wound with slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) in the wound bed. Findings include: Review of the facility's policy titled Wound Care, dated October 2010, indicated the following was to be documented in the medical record during wound care treatments: all assessment data including wound bed color, size, drainage obtained when inspecting the wound; if the resident refused the treatment and the reasons why. Review of the facility's policy titled Medication Orders, dated November 2014, indicated when recording treatment orders to specify the treatment, frequency, and duration of the treatment. Resident #27 was admitted to the facility in April 2025 with diagnoses of diabetes, a history of a left transmetatarsal amputation (TMA- a surgical procedure where the forefoot (including the toes and part of the foot bones are removed to preserve the remaining part of the foot and ankle), and history of right foot first, second and third toe amputations. Review of the Minimum Data Set (MDS) assessment, dated 5/13/25, indicated Resident #27 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Review of the medical record indicated Resident #27 was admitted with multiple wounds to the bilateral lower extremities including pressure ulcers to the bilateral heels, vascular wounds to the top of the right foot, and scattered open areas to the lower portions of the lower extremities. Review of the care plans indicated Resident #27 had open areas to the bilateral lower extremities with a goal of healing. The interventions included encouraging good nutrition, identifying and eliminating causes, following facility protocol for skin tears, inform staff of causes to prevent skin tears, to keep skin clean and dry and apply lotion to dry, scaly skin. Review of the original admission hospital paperwork from April 2025 indicated Resident #27 had dry/flaky/scaling skin to the bilateral lower extremities with daily dressing changes on the legs. No further information was provided in the hospital discharge summary. Review of the Weekly Skin Check nursing assessment, dated 4/28/25, indicated Resident #27 had an area to the rear of the right lower leg, no additional information was provided (type of wound, description, size, drainage). Review of the medical record indicated Resident #27 was sent to the hospital in May 2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the re-admission hospital paperwork, dated 5/7/25, indicated Resident #27 had a wound on the right leg at the pretibial (area towards the front of the lower leg), distal (closer to the ankle), lateral (closer to the outside of the leg, away from the midline) which was present on admission to the hospital. No additional information was provided in the hospital discharge summary regarding this wound. Review of the facility's document, Admission/readmission assessment, dated 5/7/25, failed to indicate there was a wound to the right lower leg, as indicated in the hospital discharge summary. Review of the May 2025 Treatment Administration Record (TAR) included an order, dated 4/27/25, for wound care: right leg and heel superficial wounds, normal saline cleanse and bacitracin (topical ointment to prevent skin infections from minor cuts and scrapes) with Mepore dressing (an adhesive absorbent dressing intended for treating lightly to moderately exuding wounds such as surgical wounds, cuts and abrasions) daily. Although the Resident was in the facility, the TAR did not indicate the treatment was provided on 5/1/25, 5/8/25, 5/11/25, and 5/15/25. Review of the nursing progress notes failed to indicate the wound treatments to the right lower leg were provided on 5/1/25, 5/8/25, 5/11/25 or 5/15/25. During an interview on 5/29/25 at 4:06 P.M., Resident #27 said the staff did not provide the dressing changes to his/her lower legs every day. Review of the nursing progress notes failed to indicate Resident #27 had ever refused wound treatments or any other care. Review of the medical record indicated Resident #27 was sent to the hospital a second time in May 2025. Review of the re-admission hospital paperwork, dated 5/25/25, indicated Resident #27 had bilateral shin wounds with a treatment of a wet to dry dressing (type of wound dressing where moist gauze is applied to a wound and allowed to dry, creating a mechanical debridement (removing dead tissue and debris). The discharge summary indicated the right anterior lower tibial wound bed was red, fragile, pink with a pink peri-wound on 5/25/25. Review of the May 2025 TAR indicated the previous treatment order of wound care: right leg and heel superficial wounds, normal saline cleanse and bacitracin with Mepore dressing was re-instated on 5/26/25. The TAR and nursing progress notes failed to indicate the ordered wound treatment was provided on 5/26/25. Review of the facility's document, nursing Admission/readmission assessment, dated 5/25/25, completed by Nurse #4 indicated Resident #27 had a superficial wound to the right lower leg. The comment section on the assessment indicated the bilateral shins were to be cleansed with normal saline, apply gauze dressing daily. There was no indication the treatment was now a wet to dry dressing, as indicated in the hospital discharge summary. Review of the medical record from admission through 5/29/25 including nursing progress notes, nursing assessments, physician progress notes failed to include descriptions or measurements of the wound on the right lower leg in order to monitor for any changes to the wound. