STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225215	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southshore Health Care Center	115 North Avenue Rockland, MA 02370

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on document review and interviews, the facility failed to ensure that it maintained an effective pest control program that provided an environment that was free of pests and rodents for the 79 residents residing at the facility. Findings include: During a tour of the kitchen on 8/21/2025 at 7:56 A.M., the surveyor observed the main kitchen dry food storage area and made the following observations: -On the left side of the room there were multiple shelves of canned goods with a large amount of mouse droppings on top of the cans. During an interview on 8/21/25 at 8:20 A.M., the Food Service Director (FSD) inspected the dry storage area with the surveyor and said the cans of food with rust along the ends and mouse droppings were the emergency food supply. He said they have had a mouse problem for a while. During an interview with observation on 8/21/25 at 9:00 A.M., Resident #88 said there were mice in their room. The surveyor observed a grocery store paper bag with a loaf of bread, an open box of snacks and an unopen box of snacks, none of the items were in plastic containers and were all accessible to mice. On the windowsill in the room were seven packages of shortbread cookies. During an interview on 8/21/25 at 1:00 P.M., Resident #10 said there were mice and rats in the facility, and he/she can see them and hear them run across the room. During an interview on 8/21/25 at 1:10 P.M., Resident #51 said there are mice in the resident rooms, and the residents complain about it at the Resident Council meeting. During the Resident Council meeting on 6/19/25, five residents on the [NAME] Wing said that they have seen mice all over their rooms including on the top of their beds. The resolution was listed as: pest control vendor as (sic) been notified. ˆDuring the Resident Council meeting on 7/17/25, multiple residents on both the East and [NAME] units complained that they are still seeing mice in and out of their rooms. The resolution to the issue was blank. A second resolution indicated that mouse traps were purchased and spread throughout the facility. The facility indicated they will continue to monitor the traps. During the Resident Council meeting on 8/15/25, East Wing: one resident reports he/she has seen ants and mice throughout his/her room (resolution: we have put down additional traps. I will inform the pest vendor when they come in next week). During the Resident Council meeting with the surveyor on 8/25/25 at 1:30 P.M., Resident #17 provided a written note with a concern regarding a mouse traveling from the outside into the heating duct and it then travels from room to room keeping the Resident awake half of the night. The Resident indicated that the mouse is starting to climb on things in the rooms and reported patching a hole in the tiles of the bathroom. In addition to the mouse, the Resident reported seeing ants everywhere and a cockroach or two. During a review of the Pest Control Service logs on 8/27/25, the documents indicated that the previous pest control service had not provided pest control services to the facility since 4/12/25. Further review of the Pest Control Service logs indicated that from 4/12/25 through 8/11/25 the facility was without professional pest control services. On 8/12/25, a new Pest Control Service began servicing the facility. Extensive services were documented at that time including, but not limited to:-glue boards in the drop ceiling as activity was reported by staff. The new Pest Control services' plan was to return in 2 weeks for the start of the Biweekly Pest Program. During an interview on 08/27/25 at 1:15 P.M., the Maintenance Director said that the facility did not have a professional Pest Control Service from 4/12/25 until 8/12/25, when the new Pest Control Service took over at the facility. The Maintenance Director was not aware of the (continued on next page)

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

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

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reason for the previous Pest Control Service ending its relationship with the facility or the delay in obtaining a new Pest Control vendor. During an interview on 08/27/25 at 1:30 P.M., the Administrator said that he has been the administrator at the facility since 7/2/25. He said he was aware of the pest problem as reported by staff and residents and said he brought in the current Pest Control Service on 8/12/25. He could not say why the previous administration at the facility terminated their relationship with the previous Pest Control Service, or the reason for the facility failure to ensure pest control services were provided from 4/12/25 to 8/11/25. The Administrator said that he understood that the facility is required to maintain an environment for residents that is free from pests and rodents.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council Minutes, a resident group meeting, interviews, and record reviews, the facility failed to ensure grievances brought forward from the Resident Council were addressed and promptly resolved to ensure the residents felt their concerns were acted upon. Findings include: Review of the Resident Council Minutes, dated 4/8/25, indicated but was not limited to:-Two residents on the west unit indicated they were missing clothes Further review of the Resident Council Minutes and corresponding documents, dated 4/8/25, failed to indicate the concern had been addressed and responded to by the facility. On 8/25/25 at 4:26 P.M., the Activities Director reviewed the Resident Council Minutes and corresponding documentation. The Activities Director said there should be a response from the Laundry/Housekeeping Department head but there was not. Review of the Resident Council and Food Committee Minutes, dated 5/21/25, indicated but was not limited to:-Multiple residents from both units stated that the Assistant Director of Nurses (ADON) spoke to the residents disrespectfully and they felt intimidated by her-Residents reported the food temperature was so-so Further review of the Resident Council Minutes and corresponding documents, dated 5/21/25, failed to indicate the concern regarding the ADON had been addressed and responded to by the facility. The Dining services responded that they would increase the frequency of test trays from twice monthly to once weekly. Review of the subsequent documented test trays failed to indicate weekly test trays had been conducted. On 8/25/25 at 4:26 P.M., the Activities Director reviewed the May 2025 Resident Council Minutes, and corresponding documentation. The Activities Director said the Nursing Department response should have included education to the ADON but did not. During an interview on 8/26/25 at 5:08 P.M., the Director of Nurses (DON) said she could not provide documented evidence of re-education to the ADON regarding the May 2025 Resident Council concerns. Review of the Resident Council Minutes, dated 6/19/25, indicated but was not limited to:-Five residents on the [NAME] wing stated they saw mice all over their rooms including on top of their beds Further review of the Resident Council Minutes and corresponding documents, dated 6/19/25, indicated but was not limited to:-the pest vendor was notified Review of the Resident Council Minutes, dated 7/17/25, indicated but was not limited to:-Residents on both East and [NAME] wings stated they were still seeing mice in and out of their rooms-Several residents from both wings claimed they were missing clothes Further review of the Resident Council Minutes and corresponding documents, dated 7/17/25, indicated but was not limited to:- Mouse traps were purchased and spread throughout the facility-The Laundry/Housekeeping department head would speak to residents to find out what was missing and resolve the grievance On 8/25/25 at 4:26 P.M., the Activities Director reviewed the July 2025 Resident Council Minutes and corresponding documentation. The Activities Director said the concern regarding missing clothing came up every month and the head of laundry always addressed it with residents. Review of the Resident Council Minutes, dated 8/15/25, indicated but was not limited to:-Resident on the East wing reported he/she saw ants and mice throughout his/her room Further review of the Resident Council Minutes and corresponding documents, dated 8/15/25, indicated but was not limited to:-Facility put down additional traps and would inform the pest vendor with next visit During a meeting on 8/25/25 at 1:30 P.M., the surveyor met with 12 residents during a Resident Council Meeting. The following concerns were voiced:-Resident #45 said he/she stopped attending meetings a few months ago because there was not point. Resident #45 said nothing got done and nothing changed.-Resident #58 said the same issues were brought up over and over again on repeat.-Eight out of 12 residents agreed that concerns were brought up and not addressed or corrected, one resident said the meetings were a waste of his/her time.-Seven out of 12 residents agreed laundry was frequently missing.-Seven out of 12 residents agreed mice were seen regularly. Resident #17 provided a written note with a concern regarding a mouse traveling from the outside into the heating duct and traveling from room to room, and it kept him/her awake half of the night. The Resident indicated that the mouse is starting to climb (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on things in the rooms and reported patching a hole in the tiles of the bathroom. In addition to the mouse, the Resident reported seeing ants everywhere and a cockroach or two.- Seven out of 12 residents agreed the ADON was degrading. Resident #45 said she spoke to the residents like she wanted to fight them and had a bad attitude. Resident #45 said it had been reported during Resident Council in the past but did not improve. During an interview on 8/25/25 at 4:26 P.M., the Activities Director said the Food Service Director completed the Food Committee Minutes at the start of each Resident Council Meeting and took their own notes. The Activities Director said to ensure every concern was addressed she provided the department heads with a form regarding any concerns that arose during the Resident Council Meeting, and they should respond with a resolution within three days. The Activities Director said some concerns do come up repeatedly including pests and missing laundry. Refer to F804 and F925

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on document review and interview, the facility failed to ensure the attending physician and/or responsible party was notified of changes in a resident's condition for two Residents (#83, #8), out of a total sample of 20 residents. Specifically, the facility failed:1. For Resident #83, that the physician was notified of a change in mental status, verbalizations of wanting to leave the facility and exit seeking behavior; and2. For Resident #8, to inform the attending physician of a significant weight loss. Findings include:Review of the facility's policy titled Condition: Significant Change; dated 4/2015; indicated, but was not limited to, the following: -The physician, resident/patient, and/or responsible party will be notified by the nurse in the event of a change in condition -This notification shall be documented in the clinical record 1. Resident #83 was admitted to the facility in August 2025 and had diagnoses including alcohol dependence with withdrawal and major depressive disorder. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 8/15/25, indicated Resident #83 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15, exhibited no hallucinations, delusions or behaviors, received no psychotropic medication and had an activated health care proxy (an individual designated to make medical decisions on your behalf when a doctor determines you lack the capacity to make or communicate your own decisions). Review of a Nursing Progress Note, dated 8/17/25, indicated Resident #83 called 911 (a phone number used to contact emergency services) around 7:00 A.M. and a police officer came to the facility to speak with the Resident. The note indicated Resident #83 told the officer that somebody was playing in his/her back and that he/she doesn't belong here and needs to leave. Review of a Nursing Progress Note, dated 8/18/25, indicated Resident #83 called 911 and stated there was something behind his/her window. Staff checked the window and showed the Resident that there was nothing behind the window. Review of a Nursing Progress Note, dated 8/23/25, indicated around 6:00 A.M., the lead Certified Nursing Assistant (CNA) informed the nurse that Resident #83 was outside walking in the parking lot. The nurse indicated the Resident was last seen about 10 minutes before seated in the TV room on the unit. After three attempts, the Resident agreed to return to the building. Further review of the medical record failed to indicate Resident #83's physician or HCP was notified of the Resident's change in cognitive status as evidenced by statement that somebody was playing in his/her back and something was behind his/her window, verbalization that he/she doesn't belong at the facility and needs to leave and walking in the parking lot unaccompanied the morning of 8/23/25. During interviews on 8/25/25 at 1:31 P.M. and 2:32 P.M., the Director of Nursing (DON) said the physician and HCP should have been notified of the change in the Resident's cognitive status as well as leaving the building and walking in the parking lot unaccompanied the morning of 8/23/25. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's policy titled Weights, dated 4/2015, indicated, but was not limited to, the following: -If a significant weight loss/gain is identified (> 5% in 30 days or > 10% in 6 months), the IDT [interdisciplinary team], Dietitian, Physician and Family are notified. Resident #8 was admitted to the facility in July 2025 with diagnoses including multiple sclerosis, diabetes, and hypothyroidism. Review of the MDS assessment, dated 7/29/25, indicated Resident #8 was moderately cognitively impaired as evidenced by a BIMS score of 9 out of 15. Review of Resident #8's medical record indicated the Resident's weights were documented as follows: -7/29/25: 162.4 pounds (lbs.) -8/7/25: 159 lbs. -8/18/25: 144 lbs. -8/20/25: 145 lbs. From 7/29/25 to 8/20/25, Resident #8 had lost 17.4 lbs. (or 10.71% of his/her body weight). Review of Resident #8's Progress Notes indicated that on 8/19/25, the facility dietitian identified the Resident had an 18.4-pound weight loss in two weeks. The Dietitian met with the Resident and added yogurt and ice cream to the Resident's meals twice daily to arrest in further weight loss. Further review of Resident #8's Progress Notes failed to indicate the Resident's attending physician was notified of the Resident's significant weight loss until after Unit Manager #1's interview with the surveyor on 8/26/25. The medical record failed to include a Physician's Progress Note, indicating the Resident had been seen by the attending physician, from date of admission until 8/26/25. During an interview on 8/25/25 at 3:06 P.M., Nurse #3 said if the nurse notices a Resident has had weight loss when a weight is obtained, the nurse should inform the attending physician and dietitian. Nurse #3 said she entered the Resident's weight into the medical record on 8/18/25 and notified the dietitian that the Resident had lost weight. Nurse #3 said she should have notified the Resident's attending physician but did not. During an interview on 8/26/25 at 4:06 P.M., Unit Manager #1 said there was no indication in the Resident's record that the attending physician was notified of Resident #8's weight loss. Unit Manager #1 said the attending physician should have been notified. During an interview on 8/27/2025 at 12:08 P.M., the DON said Resident #8's attending physician should have been notified of the Resident's weight loss immediately upon discovery. The surveyor attempted to contact Resident #8's attending physician on 8/27/25 and 8/28/25 but the physician was unable to be reached.