STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225216	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fitchburg Healthcare	1199 John Fitch Hwy Fitchburg, MA 01420

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, interviews, and record review, for one Resident (#43) out of a total sample of 27 residents, the facility failed to provide effective pain management consistent with professional standards of practice, resulting in persistent pain, inability to sleep, and inability to participate in scheduled occupational therapy (OT) sessions for the Resident. Specifically, the facility failed to: -ensure that an order from the Nurse Practitioner (NP) to administer Oxycodone (opioid pain medication) IR (immediate release) to the Resident every six hours as needed (PRN) for pain was implemented and administered when previous scheduled and PRN Oxycodone orders were ended/stopped. -communicate recommendations for pain management received from the Resident's Palliative Care Team on 2/4/26 to the Physician/NP until 2/6/26. -coordinate with the Physician/NP for alternative pain management instructions and medications when the Resident reported persistent pain [at a pain level of six out of 10] after he/she was administered PRN Oxycodone and the scheduled Oxycodone doses were not delivered to the facility from the pharmacy. Findings include: Resident #43 was admitted to the facility for short term rehabilitation and ordered for scheduled Oxycodone HCl Oral Tablet 7.5 mg tablet by mouth two times a day for pain for five days, effective 1/31/26 and Oxycodone HCl Oral Tablet 5 mg, every six hours PRN for pain for five days, effective 1/30/26 for Stage Four cancer. On 2/2/26, the NP assessed Resident #43 and wrote an order to continue (not to end after five days) the Resident's PRN Oxycodone. The NP order to continue the PRN Oxycodone was not entered into the computer until 10:45 A.M. on 2/5/26 (three days after the order was written) resulting in the scheduled and PRN Oxycodone orders ending on 2/4/26. On 2/4/26, Resident #43 received two 5 mg PRN Oxycodone doses (one at 12:03 A.M. and another at 4:54 P.M.), and the 9:00 A.M. scheduled 7.5 mg Oxycodone dose (total of three doses for 2/4/26). Resident #43 did not receive the 7.5 mg scheduled P.M. dose due to the order ending and no further PRN doses were administered after 4:54 P.M on 2/4/26. The Palliative Team Treatment Plan for Oxycodone medication was not addressed timely and when the Oxycodone PRN was resumed and reported by the Resident as not effective, the facility staff failed to contact the Provider for alternative instructions to manage the Resident's persistent pain. Resident #43's pain was not managed from 2/4/26 evening through 2/6/26, resulting in him/her experiencing persistent pain, inability to sleep, and unable to participate in scheduled occupational therapy (OT) sessions. Resident #43 was admitted to the facility in January 2026 with diagnoses including multiple sites of muscle wasting and atrophy, low back pain, malignant neuroendocrine tumors, and jejunal carcinoid tumor. Review of the facility's policy titled Pain Assessment and Management, dated April 2018 and last revised June 2025 indicated the following: -The purpose of the policy was to ensure pain management was provided to residents consistent with professional standards of practice, person centered care plan, and the resident goals and preferences. -Chronic pain refers to pain that typically lasts greater than three months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause. -Strategies for pain management may include but are not limited to the following: -Assessing the potential for pain, recognizing the onset, presence and duration of pain, and assessing the characteristics of the pain. -Addressing/treating the underlying causes of the pain, to the extent possible. -Identifying and using specific strategies for preventing or minimizing different levels or (continued on next page)