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/25 at 9:30 A.M., the Director of Nurses (DON) said the nurses should be documenting wound descriptions including the wound bed and drainage. She said the treatment order should not be clustered together to cover multiple wounds on a leg and each wound should have a separate treatment. She said, as far as she knew, Resident #27 had never refused treatment or care. On 5/30/25 at 10:40 A.M., the DON, the facility Wound Nurse, and the surveyor observed the lower extremity wounds of Resident #27. The bilateral lower portion of the legs were wrapped in gauze from the feet up towards the knees. After removing the gauze, a Mepore dressing was observed on the right lower lateral leg. The DON removed the adhesive bandage and said the wound bed was 100% slough. During an interview on 5/30/25 at 11:45 A.M., Nurse #4 said she had been the nurse providing care to Resident #27 on 5/29/25. She said on 5/29/25 she put bacitracin and the Mepore dressing on the wound to the right lower leg. She said the wound was not superficial and had slough on 5/29/25. She said she could not be sure if the wound had changed. She said she had not documented that the wound had slough on 5/29/25 and had not notified anyone. Review of the Interim Skin Assessment completed 5/30/25 indicated Resident #27 had a vascular wound to the right lower leg with 100% slough measuring 4.7 centimeters (cm) in length by 2.5 cm in width by 0.3 cm in depth. During an interview on 5/30/25 at 1:30 P.M., the DON said the wound bed was covered in slough and she could not be sure, based on the medical record, what the wound had looked like prior to this day.

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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 observation, interview, and record review, the facility failed to ensure one Resident (#27) received treatment to pressure areas on the bilateral heels in accordance with professional standards to promote healing, out of a total sample of 19 residents. Specifically, for Resident #27, the facility failed to assess (including wound description, shape, measurements and condition), document and provide treatments as indicated to pressure ulcers on the bilateral heels. Findings include: Review of the facility's policy titled Wound Care, dated October 2010, indicated the following was to be documented in the medical record during wound care treatments: all assessment data including wound bed color, size, drainage obtained when inspecting the wound; if the resident refused the treatment and the reasons why. Review of the facility's policy titled Prevention of Pressure Injuries, dated April 2020, indicated the following: -conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors -during skin assessment, inspect: presence of erythema (redness); temperature of skin and soft tissue; and edema -inspect the skin on a daily basis when performing or assisting with personal care -evaluate, report and document potential changes in the skin -review the interventions and strategies for effectiveness on an ongoing basis Resident #27 was admitted to the facility in April 2025 with a diagnoses of diabetes, a stage 4 (full-thickness skin and tissue loss) pressure ulcer to the sacrum (base of spine), a history of a left transmetatarsal amputation (TMA- a surgical procedure where the forefoot (including the toes and part of the foot bones is removed to preserve the remaining part of the foot and ankle), and history of right foot first, second and third toe amputations. Review of the Minimum Data Set (MDS) assessment, dated 5/13/25, indicated Resident #27 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Review of the medical record indicated Resident #27 was admitted to the facility following a two-month hospital stay for a stage 4 pressure ulcer on the sacrum and had multiple wounds to the bilateral lower extremities including pressure ulcers to the bilateral heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plans indicated Resident #27 had a pressure ulcer to the sacrum and heel and potential for pressure ulcer development related to limited mobility, initiated on 4/29/25. The goal was for the pressure ulcer to show signs of healing and remain free from infection with interventions of: weekly skin checks by licensed nurse, monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs or symptoms of infection; weekly treatment documentation to include measurement of each area of skin breakdown (width, length, depth, type of tissue and drainage); administer treatments as ordered and monitor for effectiveness. Review of the original admission hospital paperwork from April 2025 indicated Resident #27 had a pressure ulcer on the right heel since 2/25/25 and a pressure ulcer to the left heel since 4/2/25. The hospital summary indicated the left heel pressure ulcer wound bed was black with serosanguineous drainage (combination of blood and serous fluid, appearing as a light pink to red color). No further information was provided in the hospital discharge summary regarding the right heel pressure ulcer or treatments to either heel pressure ulcer. Review of the facility's document, Admission/readmission skin assessment, dated 4/27/25, indicated there was a pressure ulcer to the left heel and to the right heel. There was no additional information provided for either pressure ulcer including but not limited to the stage, measurement, description, or treatment. Review of the nursing admission progress note indicated aside from the wound on the sacrum, Resident #27 had four superficial wounds on the left leg, calf, ankle and heel and two superficial wounds on the right leg and heel. Review of the May 2025 Treatment Administration Record (TAR) included the following orders, dated 4/27/25, for wound care: -right leg and heel superficial wounds, normal saline cleanse and bacitracin (topical ointment to prevent skin infections from minor cuts and scrapes) with Mepore dressing daily (an adhesive absorbent dressing intended for treating lightly to moderately exuding wounds such as surgical wounds, cuts and abrasions.) -left leg, calf, shin, ankle and heel superficial wounds, normal saline cleanse and bacitracin with Mepore dressing daily. Review of the medical record indicated Resident #27 was sent to the hospital in May 2025. Review of the re-admission hospital paperwork, dated 5/7/25, indicated during the hospital