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards for five Residents (#72, #57, #31, #1, #5), out of a total sample of 20 residents. Specifically, the facility failed:1. For Resident #72, to implement physician's orders to apply palm rip/palm roll to the Resident's left hand; 2. For Resident #57, to implement physician's orders to apply his/her glasses and left upper extremity splint;3. For Resident #31, to implement physician's order for laboratory blood work;4. For Resident #1,a. to reconcile and implement physician's order for enteral tube feeding, andb. to reconcile and implement physician's order for oxygen use; and5. For Resident #5,a. to implement the physician's order for oxygen use, and b. to implement the physician's orders for wound treatments. 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: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. -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 #72 was admitted to the facility in February 2022 with diagnoses including dementia, cerebrovascular accident (CVA/ stroke – a disruption of blood flow to the brain, which can lead to brain damage), and muscle weakness. Review of Resident #72's Minimum Data Set (MDS) assessment, dated 7/4/25, indicated Resident #72 was severely cognitively impaired, as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. Review of Resident #72's Occupational Therapy Discharge summary, dated [DATE], indicated the Resident received skilled occupational therapy due to increased bilateral hand contractures impacting feeding as well as positioning in bed. At discharge, the Resident was able to tolerate bilateral hand palm roll orthoses for the entirety of the day shift. The Discharge Summary indicated patient and caregiver training was completed on orthosis management and it was recommended that the Resident wear bilateral palm roll orthoses for day shift at least five times per week. Review of Resident #72's Physician's Orders indicated, but was not limited to, the following: - SPLINT: Apply palm rip/palm roll to Left Hand at AM care and off PM care as tolerated. Remove splint for skin hygiene. Check skin integrity Q shift (order date 1/28/25) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- SPLINT: Apply Palm roll to right hand at AM Care and off PM care as tolerated. Remove splint for skin hygiene. Check skin integrity Q shift (order date 8/20/25) Review of Resident #72's August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated the Resident's palm rip/palm roll was applied and removed as ordered. Review of Resident #72's Care Plan indicated, but was not limited to, the following: Focus: Orthosis mgmt. [management] – maintain and promote skin integrity d/t [due to] past CVA affecting LUE [left upper extremity] and contracture R [right] hand (revised 8/20/25) Interventions: Splint: B [bilateral] palm grip orthosis/palm roll on AM care off PM care as tolerated after hand hygiene; check skin q [every] shift (revised 8/20/25) Focus: Resident has an ADL [activities of daily living] deficit related to: disease process/condition, mood/behavior problem, pain, weakness (initiated 6/22/22) Interventions: Splint: L [left] palm grip orthosis/palm roll 4-6 hours per day M-F [Monday-Friday] as tolerated after hand hygiene; check skin q shift (revised 7/18/23) Review of Resident #72's Resident Care Card indicated, but was not limited to, the following: -Splints/Braces/Immobilizers: Type: hand Where: hand When: at all x's [times] -Skin protection: Hand roll Review of Resident #72's Progress Notes failed to indicate the Resident declined to wear his/her left palm roll. During an interview on 8/21/25 8:50 A.M., the surveyor observed that Resident #72 was wearing a right-hand palm roll. Resident #72 said he/she had had a stroke. Resident #72 showed the surveyor his/her left hand and said he/she was unable to extend his/her left middle finger fully. A palm roll was observed on the Resident's bedside table. The Resident said he/she was supposed to be wearing it. On 8/21/25 at 11:30 A.M., the surveyor observed that Resident #72 was not wearing his/her left palm (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	roll. On 8/26/25 at 9:29 A.M., the surveyor observed Resident #72 wearing a right-hand palm roll only. During an observation with interview on 8/26/25 at 10:16 A.M., the surveyor observed Resident #72 wearing a right-hand palm roll only. The Resident showed the surveyor his/her left hand and was unable to fully extend his/her middle (3rd) and ring (4th) finger. The Resident said he/she should be wearing a palm roll in each hand. During an interview on 8/27/25 at 9:52 A.M., Certified Nursing Assistant (CNA) #6 said she is familiar with Resident #72, and the Resident has a device he/she wears on the right hand, but nothing on the left. CNA #6 said there is no Resident Care Card to refer to for instructions on how to care for the Resident, but there is information on the CNA assignment sheet to refer to. During an interview on 8/27/25 at 11:39 A.M., Unit Manager #2 said Resident #72 wears a splint on his/her right hand and does not wear any device on the left. During an interview on 8/27/25 at 12:08 P.M., the Director of Nursing (DON) said the therapy department should educate unit staff when implementing a new device or new exercises for a Resident. The DON said that if a Resident has an order for a device, it should be implemented as it is her expectation that the physician's orders are followed. During an interview on 8/27/25 at 1:35 P.M., Occupational Therapist (OT) #1 said Resident #72 was recently discharged from occupational therapy with bilateral palm rolls. OT #1 said that Resident #72 does like to wear the palm rolls and should be wearing them in both hands. 2. Review of the facility's policy titled Splints/Orthotics/Prosthetics, dated April 2015, indicated but was not limited to: -Nursing staff will apply/remove the designated splint/orthotic/prosthetic device during scheduled wearing times, -If the resident refuses to wear the device, notify the rehab department, physician, and responsible party Resident #57 was admitted to the facility in October 2021 with diagnoses that included cerebral infarction (stroke) with hemiplegia (weakness or paralysis of one side of the body) affecting his/her left side. Review of Resident #57's MDS assessment, dated 6/13/25, indicated he/she had impaired range of motion on one side. Review of Resident #57's Occupational Therapy Discharge summary, dated [DATE], indicated he/she received Occupational Therapy from 6/3/25 through 7/30/25 due to decreased compliance with his/her splinting device. The Discharge Summary indicated patient and caregiver training was completed on orthosis management and staff had demonstrated the ability to don/doff the splint properly. The Discharge Summary indicated Resident #57 should continue to wear the splint daily for contracture management. (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 #57's Physician's Orders indicated but were not limited to: -Apply glasses in morning, keep glasses in medication cart, dated 11/23/24 -Splint: Apply Left Palm Roll and wrist as tolerated. Apply Left elbow orthosis on with morning care and off with evening care, dated 1/28/25 Review of Resident #57's August 2025 MAR and TAR indicted his/her glasses, left palm roll, and left elbow orthosis had been signed off as administered. Review of Resident #57's Resident Care Card, dated 7/1/25, indicated but was not limited to: -Splints/braces/immobilizers: Type: hand Where: left When: at all times On the following dates and times during survey, the surveyor observed Resident #57 not wearing his/her glasses or his/her left upper extremity splint: -8/21/25 at 9:22 A.M. -8/25/25 at 9:18 A.M. and 2:55 P.M. -8/26/25 at 9:30 A.M. and 12:55 P.M. -8/27/25 at 7:41 A.M. and 11:09 A.M. Review of Resident #57's August 2025 progress notes failed to indicate he/she had refused to wear his/her left upper extremity splint or glasses. During an interview on 8/27/25 at 11:14 A.M., CNA #7 said he/she was caring for Resident #57. CNA #7 said Resident #57 never wears glasses and that he/she was not instructed to apply a splint to his/her left upper extremity. CNA #7 said sometimes the rehab department comes around and applies splints but has not applied his/hers today. During an interview on 8/27/25 at 11:19 A.M., Nurse #5 said Resident #57 should be wearing his/her left upper extremity splint. Nurse #5 said Resident #57 should be wearing his/her glasses, but she had not been able to find them. Nurse #5 said physician's orders should be followed. During an interview on 8/27/25 at 1:18 P.M., Unit Manager #2 said Resident #57 should be wearing his/her glasses and left upper extremity splint during the day. Unit Manager #2 said sometimes rehab applied the splints. During an interview on 8/27/25 at 12:27 P.M., the DON said physician's orders should be followed. (continued on next page)

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Southshore Health Care Center	115 North Avenue Rockland, MA 02370

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #31 was admitted to the facility in November 2024 with diagnoses which included End Stage Renal Disease, dependence on renal dialysis, and Type 2 diabetes mellitus. Review of Resident #31's medical record indicated that he/she received dialysis treatment at a local dialysis center every Tuesday, Thursday and Saturday, and any medical issues, either at the facility or the dialysis center, were to be documented/communicated via the Resident's dialysis communication book. Review of the Nursing Policy and Procedure Manual for Hemodialysis, dated 2015, indicated but was not limited to the following: -Communication: - The communication book/sheet will be reviewed upon return from dialysis. Review of the Hemodialysis Communication Sheet from the dialysis center, dated 8/9/25, indicated to Please check stool with stool card b/c (because) hemoglobin 7 per provider. (normal hemoglobin ranges between 14.0 grams per deciliter (gm/dL) and 17.5 gm/dL per dL). During an interview on 8/20/25 at 12:20 P.M., Nurse #2 said that he had received a telephone order from the physician on 8/9/25 to obtain a Complete Blood Count (CBC) with differential blood test (a blood test that measures the number and types of various blood cells, including red blood cells, white blood cells and platelets), on the next lab day. He said that the lab test was ordered due to communication by the dialysis center of a critically low hemoglobin of 7, following the Resident's dialysis treatment on Saturday 8/9/25. Nurse #2 said the next laboratory day would have been on Monday 8/11/25. Nurse #2 said he could not find that the CBC with differential had been done on Monday 8/11/25 as ordered. During an interview on 08/22/25 at 12:55 P.M., the DON said that Nurse #2, who received the verbal order from the physician on 8/9/25, failed to put in the request order for the blood work to be drawn on 8/11/25, the next laboratory day. The DON said she understood the Resident's hemoglobin was reported as 7, critically low, and a concern of the dialysis center when communicated via the hemodialysis communication sheet on 8/7/25. 4. Review of the facility's policy untitled, dated August 2022, indicated but was not limited to the following: - This facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any significant medication errors, and that the facility's medication error rate is less than 5 percent. - admission Processes: b. compare orders to hospital records, etc. Obtain clarification as needed; c. transcribe orders in accordance with procedures for admission orders. Resident #1 was admitted to the facility in July 2025 with diagnoses including Parkinson's disease, chronic obstructive pulmonary disease (COPD), and muscle weakness. Review of Resident #1's MDS assessment, dated 8/1/25, indicated he/she was cognitively intact as evidenced by a BIMS score of 15 out of 15. Furthermore, the MDS assessment indicated he/she had a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feeding tube and used oxygen. Review of Resident #1's medical record indicated he/she was discharged to the hospital for a change in medical status on 8/17/25 and returned to the facility on 8/19/25. a. Review of the facility's policy titled Enteral Feeding, dated April 2015, indicated but was not limited to the following: - Enteral feeding provides an alternative method of nutritional support via gastrostomy (G-Tube) or jejunostomy (J-Tube) and is used to enhance and maintain nutritional status when there is an inability to take adequate nutrients orally. - Check physician order for formula, rate and water flushes. Review of Resident #1's Physician Orders indicated but were not limited to the following: - 9/24/24 through 8/19/25: Administer Glucerna 1.2 continuous; 12 hours nocturnal via feed pump at 140 mL (milliliters)/hr (hour) (6 P.M. to 6 A.M.); flush 150 mL every 3 hours during feed time. - 1/9/24 through 8/19/25: Change tube feeding system every 24 hours (bag, tubing, and syringe); be sure to date and initial; every night shift. - 6/4/25 through 8/19/25: Enteral Feed Order in the afternoon for Bolus TF (tube feed) of 240 mL at 3 P.M. - 8/21/25: Glucerna 1.2 CAL (calories); rate 240 mL bolus feed in afternoon at 12:30 P.M. - 8/21/25: Glucerna 1.2 CAL; rate 240 mL bolus feed in afternoon at 4:00 P.M. Further review of Resident #1's Physician's orders failed to indicate a continuous TF order was in place upon return from the hospital on 8/19/25. Furthermore, the physician's orders indicated the bolus TF orders were put in place two days after the Resident returned from the hospital. Review of the MAR for August 2025 failed to indicate a continuous TF was administered to the resident from 8/19/25 to 8/26/25. Furthermore, the MAR indicated bolus TF orders were not administered on 8/19/25 and 8/20/25. Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated but was not limited to the following: - Tube feed as per dietician recommendations. During an interview on 8/22/25 at 8:26 A.M., Resident #1 said he/she has been receiving their continuous TF overnight and their two bolus feedings during the afternoon. During an interview on 8/22/25 at 12:56 P.M., Nurse #3 said Resident #1 receives a continuous TF overnight and has two bolus feedings during the afternoon. During an interview on 8/26/25 at 10:39 A.M., Nurse #3 said she worked 3:00 P.M. to 11:00 P.M. on (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/25/25 and hung Resident #1's overnight continuous tubing feeding. Nurse #3 and the surveyor reviewed Resident #1's medical record including MAR and physician's orders. Nurse #3 said there was no order for Resident #1's continuous overnight TF and there should be. Nurse #3 said there was no indication on the MAR the continuous overnight TF was completed. Nurse #3 said the continuous overnight TF should have only been put up if there were orders present. During an interview on 8/26/25 at 11:00 A.M., the Regional Dietitian said she would expect orders for tube feedings to be re-implemented when a resident returns from a hospitalization unless there is a change indicated in the discharge paperwork. The Regional Dietitian said Resident #1 should have had orders in place upon return from the hospital. The Regional Dietitian reviewed Resident #1's medical record and said it appears the continuous feeding was not implemented upon readmission to the facility, and the bolus feedings were not implemented until 8/21/25, two days after he/she returned. During an interview on 8/26/25 at 11:27 A.M., the DON said she would expect there to be orders for any tube feeding after return from a hospitalization. The DON said Resident #1's orders should have been reviewed. The DON said nursing should have clarified and inputted tube feeding orders and should not have hung a tube feeding without orders present. b. Review of Resident #1's Physician's Orders indicated but were not limited to the following: - 10/28/24 through 8/19/25: Oxygen (O2) continuously via NC (nasal cannula) at 2 liters/minute (LPM) every shift; check pulse oximetry and LPM. - 11/3/24 through 8/19/25: Change O2 tubing every Sunday on 11 P.M. to 7 A.M. - 11/3/24 through 8/19/25: Monitor O2 saturation on room air weekly; every evening shift every Sunday. - 8/22/25: O2 continuously via NC at 2-4 LPM every shift; check pulse oximetry and LPM. Further review of Resident #1's physician's orders failed to indicate an oxygen order was in place upon return from the hospital on 8/19/25. Furthermore, the physician's orders indicated the continuous oxygen orders were put in place three days after the Resident returned from the hospital. Review of the MAR for August 2025 failed to indicate continuous oxygen was administered to the Resident from 8/19/25 to 8/22/25. Review of Resident #1's comprehensive care plan for COPD indicated the following intervention was in place: - 6/4/25: Administer oxygen as ordered and monitor its effectiveness by checking oxygen saturation, as indicated. During an interview on 8/21/25 at 10:00 A.M., Resident #1 said he/she had been on oxygen for a while, and he/she has been using the oxygen since they returned from the hospital a couple days ago. During an interview on 8/22/25 at 12:57 P.M., Nurse #3 said Resident #1 had been utilizing oxygen for quite a while. Nurse #3 reviewed Resident #1's medical record and said there were not currently orders in place for Resident #1's oxygen and there should be. Nurse #3 said the orders should have (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been re-instated when Resident #1 returned from the hospital and oxygen requires an order for its use. During an interview on 8/26/25 at 11:27 A.M., the DON said she would expect any resident utilizing oxygen to have orders in place. The DON said Resident #1's oxygen orders should have been put in place upon re-admission to the facility on 8/19/25. 5. Resident #5 was admitted to the facility in July 2025 with diagnoses including: heart failure, type I diabetes, muscle weakness and hypertension. Review of Resident #5's MDS assessment, dated 8/5/25, indicated he/she was cognitively intact as evidenced by a BIMS score of 13 out of 15. Furthermore, the MDS assessment indicated he/she did not have shortness of breath or trouble breathing when at rest or lying flat. a. Review of the medical record indicated Physician's Orders for: - Oxygen (O2) continuously via nasal canula at 2 Liters/minute, every shift, check pulse oximetry and Liters per Minute (LPM), effective 7/31/25 - Change O2 tubing every Sunday (Sun) on the 11:00 P.M.-7:00 A.M. shift, every night shift, every Sun. The surveyor observed Resident #5 in bed with O2 being administered via nasal canula supplied by an O2 concentrator with the following liters per minute (L) flow rate set: - On 8/21/25 at 8:53 A.M. and 1:50 P.M.: O2 concentrator was observed at 3L. - On 8/22/25 at 10:38 A.M.: O2 concentrator was observed at 3L. - On 8/26/25 at 10:18 A.M., 12:51 P.M., and 4:20 P.M.: O2 concentrator was observed set at 2.5L. Review of Resident #5's nursing progress notes failed to indicate clinical or medical rationale for changes in O2 settings from the physician's orders. Furthermore, review of the medical record indicated nursing progress note documentation of the following: - On 8/1/25: Resident #5 continuous oxygen at 3L via nasal canula. - On 8/2/25: Resident #5 continues on oxygen 3-4 L via nasal canula with no shortness of breath or distress noted. - On 8/3/25: Resident #5 is on 3-4L of oxygen via nasal canula. - On 8/4/25: Resident #5 continues on oxygen 3-4L via nasal canula with an oxygen saturation rate of 91%, and no shortness of breath or respiratory distress noted. - On 8/5/25: 3L of oxygen via nasal canula with no shortness of breath or respiratory distress noted for Resident #5. During an interview on 8/26/25 at 10:50 A.M., Nurse #1 said Resident #5 was at baseline today with oxygen saturation rate at 94% and he/she is on 2 L of O2. Nurse #1 said she evaluates residents' (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respiratory assessment by monitoring their baseline and checking the residents' levels. During an interview on 8/26/25 at 4:40 P.M., Nurse #1 said she verified the physician's oxygen orders to be 2L/min. Nurse #1 and the surveyor observed the O2 concentrator for Resident #5. Nurse #1 said the settings were high and she lowered the oxygen flow settings down to 2L/min. During an interview on 8/27/25 at 10:52 A.M., the DON said a resident who uses oxygen should have an MD order and staff should be checking every shift for function of the oxygen, as well as liters per minute to ensure it matches the MD order. The DON and surveyor reviewed the findings made throughout the survey process. The DON said Resident #5 should have had their oxygen set to the orders as provided by the physician and checked every shift. The DON said Resident #5 should have had documentation in his/her medical record indicating the clinical/medical rationale for the changes. b. Review of the facility's policy titled Clean Dressing Technique, undated, indicated but not limited to the following: - Check physician order for current, correct treatment. - Cleanse wound with solution ordered. During an interview on 8/21/25 at 3:03 P.M., Resident #5 said he/she has wound areas from surgery and other areas as well that are being treated in the facility. Review of Resident #5's admission skin assessment, completed 7/21/25, indicated he/she had the following wound areas: -Left Heel -Right Heel -Left Outer Ankle -Left Inner Ankle -Right Inner Ankle Review of Resident #5's Physician's orders indicated the following: -Left Heel: wound wash, skin prep to peri-wound, apply dime thick amount of hydrogel, calcium alginate to inside wound bed, dry protective dressing, kling wrap. -Right Heel: wound wash, skin prep to peri-wound, apply dime thick amount of hydrogel, calcium alginate to inside wound bed, dry protective dressing, kling wrap. -Left ankle/lateral foot: wound wash, skin prep to peri-wound, apply dime thick amount of hydrogel, calcium alginate to inside wound bed, dry protective dressing, kling wrap. -Left Inner Calf: wound wash, skin prep, maxisorb, foam dressing. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Right Calf: cleanse with wound wash, apply betadine. On 8/26/25 at 1:06 P.M., the surveyor observed Nurse #1 and Unit Manager (UM) #2 perform wound care for Resident #5 and made the following observations: -Nurse #1 removed old dressing to right heel, washed heel with sterile water, applied skin prep, hydrogel, calcium alginate, 2x2 non-sterile dressing followed by kling wrap. UM #2 supported Resident #5's leg while treatment was completed. -Nurse #1 removed old dressing to left heel, washed heel with sterile water, applied skin prep, hydrogel, calcium alginate, 4x4 non-sterile dressing followed by kling wrap. UM #2 supported Resident #5's leg while treatment was completed. -Nurse #1 applied betadine to Resident #5's left inner calf, followed by 4x4 gauze and kling roll. UM #2 supported Resident #5's leg while treatment was completed. -Nurse #1 cleaned the treatment field and both Nurse #1 and UM #2 left the room. -No wound care treatment observed by surveyor for the right calf or left ankle/lateral foot areas. Review of Resident #5's TAR indicated all wound treatments were completed as ordered on 8/26/25. Furthermore, the TAR indicated all wound areas should be cleansed with wound wash. Review of Resident #5's comprehensive care plan indicated but not limited to the following interventions: - Follow MD orders for skin care and treatments (Utilize Best Practice Guidelines). During an interview on 8/26/25 at 4:23 P.M., Nurse #1 was unable to answer questions regarding the dressing changes observed and could not answer what the current dressing orders were. Nurse #1 said orders are completed and signed as completed until the wound specialist discontinues the orders. Nurse #1 said he/she completed a dressing to the left calf, left heel, and right heel but could not verify his/her current wound care orders and referred to the Unit Manager. During an interview on 8/26/25 at 4:32 P.M., the UM #2 said he/she was present for the dressing changes on the left heel, right heel, and left calf. UM #2 said wound wash should be normal saline and not sterile water. UM #2 reviewed Resident #5's orders and said there were five active wound treatment orders. During an interview on 8/27/25 at 12:15 P.M., the DON said wound treatments should be done by following the physician's orders. The DON said if the wound dressing orders are scheduled for the 7:00 A.M. – 3:00 P.M. shift, the expectation is the dressings will be completed on that shift. The DON and surveyor reviewed the findings of only three wound dressing changes out of five completed and the left inner calf was completed with the incorrect dressing. The DON said Resident #5 should have had all wound dressing orders followed as ordered and all the dressing orders should have been completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide two Residents (#15, #83), out of a total sample of 20 residents, with adequate supervision and effective interventions to prevent avoidable accidents. Specifically, the facility failed:1. For Resident #15, to develop and consistently implement effective interventions to prevent recurrent falls; and2. For Resident #83, to provide adequate level of staff supervision to maintain his/her safety in an effort to prevent an elopement from the facility.Findings include:Review of the facility's policy titled Accidents/Incidents, dated 4/2015, indicated, but was not limited to, the following: -It is the responsibility of staff to report all accidents and incidents which occur at the facility. -Occurrences of a serious nature requires notification to the Administrator and Director of Nurses. Review of the facility's policy titled Comprehensive Care Plans, revised 11/2017, indicated, but was not limited to, the follow: -The facility is committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life. -Care plans are oriented toward preventing avoidable decline in clinical and functional levels, maintaining a specific functioning and reflect resident preferences and right to refuse certain services or treatment. -The Interdisciplinary Team (IDT) develops a comprehensive Care Plan for each resident that includes measurable objectives and timelines to accommodate preferences, special medical, nursing, and psychosocial needs identified in the RAI (Resident Assessment Instrument) and IDT. -The Care Plan is evaluated and revised as needed, but at least quarterly. 1. Review of the facility's policy titled Falls Management, revised 4/2024, indicated, but was not limited to, the following: -A fall is defined as any incident in which a resident/patient unintentionally has a change in elevation/plane. -A fall risk evaluation will be conducted on each resident/patient upon admission, with the quarterly MDS (Minimum Data Set) cycle, and when a significant change in status occurs (including a fall). -The interdisciplinary team will develop, initiate, and implement an appropriate individualized care plan based on the Fall Risk Evaluation score. A score of 0-9 indicated no to low risk, while a score of 10+ indicates moderate to high fall risk. -A fall risk evaluation will be conducted by the nurse on duty/supervisor on any resident/patient sustaining a fall with or without injury. -The interdisciplinary team will meet at the next morning meeting to review any falls and evaluate (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	additional needs for changes in the plan of care. Resident #4 was admitted to the facility in November 2021 with diagnoses including dementia, psychotic disturbance, repeated falls, and Wernicke's encephalopathy (a neurological condition caused by vitamin B1 [thiamine] deficiency, characterized by symptoms of confusion, ataxia [poor muscle control], and opthalmoplegia [weakness of the eye muscles]). Review of the MDS assessment, dated 6/6/25, indicated a Brief Interview for Mental Status (BIMS) assessment was unable to be completed as Resident #4 was rarely/never understood. Further review of the MDS assessment indicated the Resident had one fall with injury since the previous MDS assessment completed 3/7/25. Review of Resident #4's Care Plans indicated but was not limited to: Focus:[Resident #4] is at risk for fall related injury Disease process/condition Dementia, Muscle weakness [sic] Fall History: Fall in the last month Fall in the last 2-6 months Fracture r/t (related to) fall in last 6 mos (dated initiated 10/11/22) Interventions: -Assess resident for pain, offer repositioning, toileting, snacks or beverage (date initiated 4/21/25) -Floor mats while in bed (date initiated 12/16/24) -Frequent checks when resident is in bed. While awake offer toileting and snacks (date initiated 7/8/24) -Frequent checks while resident is wandering and redirect as needed for safety (date initiated 6/9/23, date resolved 8/26/25) -Invite, encourage, remind, escort to activity programs consistent with resident?s [sic] interests to enhance physical strengthening needs (date initiated 10/11/22) -md review of pain management, new orders for ibuprofen (date initiated 11/7/24) -Med review (date initiated 9/27/24) -Monitor resident after visits to redirect intrusive wandering into other residents rooms (date initiated 4/22/24, date resolved 8/26/25) -Monitor Silca Splint to right hand thumb for increase [sic] edema or skin breakdown OT/PT eval as needed (date initiated 10/23/24) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor stop signs across door entrances are in proper position across door entrance not hanging on floor (date initiated 10/23/24, date resolved 8/26/25) -Notify family member ask if new clothes tapered leg pants can be bought to resident r/t (related to) recent fall 12/6/22 (date initiated 12/7/22, date resolved 8/26/25) -Offer 2nd snack prior to bedtime (date initiated 7/20/23) -Offer seat close to nurse's station when resident allows (as tolerated) and offer an activity: Sensory bin, 1:1 conversation, etc. (date initiated 10/11/22, date resolved 8/26/25) -Offer toileting/provide incontinent care prior to change of shifts (date initiated 10/27/24, date resolved 8/26/25) -Overlay to mattress to define parameters while in bed (date initiated 3/7/23) -Provide environmental adaptations; Low/platform bed Call light within reach Adequate glare free lighting Area free of clutter (date initiated 10/11/22, date resolved 8/26/25) -Referral for screen & treatment as needed PT Mental Health OT (date initiated 10/11/22) -Report falls to physician and responsible party (date initiated 4/19/25) -Toilet resident prior to meals (date initiated 4/7/23, date resolved 8/26/25) Review of Resident #4's Fall Risk Evaluations completed on 7/5/24, 7/15/24, 9/9/24, 9/27/24, 10/6/24, 10/12/24, 10/18/24, 10/26/24, 12/6/24, 12/13/24, 1/13/25, 2/23/25, 4/18/25, 6/2/25 indicated the Resident was at risk for falls. Review of Resident #4's Physician Progress Notes