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	sources of pain or pain-related symptoms based on the resident specific assessment, preferences, and choices. -Monitoring appropriately for effectiveness . including defining how and when to monitor the resident's symptoms and degree of pain relief; and -Modifying the approaches, as necessary. Review of Resident #43's January 2026 Hospital Discharge Summary indicated: -was experiencing new right sided abdominal pain. -chronic pain conditions included spinal stenosis, cancer pain, constant headaches from a pituitary tumor, arthritis, and thoracotomy pain. -The Resident was medically cleared to go to short term rehab. -Start taking: -Oxycodone IR (immediate release) 15 milligram (mg) tablet (replaces Oxycodone 5 mg capsule). Take 0.5 tablet (7.5 mg total) by mouth two times a day for five days. Max daily amount: 15 mg. -Oxycodone IR 5 mg tablet (replaces Oxycodone 5 mg capsule). Take one tablet (5 mg) by mouth every six hours as needed (PRN) for pain for up to five days. Max daily amount: 20 mg. Review of the Minimum Data Set (MDS) Assessment, dated 2/5/26, indicated Resident #43: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. -never needed to have someone help him/her when reading instructions, pamphlets, or other written material from his/her doctor or pharmacy. -prior level of function was independent for self-care, indoor mobility, and cognitive function. -level of function at the time of the MDS Assessment was partial/moderate assistance for self-care and transfers, and supervision/touching assistance for walking ten feet. -received opioid medication. -received PT (physical therapy) and OT services. -had an active diagnosis of Cancer. -demonstrated rejection of care four to six days during the observation period. -reported having pain almost constantly over the five days previous to the Assessment observation period that: -made it hard to sleep. -limited the Resident's ability to participate in day-to-day activities. -reported his/her worst pain level on a zero to 10 scale over the previous five days was nine out of 10. Review of the Pain Care Plan, initiated 1/30/26 and revised 2/2/26, indicated Resident #43: -would not experience a decline in overall function related to pain through the next review (target date 4/30/26). -would be monitored for effectiveness . from routine and PRN pain medication. -would have a referral made to the Resident's Physician to consider pre-medication for pain prior to treatments to optimize participation. -would be observed for pain and Provider updated as warranted. -changes in pain location/type, frequency/intensity would be reported to the Physician. Review of the Initial Interdisciplinary Care Meeting Note, dated 2/4/26, indicated Resident #43: -was present for the meeting. -goal was to work with Physical Therapy (PT) and Occupational Therapy (OT) to gain strength and return home. -had Palliative Care in place for a diagnosis of Stage Four Cancer. -medications were reviewed. Review of Resident #43's January 2026 Physician Orders indicated: -Acetaminophen Oral Tablet 325 milligrams (mg), give three tablets by mouth every six hours related to other low back pain, start 1/31/26. -Acetaminophen Tablet 650 mg, give 650 mg by mouth every six hours as needed for pain ., start 1/30/26. -Lidocaine External Patch 5 percent (%), apply to lower back topically one time a day related to other low back pain ., start 1/31/26. -Oxycodone HCl Oral Tablet 15 mg, give 0.5 tablet (7.5 mg) by mouth two times a day for pain for five days, ordered 1/30/26, start 1/31/26. -Oxycodone HCl Oral Tablet 5 mg, give one tablet by mouth every six hours as needed for pain for five days, start 1/30/26. -Pregabalin (anticonvulsant) Oral Capsule 75 mg, give two capsules by mouth two times a day related to other low back pain, start 1/31/26. Review of Resident #43's Nurse Practitioner (NP) Progress Note, effective 2/2/26, indicated:-chief complaint was neck pain and weakness.-has chronic pain from spinal stenosis and thoracotomy pain.-reports back pain that was worse with movement and relieved with pain medications.-was on Oxycodone 7.5 mg twice a day for five days and Oxycodone 5 mg three times a day. -The NP and Resident discussed evaluating whether the Resident's pain could be managed on 5 mg Oxycodone every six hours as needed (PRN).-The assessment and plan included: -Continue with PT and OT for generalized weakness. -Continue Oxycodone, changed to 5 mg every six hours as needed (PRN), . for chronic pain disorder. -Will evaluate if new pain regimen is working. Review of Resident #43's Physician Progress Note, effective 2/4/26, indicated to continue Oxycodone for chronic pain. Review of the Palliative Care Physician Note, dated 2/4/26 and faxed to (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	the facility on 2/4/26 at 3:35 P.M. indicated Resident #43: -was under the medical care of the Palliative Care Physician. -suffered from chronic pain which was primarily musculoskeletal. -had a carcinoid tumor, experienced an esophageal perforation, and underwent a thoracotomy and chest tube placement