admission Resident #27 had debridement (removal of dead tissue) of the necrotic (dead) tissue to the bilateral heel pressure ulcers and the pressure ulcers were unstageable likely stage 4 with plaques of adherent eschar (dead or devitalized tissue that is hard or soft in texture) and purulent drainage (a thick, milky, and often yellowish or greenish fluid). The discharge summary indicated to cover areas of the feet with Mepilex Border (an adhesive absorbent dressing intended to treat high exuding wounds) for protection or leave open to air and paint with Betadine solution to stabilize/dry the plaques of eschar daily. The hospital recommended a follow up with a podiatrist for further debridement. Review of the medical record, including the Resident Appointment Calendar, on 5/30/25 failed to indicate Resident #27 had an appointment scheduled with the podiatrist, 23 days after readmission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/30/25 at 1:55 P.M., the Director of Nurses (DON) said Resident #27 did not have a scheduled appointment with the podiatrist at this time. Review of the facility's document, Admission/readmission skin assessment, dated 5/7/25 (signed as completed on 5/11/25 by Nurse #5), indicated Resident #27 had a pressure ulcer on the right heel and a pressure ulcer on the left heel. There was no additional information provided for either pressure ulcer including but not limited to the stage, measurement, description, or treatment. Review of the medical record from admission through review on 5/29/25 including nursing progress notes, nursing assessments and physician progress notes failed to include descriptions or measurements or changes to treatments of either pressure ulcer on the heels. Review of the Wound Evaluation and Management Summary dated 5/13/25 from the wound physician consultant failed to indicate the pressure ulcers on the bilateral heels were reviewed by the physician. During an interview on 5/30/25 at 9:26 A.M., the wound physician consultant said he had seen Resident #27 one time on 5/13/25. He said, If Resident #27 had pressure ulcers to the bilateral heels, I did not see them. Review of the medical record indicated Resident #27 was sent to the hospital a second time in May 2025. Review of the re-admission hospital paperwork, dated 5/25/25, indicated Resident #27 had pressure ulcers to the bilateral heels and the left heel pressure ulcer was surgically debrided during the admission with the following treatments: -Left heel: cleanse with normal saline, wet to dry dressing (type of wound dressing where moist gauze is applied to a wound and allowed to dry, creating a mechanical debridement) daily -Right heel: cleans with normal saline, apply Santyl (an ointment for chemical debridement) then dry sterile dressing Review of the facility's document, Admission/readmission assessment, dated 5/25/25, completed by Nurse #4 indicated Resident #27 had a left heel superficial wound and a right heel with a necrotic pressure ulcer. The comment section on the assessment indicated the left heel was to be cleansed with normal saline, apply gauze dressing daily and the right heel wound with necrotic skin was to be cleansed with normal saline, apply Santyl and cover with dry sterile dressing. The comment section failed to indicate the treatment of a wet to dry dressing to the left heel as indicated in the hospital discharge summary. Review of the May 2025 TAR indicated the previous treatment orders for wound care were reinstated on 5/26/25: -left leg, calf, shin, ankle and heel superficial wounds, normal saline cleanse and bacitracin with Mepore dressing daily -right leg and heel superficial wounds, normal saline cleanse and bacitracin with Mepore dressing (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record on 5/30/25 failed to indicate either treatment had been updated to reflect the treatments for the pressure ulcers of the left heel of a wet to dry dressing or the right heel for Santyl, as indicated in the hospital discharge summary. Review of the Weekly Skin Check, dated 5/25/25, completed by Nurse #5, indicted Resident #27 had wounds to the right and left heel, no additional information was provided regarding wound descriptions, measurements or treatments. During an interview on 5/30/25 at 9:30 A.M., the DON said the nurses should be documenting wound descriptions including the wound bed and drainage. She said the treatment order should not be clustered together to cover multiple wounds on a leg and each wound should have a separate treatment. She said, as far as she knew, Resident #27 had never refused treatment or care. On 5/30/25 at 10:40 A.M., the DON, the facility Wound Nurse, and the surveyor observed the lower extremity wounds of Resident #27. The bilateral lower portion of the legs were wrapped in Kerlix (gauze) from the feet up towards the knees. After removing the Kerlix, the surveyor observed the DON remove a square non-adhesive pad from the wound bed of the left heel. She said the left heel pressure ulcer measured 3 cm in length by 2.5 cm in width by 0.5 cm in depth, was a stage 3 (full-thickness loss of skin) pressure ulcer with 5% slough. The DON then removed a square non-adhesive pad, which was sticking to the eschar in the right heel and said the wound bed was necrotic. The Wound Nurse said the right heel pressure ulcer measured 3. 