consistently identify that the Resident had falls, but failed to address the Resident's fall risk or identify any fall prevention interventions. Review of Resident #4's medical record indicated Resident #4 had 11 falls since 7/1/24. Review of Resident #4's falls indicated: (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/9/24 at 3:15 P.M., Resident #4 was found in the hallway lying in the fetal position on his/her left side. The Resident was unable to describe what happened. No injury was noted. Predisposing factors included confusion, impaired memory, and wandering. The incident report provided to the surveyor did not include any additional staff statements. No new intervention was added to the Resident's fall prevention care plan. -10/6/24 at 3:33 P.M., Resident #4 had an unwitnessed fall in another Resident's room. No injury was noted. Predisposing factors included confusion, impaired memory, active exit seeker, and wandering. Two staff statements were included with the incident report and indicated neither staff member was aware of the Resident's fall until they were informed after the incident. No new intervention was added to the Resident's fall prevention care plan. -11/16/24 at 6:15 P.M., the nurse was notified by another resident that Resident #4 was lying on the floor. The nurse observed the Resident lying on the floor, crying, with a small pool of blood under the Resident's head. The Resident was sent to the hospital for further evaluation. No predisposing factors were identified. Staff statements included with the incident report were reviewed but no staff members witnessed the fall or indicated in their statements when the Resident was last seen or what he/she was doing when last seen. No new intervention was added to the Resident's fall prevention care plan. Review of the hospital After Visit Summary, dated 11/20/24, indicated the Resident was diagnosed with a closed intertrochanteric fracture of the left femur (a fracture of the left femur at the hip joint) and underwent surgical trochanteric nail insertion on 11/16/24. The Discharge summary, dated [DATE], indicated the Resident had a history of recurrent falls and was transferred to the hospital after an unwitnessed fall. Imaging showed a left hip fracture and left olecranon (elbow) fracture. The Resident's hip fracture was repaired surgically and the elbow fracture was treated nonoperatively with a splint. The Resident was also noted to have severe compression deformities of T12 (the twelfth thoracic vertebra, or bone in the spine), L1-L2 (the first two lumbar vertebrae), and L4 (the fourth lumbar vertebra) of indeterminate age, which were managed conservatively. -12/6/24 6:42 P.M., Resident #4 was found on the floor beside his/her bed. The nurse indicated the Resident was sitting on a wedge pillow that was used in his/her bed. No injury was noted. Predisposing factors included confusion, gait imbalance, impaired memory, and recent illness. The incident report provided to the surveyor did not include any additional staff statements. No new intervention was added to the Resident's fall prevention care plan. -12/13/24 6:16 P.M., Resident #4 was found sitting on the floor next to his/her bed. No injury was noted. No predisposing factors were identified. The incident report provided to the surveyor did not include any additional staff statements. No nursing progress note was entered in the Resident's medical record on 12/13/24. The Resident's fall prevention care plan was updated to include floor mats while in bed. -2/23/25 at 11:00 A.M., Resident #4 was observed sitting in his/her wheelchair in front of the nurse's station and tried to get up and lost his/her balance and fell. A skin tear was noted on the Resident's left upper arm. No predisposing factors were identified. A staff statement included with the incident report indicated the staff member was not aware of how the Resident had fallen as she was busy assisting another resident at the time of the fall. No new intervention was added to the Resident's fall prevention care plan. Review of Resident #4's Resident Care Card indicated the Resident was at high risk for falls but failed to include the use of floor mats as indicated in the Resident's fall prevention care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/25/25 at 9:27 A.M. and on 8/27/25 at 7:20 A.M. and 8:35 A.M., the surveyor observed Resident #4 lying in bed with no floor mats in place. During an interview on 8/26/25 at 4:06 P.M., Unit Manager #1 said when a resident has a fall, a risk report is completed in the electronic medical record, and the nurse gathers statements from staff members and notifies the physician and responsible party. Unit Manager #1 said a new fall prevention intervention should be put into place at the time of the fall, but it can be difficult to develop a new intervention for a resident who falls repeatedly. During an interview on 8/27/25 at 7:25 A.M., Certified Nursing Assistant (CNA) #10 said she was familiar with Resident #4. CNA #10 said the Resident does not use floor mats next to his/her bed but has a mattress with a raised edge because he/she still does try to climb out of bed sometimes. During an interview on 8/27/25 at 8:42 A.M., CNA #5 said CNAs do not have access to the residents' care plan interventions or care card/Kardex in the electronic health record but have a paper Resident Care Card they can refer to in a binder at the nurses' station to obtain information about residents' care needs. During an interview on 8/27/25 at 11:26 A.M., Unit Manager #1 reviewed Resident #4's fall prevention care plan with the surveyor and said the Resident no longer used floor mats and he was not aware it was in the Resident's care plan. During an interview on 8/27/25 at 12:08 P.M., the Director of Nursing (DON) said that floor mats were implemented for Resident #4 after a fall and he/she should still have them in place when in bed as this intervention was not discontinued. The DON said fall prevention interventions should be updated immediately after a fall to prevent further falls and/or injury and that if needed, the interdisciplinary team could revise the interventions after the circumstances of a fall were reviewed. The surveyor attempted to contact Resident #4's attending physician on 8/27/25 and 8/28/25, but the physician was unable to be reached. 2. Review of the facility's policy titled Elopement, dated July 2015, indicated but was not limited to: -Elopement is defined as the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way. -The Licensed Nurse will conduct an Elopement Risk Screen on admission, re-admission, annually, quarterly, and upon change of condition. -A care plan will be developed and implemented for any resident at risk for elopement. Resident #83 was admitted to the facility in August 2025 following a hospitalization and had diagnoses including alcohol dependence with withdrawal and major depressive disorder. Review of the comprehensive MDS assessment, dated 8/15/25, indicated Resident #83 had moderate cognitive impairment as evidenced by a BIMS score of 9 out of 15, exhibited no hallucinations, delusions or behaviors, received no psychotropic medication and had an activated health care proxy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/25/25 at 2:03 P.M., Nurse #3 said she initiated the admission process for Resident #83 late in the evening on 8/12/25 using hospital discharge paperwork the Resident brought from the hospital. She said there was no other hospital documentation available at the time of the admission. Nurse #3 said although Resident #83 was admitted with an activated HCP, she did not wait until she could reach the HCP to complete the elopement assessment and obtained information from the Resident. Review of an initial elopement assessment, dated 8/12/25, indicated Resident #83 was not at risk for wandering and not at risk for elopement. Review of the medical record indicated but was not limited to the following nursing progress notes: -8/17/25: Around 7:00 A.M., Resident #83 called 911 and a police officer came to the facility. The Resident stated that somebody is playing in his/her back and he/she doesn't belong there and needs to leave. -8/18/25: Resident #83 called 911 and stated there was something behind his/her window. Further review of the medical record failed to indicate the Resident was reassessed or safety interventions developed and put into place after expressing delusional thoughts/hallucinations and verbalizing feeling the need to leave the facility. Review of the medical record indicated hospital documentation (for the hospitalization immediately preceding admission) was uploaded and accessible in the electronic medical record on 8/13/25. Review of hospital documents indicated but was not limited to the Resident's past medical history, hospital course of treatment and a psychiatric evaluation. The Resident had a psychiatric assessment and was found to have poor insight, poor judgment and to not have capacity to make decisions and his/her HCP was activated. The physicians' notes indicated that Resident #83's HCP reported that the Resident had a history of elopement from his/her previous facility and eloped from the hospital while there for a medical procedure in July 2025. The case manager's discharge planning notes indicated the facility offered and the HCP accepted a bed for Resident #83 on their general long-term care unit and noted that, should any elopement risk arise, they would work with his/her HCP to transfer the Resident to a facility with a secure unit. Review of a Nursing Note, dated 8/23/25, indicated around 6:00 A.M., Certified Nursing Assistant (CNA) #4 alerted Nurse #4 that Resident #83 was found outside unaccompanied in the parking lot. Nurse #4 indicated the Resident refused to come back inside the facility but agreed to come inside the facility after the third attempt. During an interview on 8/25/25 at 1:54 P.M., CNA # 4 said she came into the facility on 8/23/25 at 6:15 A.M. and as she was walking on the unit, she heard the front door alarm going off. CNA #4 said she went out to the parking lot and saw Resident #83 walking in the parking lot toward the road. She said she was able to convince him/her to sit in a chair in the front of the building, but he/she refused to come back inside. She said she left the Resident alone seated in a chair in the front of the building while she went inside to get Nurse #4. The Surveyor attempted to reach Resident #83's HCP and Nurse #4 by telephone on 8/26/25 without success. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record failed to indicate that a reassessment of the Resident's elopement risk was conducted, and no safety interventions were put into place to prevent further elopement/attempts from the facility. Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 8/25/25, indicated that on 8/23/25, Resident #83 was last seen at approximately 3:00 P.M. At 5:30 P.M., facility staff were notified by the local police department that Resident #83 was found down the street at a liquor store by police who notified emergency medical services (EMS) related to his/her confused state. Review of the elopement investigation (in progress) included written statements, dated 8/23/25 and 8/24/25, taken by the DON and the Assistant Director of Nurses indicated but was not limited to the following: -CNA #4 said on 8/23/25 around 6:15 A.M. she heard the front door alarm go off and she went to the lobby and saw Resident #83 walking around the parking lot. She indicated she asked the Resident to come inside, and he/she refused. She said she managed to get the Resident to sit in a chair in front of the building while she went to the unit to get Nurse #4. -CNA #3 said the last time she saw Resident #83 was at 3:00 P.M. on 8/23/25 lying in bed under the covers. -Nurse #3 said the last time she saw Resident #83 on 8/23/25 was around lunchtime. She indicated around supper time, the local Fire Department (sic) called to inform them that they found the Resident on the street and transferred him/her to the hospital. During an interview on 8/26/25 at 1:45 P.M., the Director of Maintenance (DOM) said they believe Resident #83 exited through the East Unit door at the end of the hallway on 8/23/25. The DOM said the door at the end of the hallway is never used, however, when residents were testing positive for COVID a few weeks ago, they started using that door to take the COVID positive residents out to smoke. He said he came into the building on 8/24/25 to troubleshoot what happened with the door to find out how the Resident could have gotten out. He said the staff that take residents out that door to smoke must enter a code into the keypad to unlock it and prop the door open because there is no keypad outside and otherwise, they would not be able to get back in. He said once the door closes, staff need to re-enter the code into the keypad to re-engage the alarm. The DOM demonstrated entering the code into the keypad, opening the door and propping it open with a pen. The door alarm sounded, then shut off after approximately 20 seconds. He removed the pen and the door closed. He said when the click sound stops, that means the door is disarmed and cannot be activated again until someone enters the code into the keypad. He opened the door again and no alarm sounded. During an interview on 8/26/25 at 11:08 A.M., Police Officer #1 provided the survey team with a police log report, dated 8/23/25. He said Resident #83 was found by police in the community at a liquor store (one mile from the facility) at 5:02 P.M. and was transported to the hospital by the local fire department's EMS. Review of the EMS run report, dated 8/23/25 at 5:17 P.M., indicated upon EMS arrival, Resident #83 was standing outside a liquor store. The Resident told emergency personnel that he/she was lost and not sure how he/she got there. EMS transported Resident #83 to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 8/25/25 at 1:31 P.M. and 8/26/25 at 10:50 A.M. and 12:40 P.M., the DON said she believes the Resident exited the facility through the East Unit door that did not have the alarm activated. She said an investigation revealed that staff prop open the alarmed East Unit door while they take residents out to smoke and after a short amount of time, the alarm disengages. She said when they came back inside, they should have ensured the door was secured shut and entered the code into the keypad to reactivate the alarm, but that did not happen. She said the physician and HCP should have been notified of the Resident's elopement attempt the morning of 8/23/25, a reassessment of the Resident's elopement risk should have been conducted, and safety interventions should have been put into place prevent the elopement that occurred later that day and that was not done.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on the results of 2 of 2 test trays (one breakfast and one lunch meal) and staff and resident interviews, the facility failed to provide residents with meals and drinks that were palatable, attractive, and at a safe and appetizing temperature. Findings include: During the Resident Council Meeting, held with the surveyor on 8/25/25 at 1:30 P.M. with 12 residents in attendance, the residents complained about the food as follows:-8 of 12 residents said the food is not good, it's repetitive, and desserts are served frozen. During interviews on 8/21/25 at 9:05 A.M., four residents (#30, #81, #27, and #13) on the [NAME] Unit complained that they disliked the meals they are served. Review of Food Committee Minutes, dated 5/21/25, indicated residents complained that the temperature of the food was so-so. The Food Service Director (FSD) indicated that dining services does at least two test trays a month and will do one every week as a follow-up.Review of Test Tray Evaluations provided by the FSD, indicated test trays were conducted with inadequate food temperatures as follows:-6/3/25 [NAME] Unit: -noodles 128 degrees -milk 46 degrees-6/25/25 East Unit: -meatloaf 128 degrees -asparagus 119 degrees -roasted potatoes 123 degrees -pudding 48 degrees-8/14/25 East Unit: -waffle 129 degrees On 8/27/25, the surveyor conducted two test trays one at the breakfast meal and one at the lunch meal. On 8/27/25 at 7:25 A.M., the surveyor observed the breakfast test tray to be assembled and loaded onto the meal truck with 19 resident meal trays. The truck left the kitchen at 7:33 A.M. and arrived to the East Unit at 7:34 A.M. The test tray was the last tray served and removed from the truck at 7:55 A.M. The surveyor conducted the test tray with the Food Service Director (FSD) present with the following results: Test Tray #1 Breakfast Meal-East Unit-French Toast-80 degrees-cool, dry, bland, and unappealing to taste.