which was painful. -now had post-thoracotomy pain. -most recent pain regimen included but was not limited to: -Oxycodone 7.5 mg twice daily. -Oxycodone 5 mg up to three times daily as needed. -Palliative Care Physician recommended continuing the Oxycodone medication. Review of Resident #43's February 2026 Medication Administration Record (MAR) indicated: *Scheduled Oxycodone: -last scheduled dose of 7.5 mg Oxycodone was administered on 2/4/26 at the 9:00 A.M. administration time. -reported pain level at the time of administration was four out of 10. -scheduled 7.5 mg Oxycodone was discontinued on 2/4/26. *PRN Oxycodone: -last PRN dose of 5 mg Oxycodone was administered to the Resident on 2/4/26 at 4:54 P.M. -reported pain level at the time of administration was eight out of 10. -The PRN dose of Oxycodone was assessed as effective for the Resident with a reported pain level of four out of 10. On 2/5/26 at 10:28 A.M., the surveyor observed Resident #43 exit the bathroom in his/her room, using a rolling walker to walk to his/her bed. The surveyor observed that the Resident was bent forward at the waist while walking. During an interview at the time, Resident #43 said he/she was having a problem with pain management while at the facility and that he/she was concerned the facility was not providing the pain medication he/she needed. Resident #43 said that he/she has Stage Four Cancer and had chronic pain for many years due to musculoskeletal problems. Resident #43 said he/she participated in a meeting with facility staff the previous day (2/4/26) and told the staff about his/her pain management regimen prescribed through his/her Palliative Care Team. Resident #43 said he/she contacted his/her Palliative Care Team and requested they fax his/her pain treatment plan to the facility. Resident #43 said he/she did not know if the Palliative Care Team had faxed the pain treatment plan to the facility yet. The Resident said the facility had discontinued his/her scheduled and PRN Oxycodone which he/she had been prescribed for years. Resident #43 said his/her last dose of Oxycodone was on Wednesday (2/4/26) and that he/she was currently in a lot of pain. Resident #43 said he/she was frustrated and had asked staff throughout the previous night if there was any update from the Doctor regarding the Oxycodone. On 2/5/26 at 10:45 A.M., the surveyor observed Nurse #4 entered Resident #43's room and give the Resident a medicine cup containing one pill. Nurse #4 was observed telling the Resident the pill was a 5 mg dose of PRN Oxycodone that she had just clarified with the Doctor to administer to the Resident. Nurse #4 was observed asking the Resident for his/her current pain level and the Resident said eight. Resident #43 accepted the 5 mg dose of PRN Oxycodone, then said that he/she should also be getting a 7.5 mg dose of Oxycodone scheduled twice daily. Nurse #4 said to the Resident that Unit Manager (UM) #2 would work on the Resident's pain medication schedule with the Doctor. Review of Resident #43's clinical record on 2/5/26 indicated: -An order dated 2/5/26, for Oxycodone HCl Oral Tablet 5 mg, give 5 mg by mouth every six hours PRN for pain related to other malignant neuroendocrine tumors. Further review of the clinical record failed to indicate any new orders for the scheduled Oxycodone medication. Review of the OT Progress Notes, dated 2/5/26 and 2/6/26, indicated Resident #43: -declined participation in his/her OT sessions due to reports of pain. -pain was assessed as: *2/5/26: -6 out of 10 at rest; constant, all over, throbbing. -9 out of 10 with movement, constant, all over, throbbing. -pain was communicated to nursing staff and that nursing staff were working on it. *2/6/26: -9 out of 10 at rest and with movement, constant, all over, discomfort, and aching. On 2/6/26 at 9:04 A.M., the surveyor observed from the hallway outside of Resident #43's room that the Resident was positioned in bed, and his/her feet were moving continuously back and forth over the edge of the bed out from under the covers. Nurse #2 was observed entering the room and administered medication to the Resident. During an interview on 2/6/26 at 9:27 A.M., UM #2 said the NP wrote a script to continue Resident #43's PRN Oxycodone when the NP assessed the Resident on 2/2/26, and the NP gave the script to UM #2. UM #2 said she did not enter the order to continue the Resident's PRN Oxycodone into the computer until (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	approximately 10:45 A.M. on 2/5/26 (three days after the script was