3 cm in length by 1.3 cm in width by 0.1 cm in depth but was unstageable due to the necrotic tissue. During an interview at this time, the Wound Nurse and the DON said neither of them had previously seen Resident #27's bilateral heel pressure ulcers and had only seen the sacral wound. During an interview on 5/30/25 at 11:45 A.M., Nurse #4 said she had been the nurse providing care to Resident #27 on 5/29/25. She said on 5/29/25 both pressure ulcers to the heels had serosanguineous drainage so she applied the bacitracin and then put an ABD (abdominal- a medical pad used to absorb fluids and protect wounds) over the wound beds because of the depth of the wounds and the drainage. During an interview on 5/30/25 at 12:50 P.M., the Physician said she had reviewed the hospital discharge paperwork and knew Resident #27 had pressure ulcers on the bilateral heels and defers treatment options to the wound specialists and would follow the hospital treatment recommendations if they provided them. During an interview on 5/30/25 at 1:00 P.M., the DON said the facility had not been focused on the heels of Resident #27 and had been focused on the pressure area on the sacrum. She said she had never reviewed the treatment orders for the heels and could not say why the treatment orders were clustered for multiple areas or why said the heel wounds were superficial. She said the bilateral heels were not superficial wounds. She said the wound physician consultant had been at the facility on 4/29/25 but had not seen Resident #27 and the wound treatments for the heels were not reviewed. She said the nurses should be reviewing the hospital discharge summary with the physicians and entering treatments as indicated. During an interview on 5/30/25 at 1:10 P.M., the wound nurse said the process was for the nurses to be completing admission skin assessments and documenting the wound descriptions and contacting the physician to review the treatments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/30/25 at 2:05 P.M., Nurse #5 said he worked on the unit three days per week and was the weekend supervisor. He said he often helped with new admissions and had been working when Resident #27 had originally been admitted . He said for the original admission he had completed entering the medications for Resident #27 in the electronic medical record and left it up to the nurses who were assigned to the Resident to complete the assessments. He said he had entered the orders for the right and left leg as a temporary treatment until the skin assessment was complete and the hospital discharge summary was reviewed. He said he would often come in and find that the assessments, including the skin assessments had not been completed and that was why he had completed the Weekly Skin Check form dated 5/25/25. He said Resident #27 had an open wound to the right heel with a daily dressing and the left heel was superficial and more like fragile skin. He said he had no idea there were pressure wounds on both heels, despite having documented completing the skin assessment on 5/25/25. He said the facility staff had been focusing on the Resident's sacral wound and not on the heels.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to schedule a podiatry appointment and failed to ensure good foot health was maintained for one Resident (#27), out of a total sample of 19 residents. Specifically, for Resident #27, the facility failed to schedule an appointment with a community podiatrist per physician's order and failed to provide diabetic foot care in accordance with hospital recommendations and professional standards for the Resident who was at risk for decline in his/her foot health related to a history of diabetes and bilateral amputations. Findings include: Review of the facility's policy titled Nursing Care of the Older Adults with Diabetes Mellitus, dated as revised in November 2020, indicated the following for skin and foot care: -skin should be kept as dry and clean as possible, apply lotion to dry skin as needed -use aseptic technique in caring for any lacerations, abrasions or breaks in skin integrity, and report the condition immediately to supervisor -bathe feet in warm (not hot) water as necessary to keep clean -keep feet dry Resident #27 was admitted to the facility in April 2025 with diagnoses of diabetes, a history of a left transmetatarsal amputation (TMA- a surgical procedure where the forefoot (including the toes and part of the foot bones is removed to preserve the remaining part of the foot and ankle), and history of right foot first, second and third toe amputations. Review of the Minimum Data Set (MDS) assessment, dated 5/13/25, indicated Resident #27 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Review of the medical record indicated Resident #27 was admitted with multiple wounds to the bilateral lower extremities including pressure ulcers to the bilateral heels, vascular wounds to the top of the right foot, and scattered open areas to the lower portions of the lower extremities. Review of the medical record indicated Resident #27 was sent to the hospital in May 2025. Review of the hospital Discharge summary, dated [DATE], indicated the following: -diabetics are prone to developing dry skin and fissures/cracking of the skin in the feet due to decreased perspiration associated with diabetic autonomic neuropathy and the skin can start to lose its protective barrier -the nerve damage can decrease the body's ability to control oil and moisture in the foot -this puts people at risk for developing foot ulcers and subsequent infections (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-it is important to be diligent about moisturizing the feet -after cleansing skin, towel dry feet thoroughly including between toes -cocoa butter products are most comparable with the composition of human skin and are higher in fatty acids, this tends to improve skin elasticity, hydrate, nourish, and provides a protective barrier to hold in moisture -inspect feet before bed each night for any breakdown -consider podiatry consult for possible debridement of eschar (dead tissue) on heels -follow up visits: specialty Podiatry; with name, phone number and office location listed Review of the May 2025 Treatment Administration Record (TAR) included a treatment order to provide diabetic foot care every night at bedtime: observation of feet, toes, ankles, soles and to document any alteration in skin integrity, color, temperature, and cleanliness in progress note. Although the Resident was in the facility, the TAR and nursing progress notes failed to