-Cream of Wheat hot cereal-120 degrees, bland and warm to taste-Orange juice-48 degrees-cool to taste -Whole milk-45 degrees-cool to taste -Hot coffee-114 degrees-lukewarm, unappealing to taste During an interview at this time, the FSD said the French toast, cream of wheat, and hot coffee temperatures were not at appropriate temperatures. The FSD tasted the French toast and said that it wasn't palatable. The FSD said that it took a significant amount of time, longer than usual, to deliver the trays. On 8/27/25 at 11:30 A.M., the surveyor observed the lunch test tray to be assembled and loaded onto the meal truck. The truck left the kitchen at 11:32 A.M. and arrived to the East Unit at 11:33 A.M. The test tray was the last tray served and removed from the truck at 11:47 A.M. Test Tray #2 Lunch Meal, East Unit-Baked chicken: 130 degrees, warm, dry, bland and unappealing to taste. -Rice: 140 degrees, warm, bland, and unappealing to taste. -Mixed vegetables: 112 degrees, lukewarm, bland, and unappealing in flavor and taste.-melon: 55 degrees, cool to taste-Milk: 42 degrees, cold to taste-Coffee: 135 degrees, hot to taste During an interview on 8/27/25 at 11:55 A.M., following completion of the lunch test tray, the FSD said that temperatures and food palatability were not acceptable for both the breakfast and lunch test trays. The FSD said the rice could use some salt.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Ensure the main kitchen dry food storage was maintained in a sanitary condition; 2. Follow proper sanitation and food handling practices while thawing chicken to prevent the outbreak of foodborne illness; and3. Ensure the tile flooring in the main kitchen was maintained in a sanitary and safe condition.Findings include:1. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: -6-501.111 Controlling Pests. Insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments.-6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by:-(B) Routinely inspecting the PREMISES for evidence of pests-(D) Eliminating harborage conditions.On 8/21/2025 7:56 A.M., the surveyor observed the main kitchen dry food storage area and made the following observations:-On the left side of the room there were multiple shelves of canned goods encrusted with rust along the can ends and a large amount of mouse droppings on top of the cans.During an interview on 8/21/25 at 8:20 A.M., the Food Service Director (FSD) inspected the dry storage area with the surveyor. He said the cans of food with rust along the ends and mouse droppings were the emergency food supply. He said they have had a mouse problem for a while, and they used to sanitize the tops of the cans because of the mouse droppings, and he thinks that is why they became rusted. The FSD said he was not aware of the rust and mouse droppings on the cans, and he needs to replace them. 2. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: -3-501.13 Thawing. TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at 5oC (41oF) or less Pf (priority foundation); or (B) Completely submerged under running water: (1) At a water temperature of 21oC (70oF) or below Pf, (2) With sufficient water velocity to agitate and float off loose particles in an overflow Pf, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5oC (41oF) Pf, or (4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under 3-401.11(A) or (B) to be above 5oC (41oF), for more than 4 hours including: (a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking Pf, or (b) The time it takes under refrigeration to lower the FOOD temperature to 5oC (41oF) Pf On 8/21/25 at 7:56 A.M., the surveyor observed in the main kitchen a large stainless steel mixing bowl placed on a sink worktable containing approximately 10 raw chicken breasts submerged in stagnant water. The outside of the mixing bowl was ambient temperature to touch. During an interview on 8/21/25 at 8:20 A.M., the FSM said the chicken in the mixing bowl was going to be served as an alternate meal today. He touched the mixing bowl with the back of his hand and said the dietary staff should have taken the frozen chicken out and placed it in the refrigerator to thaw and not left it in standing water. 3. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 1-2 Definitions 1-201 Applicability and Terms Defined 1-201.10 Statement of Application and Listing of Terms. Easily Cleanable. (1) Easily cleanable means a characteristic of a surface that: (a) Allows effective removal of soil by normal cleaning methods; (b) Is dependent on the material, design, construction, and installation of the surface; and (c) Varies with the likelihood of the surface's role in introducing pathogenic or toxigenic agents or other contaminants into food based on the surface's approved placement, purpose, and use. Smooth means: (3) A floor, wall, or ceiling having an even or level surface with no roughness or projections that render it difficult to clean. 6-201.12 Floors, Walls, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ceilings, Utility Lines. Floors that are of smooth, durable construction and that are nonabsorbent are more easily cleaned. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible and that insect and rodent harborage is minimized. On 8/21/2025 at 7:56 A.M., the surveyor observed, in the main kitchen, several areas of compromised flooring with several sections of tiling missing revealing deeply recessed areas of the floor exposing the subfloor underneath and pooling water. During an interview on 8/27/25 at 11:26 A.M., the FSD said the flooring is in need of repair and the maintenance department is aware but haven't fixed it yet.

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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. Based on observations, interview, and records reviewed, 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 to:1. Ensure Transmission Based Precautions (TBP), specifically Isolation Precautions, were implemented as indicated for residents positive for COVID-19;2. Maintain and implement a Water Management Program to mitigate the risks of Legionella;3. Ensure the infection surveillance line lists were complete and accurate;4. Ensure medications were handled in a sanitary manner during administration for one out of two nurses observed; and5. Ensure personal protective equipment (PPE) was used properly by staff while caring for Resident #1 who was on Enhanced Barrier Precautions (EBP) to prevent the potential spread of infection. Findings include:1. Review of the facility's policy titled COVID-19 New Facility Outbreak for Massachusetts (MA), dated 6/24/23, indicated but was not limited to the following: -Residents with COVID-19 should be placed in a private room or in a room with another confirmed COVID-19 positive individual. (Use MA Department of Public Health (DPH) Isolation Sign for positive residents). -Place Pink Isolation sign on the door. Review of the facility's policy titled Section 1: Isolation, dated as last revised 3/2025, indicated but was not limited to the following: -TBP are for patients who are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. Review of the MA DPH Isolation sign posted at the doorway of Residents #28, #77, #52, and #39's rooms indicated but was not limited to the following: -In Addition to Standard Precautions Staff and Providers MUST Clean Hands when entering and exiting, Gown (change between each resident), N95 Respirator, Eye Protection, and Gloves. Review of the medical records for Residents #28, #77, #52, and #39 indicated they had tested positive for COVID-19 and were on Isolation Precautions. The surveyor made the following observations on 8/21/25: -At 8:57 A.M., a staff member was at the doorway of Resident #28 and #77's room, she donned (put on) a gown, gloves, and face shield. She was wearing a surgical mask and did not don an N95 Respirator. Resident #39 exited his/her room, and the Certified Nursing Assistant (CNA) redirected him/her back into their room. Upon re-entry to the hallway, she donned a new gown, gloves, and face shield. She was wearing a surgical mask and did not don an N95 Respirator and proceeded to enter the room to answer the call light. -At 9:01 A.M., a Laundry Worker was pushing a large linen cart down the hallway delivering personal laundry. She parked the cart outside of Resident #28 and #77's room. She donned a gown, gloves, and N95 Respirator. She did not put on a face shield. She then proceeded to bring the laundry into their (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southshore Health Care Center	115 North Avenue Rockland, MA 02370

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. Upon exiting the room, she donned a clean surgical mask and moved her cart to Resident #52 and #39's room. She donned a gown and gloves. She did not don an N95 Respirator or face shield and entered the room to deliver the laundry. -At 9:18 A.M., CNA #5 donned a gown and gloves and entered Resident #28 and #77's room. She was wearing a surgical mask and did not have an N95 or a face shield on. -At 9:21 A.M., Nurse #7 donned a gown, face shield and gloves and entered Resident #28 and #77's room. She was wearing a surgical mask and did not have an N95 on. -At 9:26 A.M., an X-Ray Technician entered the room of Resident #28 and #77 with no PPE on. Nurse #7 came to the doorway of the room, and they entered the room together. -At 9:50 A.M., CNA #5 donned a gown, gloves, and face shield and entered Resident #28 and #77's room. She was wearing a surgical mask and did not have an N95 on. -At 9:54 A.M., Nurse #7 was at the med cart in front of Resident #39 and #52's room pouring medications. She donned a gown, put an N95 over her surgical mask, donned gloves, and a face shield. She entered the room with the medications. -At 9:56 A.M, CNA #5 donned a gown, gloves, and face shield and entered Resident #28 and #77's room. She was wearing a surgical mask and did not have an N95 on. -At 2:15 P.M., a staff member was outside with Residents #28 and #77. The residents were smoking. The staff member was wearing a gown, gloves, and face shield. She was wearing a surgical mask and did not have an N95 on. -At 4:08 P.M., a staff member was outside with Residents #28 and #77. The residents were smoking. The staff member was wearing a gown, gloves, and face shield. She was wearing a surgical mask and did not have an N95 on. During an interview on 8/21/25 at 10:32 A.M., Nurse #1 said Residents positive for COVID-19 have an isolation sign and all staff should have a gown, N95, face shield, and gloves on when they enter the room. During an interview on 8/21/25 at 10:46 A.M., CNA #5 said staff should have a gown, N95, face shield, and gloves on when they enter the COVID-19 rooms. She said she was unsure if they always had to wear the N95, but said she usually wears one. During an interview on 8/21/25 at 10:53 A.M., Nurse #7 said for the COVID positive rooms you are supposed to wear a gown, gloves, N95, and a face shield. She said sometimes she puts the N95 over her surgical mask, like she did today, but not always. She said the X-Ray Technician should have put PPE on, but he refused. During an interview on 8/22/25 at 1:05 P.M., the Staff Development Coordinator (SDC)/Infection Preventionist (IP) and the Director of Nurses (DON) said all staff should have full PPE on to enter the COVID positive rooms. She said that it includes a gown, N95, face shield, and gloves. Additionally, she said the PPE expectations is the same when the staff take the Residents out to smoke and the N95 should not be placed over a surgical mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's policy titled Section L: Legionella Policy, dated as last reviewed 1/2025, indicated but was not limited to the following: -It is the policy of this facility to have a water management program to reduce legionella bacteria growth and spread in the facility, and to educate staff on hire and annually on legionella symptoms. (Refer to the separate Water Management Program Policy). -Common Sources of infection: Outbreaks of Legionnaires' disease are often associated with large or complex water systems. The most likely sources of infection include water used for showering (potable water), cooling towers, decorative fountains, and hot tubs. -Legionella is usually spread through water droplets in the air. Review of the facility's policy titled Water Management Plan, undated, indicated but was not limited to the following: -All Healthcare facilities shall comply with the federal requirements for the purpose of reducing the risk of growth and spread of Legionella and other opportunistic pathogens in the water system. -Facilities shall adopt and implement a water management plan for their water system. The plans should include at minimum an overview of the facility characteristics, description of water supply, areas of concern, and sample sites to be tested. -Environmental assessments shall be updated annually and under the following conditions: positive case of legionellosis, completion of construction, modification, or repair activities that may affect the water system, and any other conditions specified by the department. The facility shall retain copies of completed environmental assessment forms. -Facility shall maintain the environmental assessment, sampling and management plan and any associated sampling results, on the facility premises for at least three years. Such records should be made available to the local and state department upon request. Review of the Water Management Plan Binder indicated but was not limited to the following: -Environmental Assessment and Procedures, dated 2/27/18, indicated the assessment is to discover any vulnerabilities that would allow for amplification of Legionella and to structure a response in advance. Showers, tubs, faucet taps should be periodically flushed to help mitigate the potential for stagnation. Daily testing of the water temperature delivered at the taps and recorded should be conducted. Environmental sampling for Legionella will be performed annually. Once Assessment is completed, it should be reviewed and updated at least one time per year. Water Management Committee members should include at minimum: Infection Control, Facilities Management, Nursing, and Administration. -Annual Water Management Plan Revision and Updates, dated 2/11/19 and 3/10/20, were in the binder. No additional annual updates were provided. Review of the Weekly Water Temperature logs indicated but were not limited to the following: -Record from 3/2/24 through 11/30/24 indicated three rooms on East Unit, three rooms on [NAME] (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Unit, the Kitchen, and Laundry rooms were all temperature tested weekly. -Record from 12/7/24 through 8/15/25 indicated four rooms on East Unit and four rooms on [NAME] Unit were temperature tested weekly. The log failed to indicate water temperature testing was conducted in the kitchen or laundry rooms. During an interview on 8/22/25 at 1:05 P.M., the IP and DON said they were not part of a Water Management/Legionella Committee or team. They said water committee includes the Administrator and Maintenance Supervisor and they were not routinely part of it and did not know when the Water Management Plan was discussed. During an interview on 8/22/25 at 1:55 P.M., the Maintenance Supervisor said the weekly water temperature testing logs should have sinks/showers/faucets from varying rooms on each unit, the shower/tub room, laundry, kitchen and kitchenettes. He said when they run the water they check the temperature. He said when the form was full at the end of November it appears the other sites dropped off. He said only the rooms on the units have been checked since November 2024 and there was no log of any temps in any kitchen/laundry areas. He said it seems when the copies with site written on them ran out, they just started doing four rooms on each unit and he did not know why. The Maintenance Director said he did not have a Water Management Committee or meetings. He said the Water Management Plan says it should be updated annually and did not know why it had not been done since 2020. Additionally, he said he has never met with the firm that does that Water Management Plan. He said the binder is on the shelf and they put the documents in it once they are done, same with the lab that does the Legionella testing. During an interview on 8/22/25 at 2:30 P.M., the Administrator said he had only been at the facility for a couple months and was under the impression the water temps, pressure, flushing was all up to date. He said the Maintenance Department handles it and he has not seen the plan or been part of any committee meetings as he had only been at the facility for less than two months. He said they only had informal conversations to ensure the logs were complete, but he had not seen the actual logs. He said the logs should include resident rooms on each unit, the laundry, kitchen, kitchenettes, administration wing etc. He said the exact location should vary every week. He said it was concerning it had not been done correctly since November and no one noticed. 