written). UM #2 said Resident #43 did not have access to PRN Oxycodone any time after 6:00 P.M. on 2/4/26 until 10:45 A.M. on 2/5/26. UM #2 said she had just spoken with the NP this morning (2/6/26) regarding Resident #43's Palliative Care Physician's recommendations for Oxycodone that were faxed to the facility on 2/4/26. UM #2 said the NP approved the Oxycodone recommendations made by the Palliative Care Team and the Resident's scheduled Oxycodone was not expected to be delivered to the facility by the pharmacy until between 2:00 P.M. and 3:00 P.M. on 2/6/26. UM #2 said Resident #43 could request the ordered 5 mg dose of PRN Oxycodone every six hours until the scheduled dose for 7.5 mg Oxycodone was delivered to the facility. During an interview on 2/6/26 at 9:43 A.M., Nurse #2 said Resident #43 did not really talk much about his/her pain at the beginning of the week when he/she had been receiving PRN and scheduled Oxycodone. Nurse #2 said by Wednesday (2/4/26), the Resident was talking about his/her pain more and expressed frustration that his/her Oxycodone prescriptions were not being filled. Nurse #2 said Resident #43 told her that he/she had been under Palliative Care. Nurse #2 said this morning (2/6/26), the Resident reported a pain level of 7 out of 10 and described the pain as cancer pain, and Nurse #2 administered 5 mg of PRN Oxycodone to the Resident. Nurse #2 said Resident #43 told her that he/she was frustrated with the lack of having the scheduled Oxycodone reinstated (two days since the scheduled Oxycodone had been last administered). During an interview on 2/6/26 at 11:30 A.M., Resident #43 said when he/she did not have access to scheduled and PRN Oxycodone from the evening of 2/4/26 through the night and into the morning on 2/5/26, he/she was not able to sleep, experienced a lot of pain and continually asked staff if there was any update on whether he/she could have Oxycodone. Resident #43 said when Oxycodone was administered to him/her at the facility, the Nurses would not always return to ask whether the Oxycodone had been effective. Resident #43 also said he/she had not been pain-free for years and that he/she had been living at a pain level of 4 to 5 out of 10 for a long time. Resident #43 said a pain level of 4 to 5 out of 10 was acceptable for him/her. Resident #43 said he/she did not like to take Acetaminophen because Acetaminophen did nothing for his/her cancer related pain. Resident #43 said all he/she wanted was for the facility to provide Oxycodone the way he/she had been prescribed prior to admission to the facility so that he/she could have an acceptable level of pain. During an interview on 2/6/26 at 12:15 P.M., the Occupational Therapist (OT) said Resident #43 had been doing well with OT at the beginning of the week and around Wednesday (2/4/26), the Resident complained of more pain and was worried about his/her ability to access medication for pain. The OT said Resident #43 was unable to participate in his/her scheduled OT session on 2/5/26 because the Resident was in too much pain when she approached him/her in the morning and the OT session was rescheduled to the afternoon. The OT said Resident #43 did not participate in the rescheduled afternoon OT session on 2/5/26 because the Resident was not receiving scheduled Oxycodone and was in pain. The OT said she had not approached the Resident yet today (2/6/26) for the Resident's OT session. During an interview on 2/6/26 at 1:10 P.M., Nurse #2 said a resident's pain report could change throughout a shift and that when a resident was assessed for every shift pain monitoring, it did not mean the resident's pain stayed at their reported level for the whole shift. Nurse #2 said if a resident reported no pain or an acceptable level of pain for that resident during the required shift pain assessment, she did not typically check on that resident's pain level again during the shift unless the resident notified her that their pain had increased or became unacceptable. Nurse #2 said she reassessed Resident #43's pain after administering 5 mg of PRN Oxycodone to the Resident this morning (2/6/26) to determine whether the PRN Oxycodone had been effective for the Resident. Nurse #2 said the Resident reported his/her pain had decreased to 6 out of 10 from 7 out of 10 and that she was aware the Resident's acceptable level of pain was 4 to 5 out of 10. Nurse #2 said the 5 mg PRN dose of Oxycodone she had administered that morning was not effective for the Resident. Nurse #2 said she could have called the Provider for instructions