indicate the diabetic foot care was provided on 5/1/25, 5/11/25, 5/15/25, 5/25/25, and 5/26/25. During an interview with observation on 5/30/25 at 10:40 A.M. with the Director of Nurses (DON) and facility Wound Nurse present, Resident #27 said staff had not been washing his/her feet or applying lotion. The feet and lower extremities of Resident #27 were observed with dry, flaky skin and parts of the skin were removed when the DON removed an adhesive dressing from the right lower extremity. During an interview on 5/30/25 at 11:45 A.M., Nurse #4 said she has provided care to Resident #27 on the evening shift, including on 5/29/25. She said the licensed nurses were responsible for diabetic foot care. She said diabetic foot care meant to inspect the feet to make sure there were no new open areas or redness and that even the smallest pinpoint could be an issue for a resident who was diabetic because it could open further and the resident might not be able to feel it. She said, Yes, diabetic foot care was only inspecting the feet and she had not washed the feet or applied lotion for Resident #27. During an interview on 5/30/25 at 1:30 P.M., the DON said that diabetic foot care was more than just looking at the feet and the nurses should be washing the feet and using lotion if needed daily. Review of the medical record for Resident #27 indicated on 5/12/25 the DON had entered a physician order for a podiatry visit to be scheduled with the community Podiatrist who was indicated in the hospital paperwork dated 5/7/25 for foot ulcers. Review of the medical record including the resident Appointment Calendar on 5/30/25 failed to indicate Resident #27 had an appointment scheduled with the podiatrist, 23 days after readmission. During an interview on 5/30/25 at 1:55 P.M., the DON said she checked with the receptionist and the appointment had not been scheduled as of this time, but the receptionist was working on it. During an interview on 5/30/25 at 2:01 P.M., the receptionist said she had not heard prior to this day about scheduling an outside podiatry appointment for Resident #27.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the monthly drug regimen review identified irregularities for one Resident (#34), out of 19 sampled residents. Specifically, the Pharmacist failed to identify and report irregularities (use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) related to the duration of an antibiotic medication (Flagyl) resulting in the Resident receiving an additional 37 doses. Findings include: Review of the facility's policy titled Medication Regimen Review (MRR), dated as revised 5/2019, indicated but was not limited to: -The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication -The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors and other irregularities, for example: a. medications ordered in excessive doses or without clinical indication b. incorrect medications, administration times or dosage forms, c. other medication errors, including those related to documentation -Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity -An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of the adverse consequences Resident #34 was admitted to the facility in April 2022 and had diagnoses which included pyelonephritis (inflammation of the kidneys, typically caused by a bacterial infection), renal and perinephric abscess (result of infection involving the kidney and the surrounding fat and tissues). Review of the Minimum Data Set (MDS) assessment, dated 4/20/25, indicated Resident #34 was receiving antibiotics. Review of Resident #34's Hospital Discharge summary, dated [DATE], indicated he/she should receive Flagyl three times per day for 90 doses. Review of Resident #34's Physician's Orders indicated but was not limited to: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Flagyl oral tablet 500 milligrams (mg) give one tablet by mouth three times a day related to renal and perinephric abscess for 89 days 90 doses, start date 4/15/25 Review of Resident #34's April and May 2025 Medication Administration Record (MAR) indicated he/she had received 127 doses of Flagyl as of 5/29/25. Review of the Monthly MRRs, dated 4/28/25 and 5/26/25, indicated Resident #69's medications had been reviewed and there were no irregularities. During a telephonic interview on 5/29/25 at 12:08 P.M., the Pharmacy Consultant said she conducts monthly MRRs and submits any reports of irregularities to the facility. The Pharmacy Consultant said when reviewing medications she reviewed the residents' orders to ensure the medication dosing was appropriate, stop dates were in place when indicated and the orders were in line with professional standards. During an interview on 5/29/25 at 1:14 P.M., the Pharmacy Consultant said she reviewed Resident #34's medical record and did not catch the conflict in the order of 89 days and 90 doses but she should have. The Consultant Pharmacist said she saw that the order had a stop date and did not report any irregularities to the facility. During an interview on 5/29/25 at 10:57 A.M., the Regional Nurse said the monthly MRRs should identify irregularities and be reported to the facility. During an interview on 5/29/25 at 12:26 P.M., the Director of Nurses (DON) said for Resident #34, the order should have included only the number of days for administration and not both the number of days and doses. The DON said the MRRs conducted by the Consultant Pharmacist should help the facility catch discrepancies and irregularities in orders. Refer to F757