3. Review of the facility's policy titled Infection Prevention Program, dated as last reviewed 1/2025, indicated but was not limited to the following: -Elements of the Infection Prevention Program include but are not limited to monitoring and documenting infections, tracking and analyzing outbreaks of infections. -Analyze trends and clusters of infections, and any increase in the rate of infection or resistant organisms, in a timely manner. -Maintain the monthly infection reports by unit to record each resident infection. -Monitor community acquired (CA) infections in residents admitted to the facility and attempt to obtain results and diagnosis of infection. -If an infection is counted for the month and continues in to the next month it is only counted once. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Monthly Infection Reports from January through July 2025 indicated but were not limited to the following: JANUARY -A Resident was coded with an ongoing infection with an antibiotic listed. No additional information related to the infection was documented. Site, date of onset, symptoms, culture date/results, and comments were all left blank. -A Resident was coded with pneumonia on three occurrences and treated with the same antibiotic. The first was listed as not meeting criteria to be counted due to only having one symptom, the second had four symptoms listed and was coded as ongoing, and the third was coded as asymptomatic with a positive chest X-Ray. -A Resident was coded with a urinary tract infection (UTI), one symptom was listed, no culture or results were documented. -A Resident was coded on two lines with skin listed as the category, both lines had different antibiotics, comment was cellulitis. No symptoms were documented on either line. -On 24 of 24 line items, the box Infection Cleared Y/N was left blank. FEBRUARY -A Resident was coded with a UTI and on an antibiotic. The date of onset was listed as ongoing. This UTI was not on the January line list and no other information related to the infection was documented. -A Resident was coded with a blood stream infection with an antibiotic listed, symptoms were listed as ongoing. The date of onset was listed as 2/20/25. No other information related to the infection was documented. -A Resident was coded with a UTI and on antibiotics, the culture date and results was left blank. -On 19 of 19 line items, the box Infection Cleared Y/N was left blank. MARCH -A Resident was coded with a Gastrointestinal (GI) infection and on antibiotics. No other information related to the type of infection was documented. -A Resident was coded with an other infection, symptom was chest pain, and on an antibiotic. Comment was leukocytosis (high white blood cells), no blood work results were documented. -On 17 of 17 line items the box Infection Cleared Y/N was left blank. APRIL -A Resident was coded with a skin infection, listed as onset date 4/1/25, on antibiotics, and coded as ongoing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-For eight Infections, the box indicating to count or not count was left blank. -On 19 of 19 line items, the box Infection Cleared Y/N was left blank. MAY -A Resident was coded with an other infection, comments indicate C. Diff infection, no symptoms, culture date/results were documented. -On 16 of 16 line items, the box Infection Cleared Y/N was left blank. JUNE -A Resident was listed with a date of onset 6/16/25, no category was listed, an antibiotic was listed, no culture date/results were documented. -On 16 of 16 line items, the box Infection Cleared Y/N was left blank. JULY -A Resident was coded with a GI infection and on antibiotics, date of culture was left blank -On 8 of 8 line items, the box Infection Cleared Y/N was left blank. The sample of the line lists reviewed failed to consistently indicate infection symptoms, culture dates/results, and if the infection had cleared. Additionally, infections were listed as ongoing when they were not all on the month prior. During an interview on 8/22/25 at 1:05 P.M., the IP said when things are coded as ongoing, they were carried over from the month prior. She said they should have been on the line list the month prior; however, some were missing. The IP said they all should have every applicable box filled out on the worksheet, including if the infection cleared or not. She said the culture dates and results should be there for tracking purposes as well. She said the follow-up notes when not meeting criteria could be better and she was working on that. During an interview on 8/22/25 at 1:05 P.M., the DON said the line list should be complete for tracking purposes. She said usually when information is missing the lab will call and we probably tell them over the phone without updating the paper copy. She said the ones listed as ongoing should have been carried over from the month prior. Additionally, the DON said without the culture results listed a pattern cannot be identified with the data as it is listed. She said the IP was still learning the role. 4. Review of the facility's policy titled Medication Administration, Oral, dated June 2015, indicated but was not limited to the following: -Do not touch the medication when opening a bottle or unit dose packing Resident #24 was admitted to the facility in September 2024. Review of the current Physician's Orders for Resident #24 indicated, but were not limited to the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following: - Diltiazem HCL ER 120 milligrams (mg) 1 cap daily (9/28/24) - Duloxetine HCL 60mg 1 cap in the morning (1/3/25) - Metoprolol Tartrate 50mg 1 tab two times a day (9/28/24) - Gabapentin 300mg capsule two times a day (9/28/24) On 8/21/25 at 9:11 A.M., the surveyor observed Nurse #2 preparing medications for Resident #24. While verifying the medications and removing them from their individual unit dose packages, the nurse was observed to pop the following medications from their individual dose packages directly into his hands: - Diltiazem HCL ER 120mg 1 cap - Duloxetine HCL 60mg 1 cap - Metoprolol tartrate 50mg 1 tab - Gabapentin 100mg - 3 individual tabs to equal the 300mg dose During an interview on 8/21/25 at 9:43 A.M., Nurse #2 said he did not realize he had popped those pills directly into his hand prior to placing them into the medication cup and he shouldn't have done that. He said nurses should not touch the pills before administering them to the residents, as that would be a concern for germs. During an interview on 8/21/25 at 11:11 A.M., the IP said the expectation is for the licensed nurses to complete medication administration with good infection control practices, like hand hygiene. The IP said the licensed nurses should not be touching any of the medications or popping them directly into their hands during medication pass or at any time. She said this would be a breech in the infection control practices and should not be occurring. 5. Review of the facility's policy Enhanced Barrier Precautions Policy, dated July 2022, indicated but was not limited to the following: - It is the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multi-drug resistant organisms (MDROs). Novel or targeted MDROs are organisms that are resistant to all or most antibiotics tested, are uncommon in a geographic area, or have special genes that allow them to spread their resistance to other germs. - Enhanced barrier precautions require the use of a gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk for transmission of multidrug-resistant organisms. - High-contact resident care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Enhanced barrier precautions will also be implemented for residents with wounds, or indwelling medical devices (central lines, catheter, feeding tube, etc.) regardless of their MDRO colonization status that reside on a unit or wing where a resident known to be infected or colonized with a novel or targeted MDRO resides. - Signage will be posted on the door or wall outside of the resident room indicated the need for enhanced barrier precautions, the required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. - Carts with appropriate PPE will be placed outside the resident's room. Resident #1 was admitted to the facility in July 2025 with diagnoses including but not limited to Parkinson's disease and muscle weakness. Review of Resident #1's Minimum Data Set (MDS) assessment, dated 8/1/25, indicated he/she was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. Furthermore, the MDS assessment indicated Resident #1 had a feeding tube and required assistance from staff for activities of daily living (ADL) and functional mobility. Review of Resident #1's comprehensive care plans indicated he/she had an increased susceptibility for infection related to a G-Tube (gastrostomy tube – surgically placed to give access to the stomach for supplemental feeding, hydration or medicine). Interventions for the comprehensive care plan were implemented on 5/13/24 and included but were not limited to EBP as ordered. On 8/22/25 at 2:23 P.M., the surveyor made the following observations: - Resident #1 had an EBP sign posted on the doorway entrance to his/her room and a PPE cart outside of the doorway that included gowns, gloves, masks and face shields. - At 2:23 P.M., the surveyor observed CNA #1 transferring Resident #1 from a wheelchair at beside to his/her bed. CNA #1 was not wearing a gown or gloves. - At 2:27 P.M., CNA #1 re-entered Resident #1's room without donning any PPE. - At 2:45 P.M., CNA #1 exited Resident #1's room with a pair of pants and no PPE. During an interview on 8/22/25 at 2:45 P.M., CNA #1 said she assisted Resident #1 with transferring from his/her chair to their bed. CNA #1 said she also helped assist Resident #1 with changing his/her clothing. CNA #1 said she did not wear a gown because she was not performing ADL care with the resident. CNA #1 and the surveyor reviewed the signage outside of Resident #1's room which indicated a gown was required when transferring and/or dressing. CNA #1 said she did not wear a gown when assisting Resident #1 and did not need to because she did not perform ADL care. During an interview on 8/22/25 at 2:51 P.M., the Assistant Director of Nursing (ADON) said gowns and gloves should be worn when transferring or undressing a resident. During an interview on 8/22/25 at 2:52 P.M., the IP said CNA #1 should have worn a gown and gloves when transferring or undressing Resident #1.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interviews, the facility failed to ensure one Resident (#5), out of a total sample of 20 residents, had their call light accessible and within reach in order to utilize to call for assistance. Findings include: Review of the facility's policy titled Call Light, Use of, dated April 2015, indicated but was not limited to the following:- All [Corporate Name] Health Care Systems resident/patients will have a call light or alternative communication device within his/her reach when unattended.- When providing care to the residents/patients be sure to position the call light conveniently, telling/showing the resident/patient where the call light is located. Resident #5 was admitted to the facility in July 2025 with diagnoses including muscle weakness, abnormalities of gait and mobility and heart failure. Review of Resident #5's Minimum Data Set (MDS) assessment, dated 8/5/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. On 8/22/25 at 10:41 A.M., the surveyor observed Resident #5 in bed with his/her call light device tucked into the second drawer of their bedside dresser. The call light was not within reach.On 8/22/25 at 12:01 P.M., the surveyor observed Resident #5 in bed with his/her call light tucked into the second drawer of their bedside dresser. The call light was not within reach.On 8/26/25 at 4:20 P.M., the surveyor observed Resident #5 in bed with his/her call light device tucked into the drawer of their bedside dresser. The call light was not within reach. Review of Resident #5's comprehensive care plan for falls indicated but was not limited to the following interventions:- Provide environmental adaptations: call light within reach During an interview on 8/22/25 at 10:41 A.M., Resident #5 said the staff move the call light a lot and he/she cannot get to it. Resident #5 said he/she likes to have the call light next to them so he/she can reach it. During an interview on 8/22/25 at 11:00 A.M., Certified Nursing Assistant (CNA) #5 said all residents on the [NAME] Unit use a traditional call bell plugged into the wall. CNA #5 said all residents should have their call bell in reach at all times. CNA #5 said she usually ties the call bell to a resident's side rail but if they do not use side rails, they can use the clip to leave them with a resident. During an interview on 8/22/25 at 11:01 A.M., CNA #9 said all residents should have a call bell in reach to communicate their needs to the staff. CNA #9 said staff make sure call bells are within reach at all times. CNA #9 said call bells should have a clip but when they do not, they are tied to the side rails. During an interview on 8/27/25 at 1:00 P.M., Nurse # 5 said call bells should always be left in reach of the resident. Nurse #5 said Resident #5 is able to use their call bell to ask for assistance from staff. During an interview on 8/27/25 at 1:02 P.M., the Director of Nursing (DON) said call bells should always be left within the resident's reach. The DON said a call bell should never be left in a resident's drawer and out of their reach.