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the drug regimen for one Resident (#34), out of 19 sampled residents, was free of unnecessary drugs. Specifically, the facility failed to ensure an antibiotic medication (Flagyl) was not given in excessive duration resulting in the Resident receiving an additional 37 doses. Findings include: Resident #34 was admitted to the facility in April 2022 and had diagnoses which included pyelonephritis (inflammation of the kidneys, typically caused by a bacterial infection), renal and perinephric abscess (result of infection involving the kidney and the surrounding fat and tissues). Review of the Minimum Data Set (MDS) assessment, dated 4/20/25, indicated Resident #34 was receiving antibiotics. Review of Resident #34's Hospital Discharge summary, dated [DATE], indicated he/she should receive Flagyl three times per day for 90 doses. Review of Resident #34's Physician's Orders indicated but was not limited to: -Flagyl oral tablet 500 milligrams (mg) give one tablet by mouth three times a day related to renal and perinephric abscess for 89 days 90 doses, start date 4/15/25 Review of Resident #34's April and May 2025 Medication Administration Record (MAR) indicated he/she had received 127 doses of Flagyl as of 5/29/25. Review of Resident #34's progress notes failed to indicate a provider had been consulted to extend the duration of the Flagyl. During an interview on 5/29/25 at 9:28 A.M., Physician #1 reviewed Resident #34's physician's orders and said 90 doses would have been roughly 30 days. Physician #1 said she did not recall extending the duration of his/her Flagyl. During an interview on 5/29/25 at 10:57 A.M., the Regional Nurse said the order for Flagyl was transcribed with a stop date that was 89 days out, but additional notes indicated the order was for only 90 doses. During an interview on 5/29/25 at 12:26 P.M., the Director of Nurses (DON) said Resident #34's Flagyl order should have included only the number of days for administration and not both the number of days and doses. The DON said the confusion occurred because the order included both doses and days of duration.

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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 observation and interview, the facility failed to ensure that medications in the refrigerator were stored under the proper temperature for 2 out of 2 medication rooms. Findings include: Review of the Facility's Medication Room Refrigerator Temperature Log indicated medications are to be stored between 36-46 degrees Fahrenheit. The Log further indicated temperature below 36 degrees (F) are too cold and temperature above 46 degrees (F) are too high. The facility requires staff to document any out-of-range temperatures then call the state or local health department immediately. On 5/28/25 at 10:39 A.M., the surveyor along with Nurse #6 entered the medication room on Unit A to perform a review of the medication room. Upon opening the refrigerator, the thermostat temperature was observed to read 70 degrees. Review of the refrigerator contents included three Mounjaros injection pens stored in the lock box, two insulin kits, suppositories, as well as unopened individual insulin pens and vials. During an interview on 5/28/25 at 11:05 A.M., Nurse #6 said the refrigerator temperature was extremely high. He said medications requiring refrigeration should be stored between 36°F and 46°F (2°C and 8°C). On 5/28/25 at 11:17 A.M., the surveyor along with Nurse #5 observed the medication storage room on Side B. Upon opening the refrigerator, the temperature on the thermometer read 59 degrees (F). Review of the refrigerator contents included: - 11 Lantus Insulin Pen (Glargine Injection 100 Units/Ml Exp (expiration) 4/30/27) ; - Two Novolog Insulin Injection Flex 100 units/ml for subcutaneous use Pen Exp 6/30/27; - Insulin Kit House Stock E-Kit Unit C delivered 5/27/25 Kit # I2105 Replace 5/27/26; - I2033 Insulin Kit B Unit; - I2233 B Unit; - Lantus Vial insulin glargine 100 unit/ml; and - Humulin Regular 10 ml multiple dose due for refill 6/1/2 During an interview at 9:50 A.M., Nurse #5 said the temperature of the refrigerator was in the danger zone. He said medications requiring refrigeration should be stored between 36°F and 46°F (2°C and 8°C). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/29/25 at 10:17 A.M., the surveyor observed Nurse #4 during a medication pass. Nurse #4 entered the medication room on side B to retrieve a medication. Upon entering the medication room on Side B, the surveyor rechecked the refrigerator's temperature in the medication room in the presence of the nurse and it was 30 degrees Fahrenheit (F). Review of the refrigerator contents included: - Insulin Kit I2033 dated 5/16/25; I2233 dated 5/3/25; - I2105 dated 5/23/25 were observed back in the refrigerator; - Risperidone dated 5/22/25; and - Unopened insulins previously stored in the refrigerator were observed back in it. During an interview at 10:40 A.M., Nurse # 4 said it is not appropriate to keep refrigerated medications in unstable temperatures. During an interview on 05/29/25 at 01:50 P.M., the Director of Nursing (DON) said she was not aware both refrigerators in the medication rooms were out of temperature range. She said she knew that the medications should be stored at the proper temperature but was not aware of the discrepancies of the two refrigerators. She said if the temperature is out of range on both refrigerators, it is an indication that something is wrong with them. On 05/29/25 at 02:10 P.M., the surveyor along with the DON reviewed the refrigerator temperature on Unit B and it was found to be 31 degrees Fahrenheit.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on record review and interviews, for one Resident (#69), of 19 sampled residents, the facility failed to provide specialized rehabilitative services, specifically physical and occupational therapy, as ordered. Findings include: Resident #69 was admitted to the facility in February 2025 with diagnoses which included right lower extremity tibia (one of the long bones located in the lower leg) fracture status post-surgical repair. Review of Resident #69's Physician's Orders for Physical Therapy (PT) and Occupational Therapy (OT) indicated but was not limited to: -PT order for 5 times per week for 4 weeks to address therapeutic activities, therapeutic exercise, gait training, neuro re-education, manual therapy, wheelchair management, patient/caregiver education, and discharge planning per plan of care, order date 2/7/25 and end date 3/9/25 -PT updated plan of care as of 3/8/25 for 5 times per week for 4 weeks for continued care and management, order date 3/11/25 and end date 4/30/25 -PT updated plan of care 5 times per week for 4 weeks for therapeutic exercises, therapeutic activities, group therapy, wheelchair management, gait training, and safety education, order date 4/6/25 and end date 5/29/25 -PT updated plan of care 5 times per week for 4 weeks with therapeutic exercise, therapeutic activities, neuro re-education, gait, group therapy, and wheelchair safety, order date 5/5/25 and end date 5/29/25 -PT evaluation and treat for 4 times per week for 4 weeks for therapeutic exercise, therapeutic activity, neuro re-education, gait training, group therapy, manual therapy, and safety education, order date 5/21/25 and end date 5/29/25 -OT 5 times per week for 4 weeks to include therapeutic exercise, therapeutic activities, self-care skills, neuro re-education, group as indicated, and patient/caregiver education as per plan of care, order date 4/3/25 and end date 4/30/25 -OT 5 times per week for 4 more weeks to include therapeutic exercise, therapeutic activities, self-care skills, neuro re-education, group as indicated, and patient/caregiver education as per plan of care, order date 4/28/25 and end date 5/26/25 Review of the PT treatment dates indicated for 8 out of 14 weeks reviewed the facility failed to provide PT 5 times per week: -week of 2/21/25 through 2/27/25: two visits -week of 3/7/25 through 3/13/25: four visits (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-week of 3/14/25 through 3/20/25: four visits -week of 3/28/25 through 4/3/25: four visits -week of 4/4/25 through 4/10/25: three visits -week of 4/11/25 through 4/17/25: three visits -week of 4/18/25 through 4/24/25: three visits -week of 5/2/25 through 5/8/25: four visits Review of the OT treatment dates indicated for 3 out of 6 weeks reviewed the facility failed to provide OT 5 times per week: -week of 4/3/25 through 4/9/25: one visit -week of 4/10/25 through 4/16/25: zero visits -week of 4/17/25 through 4/23/25: four visits During an interview on 5/27/25 at 3:06 P.M., Resident Representative #1 said up until recently Resident #69 was supposed to receive both PT and OT five times each per week but she did not believe this had occurred. During an interview on 5/29/25 at 9:57 A.M., the Director of Rehab reviewed Resident #69's medical record and said he/she should have received PT 5 times per week from 2/7/25 through 5/21/25 and should have received OT 5 times per week from 4/3/25 through 5/16/25. The Director of Rehab said Resident #69 was not seen by PT 5 times per week for 8 out of 14 weeks reviewed and was not seen by OT for 3 out of 6 weeks reviewed. The Director of Rehab said therapy should have been provided to Resident #69 per physician's orders and an encounter note should have been created. The Director of Rehab said if a resident was not provided with their scheduled therapy visit a missed visit note should have been completed to indicate why he/she was not seen, but there was no additional evidence of therapy visits in Resident #69's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 2. Review of the facility's policy titled Surveillance for Infections, dated as revised 9/2017, included but was not limited to: -The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare associated infections, to guide appropriate interventions, and to prevent future infections -The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and/or QAPI committee may be involved in interpretation of the data -The surveillance should include a review of any or all of the following information to help identify possible indicators of infections: a. Laboratory records, b. Skin care sheets, c. Infection control rounds or interviews, d. Verbal reports from staff, e. Infection documentation records, f. Temperature logs, g. Pharmacy records, h. Antibiotic review; and i. Transfer log/summaries -if laboratory reports are used to identify relevant information, the following find its merit further evaluation: a. Positive blood culture; b. Positive wound cultures that do not just represent surface colonization; c. Positive urine cultures with corresponding signs and symptoms that suggest infection; d. Positive sputum culture e. Other positive cultures; and f. All cultures positive for Group A streptococcus (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-for residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: a. Identifying information (resident name, age, room number, unit, and attending physician), b. Diagnoses, c. admission date, date of onset of infection d. Infection site e. Pathogens f. Invasive procedures or risk factors g. Pregnant remarks; and h. Treatment measures and precautions -Using the current suggested criteria for health care associated infections, determine if the resident has a healthcare associated infection - For targeted surveillance using facility created tools, follow these guidelines. a. Daily (as indicated): record detailed information about the resident and infection on an individual infection report form b. Monthly: collect information from individual resident infection reports and enter line listing of infections by resident for the entire month c. Monthly: summarize monthly data for each nursing unit by site and by pathogen d. Monthly/Quarterly: identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording them month to month and observing trends e. Monthly/Quarterly: compare incidents of current infections to previous data to identify trends and patterns. Use an average infection rate over a previous time period as the baseline. Compare subsequent rates to the average rate to identify possible increases in infection rates -Interpreting