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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 their abuse policy when one Resident (#51), was involved in a resident-to-resident altercation, in a total sample of 20 residents. Specifically, the facility failed to ensure facility staff who were aware of the incident reported the altercation to leadership to allow for reporting, investigating, and implementing measures to prevent potential future altercations. Findings include: Review of the facility's policy titled Abuse, Neglect and Exploitation, dated as reviewed 2/2023, indicated but was not limited to:1.Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.2. The facility will develop and implement written policies and procedures that establish policies and procedures to investigate any such allegations.3. The facility will provide ongoing oversight and supervision of staff to assure that its policies are implemented.4. The facility will have written procedures to assist staff in identifying the different types of abuse, this includes certain resident-to-resident altercations.5. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.6.Written procedures for investigation include: -Identifying staff responsible for the investigation-Identifying and interviewing all involved persons including the alleged victim, alleged perpetrator, witness, and others who might have knowledge of the allegation-Focusing the investigation on determining if abuse, neglect, exploitation, and/ or mistreatment has occurred-Providing complete and thorough documentation of the investigation7. The facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult Protective Services and to all other required agencies within specified timeframes (Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury). Resident #51 was admitted to the facility in July 2023 with diagnoses which included metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance). Review of Resident #51's Minimum Data Set (MDS) Assessment, dated 7/18/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #51's progress note, dated 7/22/24, indicated but was not limited to:-Resident #51 told staff that Resident #14 made fun of him/her in the hallway-Nurse spoke to Resident #14 who denied making fun of Resident #51 Review of the facility grievance binder and the Health Care Facility Reporting System (HCFRS, a web-based system that health care facilities must use to report incidents and allegations of abuse, neglect, and misappropriation) failed to indicate the resident-to-resident altercation had been documented and/or reported. During an interview on 8/27/25 at 11:14 A.M., Certified Nursing Assistant (CNA) #7 said when there is an incident between residents the staff should ensure residents are safe and report it to a nurse or a facility manager. During an interview on 8/26/25 at 5:01 P.M., Nurse #6 said any time a resident-to-resident altercation occurs the facility staff must make sure the resident is safe and notify the facility management team so they can investigate it. Nurse #6 said a resident-to-resident altercation included physical touch, verbalizations, and/or gestures. Nurse #6 said even if the accused is joking it is about how the resident on the receiving end feels about it. During an interview on 8/27/25 at 11:19 A.M., Nurse #5 said when a resident-to-resident altercation occurs the staff must ensure everyone is safe and then notify the manager. Nurse #5 said if a resident reported being made fun of, she would follow the abuse policy. During an interview on 8/27/25 at 11:50 P.M., Social Worker #1 said when a resident-to resident altercation occurs it needs to be reported and investigated. During an interview on 8/27/25 at 12:27 P.M., the Director of Nurses (DON) said when a resident-to-resident altercation occurs staff should ensure that all residents are safe. The DON said that abuse, allegations of abuse, or suspicion (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of abuse should be reported in the HCFRS and investigated. The DON said the facility should also ensure interventions to prevent any potential future abuse are implemented. During an interview on 8/27/25 at 2:55 P.M., the DON said she was still looking to see if there was an investigation for the 7/22/24 resident-to-resident altercation. During an interview on 8/27/25 at 3:18 P.M., the DON said the nurse did not report the altercation to management and it was not reported or investigated. The DON said the policy should have been followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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, for one Resident (#51), of 20 sampled residents, the facility failed to ensure an allegation of abuse was reported timely to the state agency as required. Findings include:Review of the facility's policy titled Abuse, Neglect and Exploitation, dated as reviewed 2/2023, indicated but was not limited to:-Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability-The facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult Protective Services and to all other required agencies within specified timeframes (Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury)-Appendix A; Massachusetts: Abuse, neglect, and/or exploitation allegations should be reported via the electronic reporting platform to the Massachusetts Department of Public Health within the appropriate timeframe. Resident #51 was admitted to the facility in July 2023 with diagnoses which included metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance) Review of Resident #51's Minimum Data Set (MDS) Assessment, dated 7/18/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #51's progress note, dated 7/22/24, indicated but was not limited to:-Resident #51 told staff that Resident #14 made fun of him/her in the hallway-Nurse spoke to Resident #14 who denied making fun of Resident #51 Review of the facility grievance binder and the Health Care Facility Reporting System (HCFRS, a web-based system that health care facilities must use to report incidents and allegations of abuse, neglect, and misappropriation) failed to indicate the alleged resident-to-resident altercation was documented and/or reported. During an interview on 8/26/25 at 5:01 P.M., Nurse #6 said any time a resident to resident altercation occurs the facility staff should ensue the resident is safe and notify the facility management team. Nurse #6 said a resident-to-resident altercation included physical touch, verbalizations and/or gestures. Nurse #6 said even if the accused is joking it is about how the resident on the receiving side of the joke feels. During an interview on 8/27/25 at 11:19 A.M., Nurse #5 said when a resident-to-resident altercation occurs the staff must ensure everyone is safe and then notify a manager. Nurse # 5 said if a resident reported being made fun of she would follow the abuse policy. During an interview on 8/27/25 at 11:50 P.M., Social Worker # 1 said when a resident-to resident altercation occurs it needs to be reported. During an interview on 8/27/25 at 12:27 P.M., the Director of Nurses (DON) said abuse/allegations of abuse, suspicion of abuse should be reported to HCFRS. During an interview on 8/27/25 at 3:18 P.M., the DON said the nurse did not report the 7/22/24 altercation to management and it was not reported. The DON said the policy should have been followed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interviews, for one Resident (#51), of 20 sampled residents, the facility failed to ensure allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated. Specifically, for Resident #51, the facility failed to ensure a resident-to-resident verbal altercation was investigated. Findings include:Review of the facility's policy titled Abuse, Neglect and Exploitation, dated as reviewed 2/2023, indicated but was not limited to:1. Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.2. The facility will develop and implement written policies and procedures that establish policies and procedures to investigate any such allegations.3. The facility will provide ongoing oversight and supervision of staff to assure that its policies are implemented.4. The facility will have written procedures to assist staff in identifying the different types of abuse, this includes certain resident-to-resident altercations.5. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.6.Written procedures for investigation include: -Identifying staff responsible for the investigation-Identifying and interviewing all involved persons including the alleged victim, alleged perpetrator, witness, and others who might have knowledge of the allegation-Focusing the investigation on determining if abuse, neglect, exploitation, and/ or mistreatment has occurred-Providing complete and thorough documentation of the investigation7. The facility will have written procedures that include reporting of all alleged violations to the administrator, state agency, adult Protective Services and to all other required agencies within specified timeframes (Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury). Resident #51 was admitted to the facility in July 2023 with diagnoses which included metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance). Review of Resident #51's Minimum Data Set (MDS) Assessment, dated 7/18/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #51's progress note, dated 7/22/24, indicated but was not limited to:-Resident #51 told staff that Resident #14 had made fun of him/her in the hallway-Nurse spoke to Resident #14 who denied making fun of Resident #51 Review of the facility grievance binder and the Health Care Facility Reporting System (HCFRS, a web-based system that health care facilities must use to report incidents and allegations of abuse, neglect, and misappropriation) failed to indicate the alleged abuse had been investigated. During an interview on 8/26/25 at 5:01 P.M., Nurse #6 said any time a resident-to-resident altercation occurs the facility staff should ensure the resident is safe and notify the facility management team so they can investigate it. During an interview on 8/27/25 at 11:19 A.M., Nurse #5 said when a resident-to-resident altercation occurs the staff must ensure everyone is safe and then notify a manager. Nurse # 5 said if a resident reported being made fun of, she would follow the abuse policy. During an interview on 8/27/25 at 11:50 P.M., Social Worker #1 said when a resident-to resident altercation occurs it needs to be investigated. During an interview on 8/27/25 at 12:27 P.M., the Director of Nurses (DON) said when a resident-to-resident altercation occurs staff should ensure that all residents are safe. The DON said that abuse/allegations of abuse, suspicion of abuse should be investigated. During an interview on 8/27/25 at 2:55 P.M., the DON said she was still looking to see if there was documentation, including an investigation, regarding the 7/22/24 resident-to-resident altercation. During an interview on 8/27/25 at 3:18 P.M., the DON said the nurse did not report the altercation to management and it was not investigated. The DON said the policy should have been followed.