surveillance data: Analyze the data to identify trends Review of the February, March, and April 2025 line listings indicated but was not limited to: February 2025: -8 out of 15 residents had no documented signs and symptoms of an illness, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3 out of 4 urinary tract infections treated failed to include culture results identifying the organism/bacteria March 2025: -6 out of 9 residents had no documented signs and symptoms of an illness, and -1 out of 1 urinary tract infections treated failed to include culture results identifying the organism/bacteria April 2025: -4 out of 5 urinary tract infections treated failed to include culture results identifying the organism/bacteria, and -Review of Resident #19's medical record indicated a urine culture and sensitivity report resulted on 4/25/25 which indicated extended spectrum beta lactamase (ESBL, an organism enzyme produced by certain bacteria that allows them to resist the effects of certain antibiotics) had been detected but these results were not recorded on the facility line listing During an interview on 5/29/25 at 10:57 A.M., the Regional Nurse and Infection Control Nurse said the facility utilizes McGeer criteria (a set of standardized definitions used in infection surveillance) to determine if an infection was present and collects data by reviewing new orders in the facility and communicating with staff. The Infection Control Nurse said residents with antibiotics were added to the line listing based on order review and reports from staff. The Regional Nurse and Infection Control Nurse said the culture results, lab review, and symptoms were not consistently put on the tracker/line listing. During an interview on 5/29/25 at 12:26 P.M., the Director of Nurses said infection surveillance should have included symptoms and organisms for accurate tracking/monitoring and should have been completed. Based on observation, interview, and record review, the facility failed to 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. Specifically, the facility failed: 1. For Resident #57, to follow infection control standards while completing a dressing change; and 2. To maintain an infection prevention and control program which included a complete and accurate system of surveillance to identify any trends or potential infections. Findings include: 1.Review of the facility's policy titled Wound Care, revised October 2010, indicated but was not limited to the following: -The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wash and dry your hands thoroughly -Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites -Put on gloves, loosen tape and remove dressing -Pull glove over dressing and discard -Wash and dry your hands thoroughly Resident #57 was admitted to the facility in March 2025 with diagnoses including dementia and unstageable pressure ulcers. Review of the Minimum Data Set (MDS) assessment, dated 4/16/25, indicated Resident #57 scored 99 on the Brief Interview for Mental Status, indicating he/she was severely cognitively impaired, and the Resident had an activated Health Care Proxy. Review of the Physician's Order indicated the following: -wound care: right medial foot: cleanse site with normal saline, pat dry, followed by calcium alginate (highly absorbent wound dressing) and silicone bordered super absorbent gelling fiber dressing every day shift. -wound care: left lateral foot: cleanse site with normal saline, pat dry, followed by calcium alginate and silicone bordered super absorbent gelling fiber dressing every day shift. On 5/29/25 at 1:38 P.M., the surveyor observed the following: -Nurse #6 washed her hands, applied a protective gown, surgical face mask, and gloves. -Nurse #6 removed the old dressing from the left lateral foot and placed it in the trash. -Nurse #6 did not perform hand hygiene or change her gloves. -Nurse #6 then cleansed the wound on the left lateral foot with normal saline soaked gauze pads. -Nurse #6 then removed the old dressing from the right medial foot and placed it in the trash. -Nurse #6 did not perform hand hygiene or change her gloves. -Nurse #6 then cleansed the wound on the right medial foot with normal saline soaked gauze. -Nurse #6 then removed her gloves, performed hand hygiene and applied the calcium alginate to the left lateral wound bed with the dressing extending over to the intact surrounding skin. -Resident #57 began moving his/her foot, and the calcium alginate fell onto the towel that was placed under his/her feet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #6 picked up the calcium alginate from the towel and re-applied it to the wound bed, and the calcium alginate fell off the wound onto the bed linens. -Nurse #6 picked up the calcium alginate and re-applied it to the wound bed and then covered it with a silicone bordered dressing. -Nurse #6 did not perform hand hygiene or change her gloves -Nurse #6 then applied calcium alginate to the right medial foot wound bed and covered it with a silicone bordered dressing. -Nurse #6 then removed all the dressing supplies, removed her gloves, gown, and mask and performed hand hygiene. During an interview on 5/29/25 at 4:09 P.M., Nurse #6 said she should have changed her gloves and performed hand hygiene after removing the old dressings. She said once the calcium alginate fell off the wound onto the bed she should have applied a new clean one. Nurse #6 said the Resident was moving his/her leg so much during the dressing change it made it difficult for her. During an interview on 5/29/25 at 4:50 P.M., The Director of Nursing (DON) said you must change your gloves and perform hand hygiene, once you remove an old dressing, prior to cleansing the wound. She said once a dressing becomes contaminated, it must never be re-applied, as it increases the risk of the wound developing an infection. The DON said calcium alginate should only be placed over an open wound, not over the intact surrounding skin.