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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 comprehensive care plans for three Residents (#83, #51, and #5), out of a total sample of 20 residents. Specifically, the facility failed:1. For Resident #83, to develop and implement comprehensive care plans for a change in mental status including delusions and hallucinations and elopement risk;2. For Resident #51, to ensure a comprehensive care plan was developed to address his/her history of thoughts to self-harm; and3. For Resident #5, to ensure a comprehensive care plan was developed to address his/her oxygen therapy usage. Findings include:Review of the facility's policy titled Comprehensive Care Plans, last revised November 2017, indicated but was not limited to: -This facility is committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life. Recognizing each resident as an individual, we identify and meet those needs in a resident-centered environment. Care plans are oriented toward preventing avoidable decline in clinical and functional levels, maintaining a specific level of functioning and reflect resident preferences and right to refuse certain services or treatment. -Care plans are a combination of: -Data concerning the resident that is obtained from the physician -Clinical records such as the hospital discharge summary -Evaluations done professional and other disciplines -The resident and/or family goals for treatment -Acute/chronic events, behaviors and/or illness -Based on the above, the Interdisciplinary Team develops a comprehensive Care Plan for each resident that includes measurable objectives and timelines to accommodate preferences, special medical, nursing and psychosocial needs identified in the RAI and IDT -The Care Plan is evaluated and revised as needed, but at least quarterly 1. Resident #83 was admitted to the facility in August 2025 and had diagnoses including major depressive disorder. Review of the Minimum Data Set (MDS) assessment, dated 8/15/25, indicated Resident #83 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15, exhibited no hallucinations, delusions or behaviors, received no psychotropic medication and had an activated health care proxy (an individual designated to make medical decisions on your behalf when a doctor determines you lack the capacity to make or communicate your own decisions). Review of a Nursing Progress Note, dated 8/17/25, indicated Resident #83 called 911 (a phone number used to contact emergency services) around 7:00 A.M. and a police officer came to the facility to speak with the Resident. The note indicated Resident #83 told the officer that somebody was playing in his/her back and that he/she doesn't belong here and needs to leave. (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 a Nursing Progress Note, dated 8/18/25, indicated Resident #83 called 911 and stated there was something behind his/her window. Staff checked the window and showed the Resident that there was nothing behind the window. Review of a Nursing Progress Note, dated 8/23/25, indicated around 6:00 A.M., the lead Certified Nursing Assistant (CNA) informed the nurse that Resident #83 was outside walking in the parking lot. The nurse indicated the Resident was last seen about 10 minutes before seated in the TV room on the unit. After three attempts, the Resident agreed to return to the building. Review of comprehensive care plans failed to indicate a care plan had been developed to address the Resident's change in mental status, verbalizations of needing to leave the facility, and elopement attempt on 8/23/25. During an interview on 8/25/25 at 1:31 P.M., the Director of Nursing (DON) said care plans should have been developed and interventions put into place to address the change in the Resident's mental status and elopement risk but were not. 2. Resident #51 was admitted to the facility in July 2023 with diagnoses which included schizoaffective disorder (a mental health condition characterized by symptoms such as hallucinations, delusions, and mood disorders) and auditory hallucinations (the perception of the presence of hearing something that is not actually there). Review of Resident #51's MDS assessment, dated 7/18/25, indicated Resident #51 reported feeling down, depressed or hopeless and experienced social isolation at times during the assessment look back period. Review of Resident #51's progress notes indicated but was not limited to: -3/19/25: Resident #51 vocalized auditory hallucinations of self-harm, he/she was placed on one-to-one supervision, the provider was notified and a new order to transfer him/her to the hospital was obtained. -3/19/25: Facility staff received a call from the hospital stating Resident #51 was cleared for any mental health concerns and will return to the facility. -3/20/25: Resident #51 returned from the hospital and had psychiatrically cleared. Review of Resident #51's care plan failed to indicate it had been individualized to include his/her history of thoughts to self-harm. During an interview on 8/27/25 at 11:19 A.M., Nurse #5 reviewed Resident #51's care plans and said there was no care plan for his/her history of thoughts of self-harm. During an interview on 8/27/25 at 11:50 A.M., Social Worker #1 said Resident #51's care plans had not been personalized to include his/her history of thoughts of self-harm. During an interview on 8/27/25 at 12:27 P.M., the DON said care plans should be personalized and specific to each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #5 was admitted to the facility in July 2025 with diagnoses including heart failure and hypertension. Review of Resident #5's MDS assessment, dated 8/5/25, indicated he/she did not have shortness of breath or trouble breathing when at rest or lying flat. The MDS did not indicate the Resident was using oxygen (O2) therapy in the facility. The surveyor observed the Resident in bed receiving O2 via a nasal canula supplied by an O2 concentrator as follows: - On 8/21/25 at 8:53 A.M. and 1:50 P.M. - On 8/22/25 at 10:38 A.M. - On 08/26/25 at 10:18 A.M., 12:51 P.M., and 4:20 P.M. Review of the medical record indicated Physician's Orders for: - O2 continuously via nasal canula at 2 Liters/minute, every shift, check pulse oximetry and Liters per Minute (LPM), effective 7/31/25 - Change O2 tubing every Sunday on the 11:00 P.M.-7:00 A.M. shift, every night shift, every Sun. Review of Resident #5's comprehensive care plans failed to indicate a care plan related to oxygen use was developed or implemented. During an interview on 8/27/25 at 10:46 A.M., Nurse #5 said the unit manager is responsible for updating the care plans and would oversee the care plan status. Nurse #5 said when a resident is admitted on O2, they should have a care plan related to O2. Nurse #5 said any nurse can update the information as needed in a care plan if anything changes or needs to be updated. The nurse reviewed Resident #5's care plans and said she did not see a care plan related to O2 but would expect there to be one. During an interview on 8/27/25 at 10:52 A.M., the DON said a resident who uses O2 should have a respiratory care plan with interventions that indicate their need for O2 use. The DON said Resident #5 should have a respiratory care plan related to their O2 use.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to provide indwelling catheter (a flexible tube inserted into the bladder to drain urine outside of the body) care and management consistent with professional standards for one Resident (#5), out of a total sample of 20 residents. Specifically, the facility failed to ensure the Foley catheter was assessed for removal as soon as possible or determine a clinical condition related to the Foley catheter placement on admission to the facility. Findings include:Resident #5 was admitted to the facility in July 2025 with diagnoses including heart failure, muscle weakness, and diabetes. Review of the Minimum Data Set (MDS) assessment, dated 8/4/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Furthermore, the MDS assessment indicated he/she had an indwelling catheter and no genitourinary diagnoses. During an observation with an interview on 8/21/25 at 2:08 P.M., the surveyor observed Resident #5 in bed with a Foley catheter hanging from the side of the bed. Resident #5 indicated he/she was unsure of the reason for the catheter and did not know how long he/she had had it. Review of Resident #5's Physician's Orders indicated but were not limited to the following:- 7/31/25: Foley catheter care every shift- 7/31/25: Replace Foley catheter as needed if still not draining after irrigation- 7/31/25: Insert Foley catheter 16 Fr (French - catheter size) with 10 mL (milliliter) balloon- 7/31/25: Call physician if Foley catheter does not drain after replacement Review of the Hospital Discharge Summary documentation indicated Resident #5 had a Foley catheter. The documentation further indicated a voiding trial should be initiated and the Resident may need a consult with Urology if he/she failed the trial. Review of Resident #5's medical record failed to indicate a voiding trial had been attempted upon admission to the facility. Further review of the medical record failed to indicate any clinical rationale for continued use of the Foley catheter and/or supporting diagnoses for its use. Review of the Physician (MD) progress notes failed to indicate a clinical or medical reasoning for the current placement of the Foley catheter, voiding trial and/or follow up with Urology regarding Foley catheter placement. During an interview on 8/26/25 at 10:50 A.M., Nurse #1 said when a resident admits to the facility with a Foley catheter, orders are put in place for care and management, including size of the catheter and to change the catheter once a month. Nurse #1 said residents with Foley catheters will have voiding trials completed if there is an order in the medical record. Nurse #1 said a diagnosis of urinary retention would be expected for a resident with a Foley catheter. During an interview on 8/27/25 at 12:15 P.M., the Director of Nursing (DON) said a resident who admits to the facility with a Foley catheter is expected to have a diagnosis related to the need for the catheter use, such as urinary retention or neurogenic bladder. The DON said unless otherwise indicated, all residents with a Foley catheter would have a voiding trial to attempt to remove the Foley catheter. The DON and the surveyor reviewed the findings of Resident #5. The DON said a voiding trial should have been completed for Resident #5 and he/she should have documentation in their record of an appropriate diagnosis for the use of the Foley catheter. The DON said if there was any contraindication for the voiding trial it should be documented in the medical record by the attending Physician and/or consulting Physicians such as a Urologist.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, record review, and interview, the facility failed to ensure medications were stored in accordance with acceptable professional standards for one Resident (#1), out of a total sample of 20 residents. Specifically, the facility failed to ensure Resident #1's inhaler, topical gel, and allergy nasal spray medications were stored securely. Findings include:Review of the facility's policy titled Medication Storage Room/Medication Cart Policy, dated February 2018, indicated but was not limited to the following:- The facility provides pharmaceutical services that are conducted in accordance with accepted ethical and professional standards of practice and that meet applicable Federal, State and Local Laws, rules and regulations.- Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. Resident #1 was admitted to the facility in July 2025 with diagnoses including Parkinson's Disease, muscle weakness, and chronic obstructive pulmonary disease (COPD). Review of Resident #1's Minimum Data Set (MDS) assessment, dated 8/1/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #1's Physician's Orders indicated but were not limited to:- 8/20/25: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 base) MCG (micrograms)/ACT (actuation); 2 puff inhale orally three times a day.- 8/20/25: Diclofenac Sodium External Gel 1%; apply topically two times a day. On the following dates and times, the surveyor made the following observation of medications unsecured in Resident #1's room:- 8/21/25 at 10:00 A.M.: an Albuterol Sulfate Inhaler was on his/her bedside table, and two Diclofenac Sodium Gel tubes were observed on a dresser and windowsill.- 8/22/25 at 8:28 A.M.: an Albuterol Sulfate Inhaler was on his/her bedside table, and two Diclofenac Sodium Gel tubes were found on a dresser and windowsill. A Fluticasone Propionate Nasal Spray (allergy nasal spray) 50 MCG bottle was also noted on his/her bedside table.- 8/22/25 at 10:54 A.M.: an Albuterol Sulfate Inhaler was on his/her bedside table, and two Diclofenac Sodium Gel tubes were found on a dresser and windowsill. A Fluticasone Propionate Nasal Spray (allergy nasal spray) 50 MCG bottle was also noted on his/her bedside table. Review of Resident #1's Self-Administration of Medication evaluation, dated 5/18/23, indicated he/she did not desire to self-administer medications. Furthermore, the medical record failed to indicate any consents for self-administration of medications. During an interview on 8/21/25 at 10:01 A.M., Resident #1 said the nurses generally leave his/her inhaler in their room because he/she takes it three times a day. During an interview with observation on 8/22/25 at 12:54 P.M., Nurse #3 was observed to leave Resident #1's room with an inhaler and bottle of nasal spray in her hand. Nurse #3 said she just removed an inhaler and nasal spray bottle from Resident #1's room as they were supposed to be stored in the medication cart. Nurse #3 said Resident #1 is not able to self-administer medications and all of his/her medications should be stored in the locked medication cart. Nurse #3 and the surveyor reviewed the observations made during the survey. Nurse #3 said Resident #1's topical gels should be stored in the locked treatment cart on the unit. Nurse #3 said Resident #1 should have an order for his/her allergy nasal spray and it was likely not reinstated when he/she was re-admitted to the facility recently. During an interview on 8/22/25 at 1:08 P.M., the Director of Nursing (DON) said inhalers and nasal spray medications should be kept in the locked medication cart on the unit and not in the resident's room unless a self-administration assessment has been completed. The DON said topical gels should be kept in the locked treatment carts on the unit. The DON and the surveyor reviewed the observations made during the survey process. The DON said Resident #1 should not have any medications or treatments left at his/her bedside.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility failed to ensure the garbage storage area was maintained in a sanitary condition to prevent the harborage and feeding of pests.Findings include: Review of the 2022 Food Code (a model for safeguarding public health and ensuring food is unadulterated and honestly presented when offered to the consumer) by the U.S. Food and Drug Administration (FDA) indicated outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.On 8/26/25 at 11:33 A.M., the surveyor observed two dumpsters with the top lids closed, however, the dumpster on the left's cover was bent and not tight fitting exposing the garbage to potential harborage and feeding of pests. The surrounding area had a buildup of trash and debris including but not limited to cardboard boxes, used blue gloves, plastic spoons, 11 mattresses, an overbed table, office chair, bi-fold interior doors, a television, corrugated drainage tubing, folding tables and multiple wooden pallets. The trash and debris were not properly contained in the dumpster.During an interview on 8/28/25 at 2:50 P.M., the surveyor reviewed the observations with the Maintenance Director who said the mattresses and other items have been there for a while and the trash vendor would only take them away one item at a time.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on document review and interview, the facility failed to encode and transmit discharge Minimum Data Set (MDS) assessments for two Residents (#33 and #71), out of two MDS assessments reviewed. Findings include:Review of the medical record for Resident #33, on 8/21/25, indicated but was not limited to the following:- the Resident was discharged to another facility on 3/25/25- an MDS had not been completed since for the Resident's discharge and was 133 days overdue Review of the medical record for Resident #71, on 8/21/25, indicated but was not limited to the following:- the Resident was discharged home on 3/26/25- an MDS had not been completed since for the Resident's discharge and was 134 days overdue During an interview on 8/22/25 at 7:32 A.M., the MDS Nurse reviewed the medical record of both Resident #33 and #71 and said the MDSs should have been completed within seven days and transmitted within 14 days following the discharges and that she must have just missed these two.