to see if anything else could be offered to manage the Resident's pain, but she did not. During an interview on 2/10/26 at 12:36 P.M., the NP said she assessed Resident #43 on (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2/2/26 and that she was not aware the Resident had been under Palliative Care at the time of the assessment. The NP said she followed the recommendations from the hospital to discontinue the scheduled (7.5 mg) Oxycodone on 2/4/26. The NP said she gave a verbal order and also wrote a script on 2/2/26 to continue 5 mg Oxycodone every six hours PRN for the Resident since the scheduled Oxycodone was going to be discontinued. The NP said she discussed this plan with the Resident and that her plan had been to re-evaluate the Resident on Saturday (2/7/26). The NP said the Resident's other medications prescribed for pain were long-acting medications, and the Oxycodone that was prescribed was a short-acting medication. The NP said the Resident should never have experienced a period of time when PRN Oxycodone was not available. The NP said the facility did not alert her that the Resident had persisting pain and of the recommendations from the Palliative Care Physician until the morning of 2/6/26. The NP said at that time she approved the Palliative Care Physician's recommendations for scheduled (7.5 mg) Oxycodone twice a day for the Resident.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record reviews, the facility failed to ensure that one Resident (#12) out of total sample of 27 residents, on one (Three West) of four units observed, was afforded a dignified dining experience.Specifically, for Resident #12, the facility failed to ensure the Resident was positioned per preference and that staff were seated and not standing over the Resident while assisting him/her to eat. Findings include: Review of the facility policy titled Resident Meal Service and Dining, revised 7/2024, included but was not limited to:-Residents are served food and beverages in a manner that provides nourishing and attractive meals, dignity, and social interaction based on the resident preferences to the degree possible. -The facility staff strives to provide a pleasant dining experience and create an environment(s) where residents eat that are homelike and conducive to dining. This may include but not limited to:>Providing positive and encouraging interactions between staff and residents that are polite, respectful and maintain resident confidentiality.>Staff sit down next to the resident while feeding and/or assisting with feeding. >Confirming the residents are properly positioned to maximum eating abilities. Review of the facility policy titled Activities of Daily Living (ADL), Supporting, revised 11/2024, included but was not limited to: -Residents will be provided with care, treatment and services as appropriate to maintain or improve as able their ability to carry out activities of daily living (ADLs).-Residents who are unable to carry out activities of daily living independently will receive the services necessary for activities of daily living. -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:>Dining (meals and snacks). Resident #12 was admitted to the facility in January 2018 with diagnoses including Multiple Sclerosis, Dysphagia Oropharyngeal Phase, Spastic Hemiplegia affecting unspecified side, Abnormal posture, Dysphagia, and Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side. Review of the Minimum Data Set (MDS) Assessment, dated 12/15/25, indicated Resident #12:-was severely cognitively impaired as evidence by a Brief Interview for Mental Status (BIMS) score of three out of a possible score of 15. -has an impairment on one side of his/her upper extremity.-has impairment on both lower extremities. -was dependent on staff for eating. Review of Resident #12's current Physician orders dated 2/10/26, indicated:-Elevate head of bed (HOB) as tolerated to promote ease of breathing and prevent shortness of breath (SOB) while lying flat every shift, initiated 6/17/24.-Monitor for signs and symptoms (s/s) of aspiration (accidental inhalation of food, liquid, saliva, or vomit into the airway and lungs) every shift, initiated 2/7/19. -Diet: Regular Diet, puree texture, honey thick liquids related to dysphagia oropharyngeal phase (difficulty swallowing foods or liquids, ranging from mild difficulty to complete and painful blockage), initiated 6/7/25. On 2/10/26 at 8:04 A.M., the surveyor observed Certified Nurses Aide (CNA) #1 assisting Resident #12 to eat his/her breakfast meal while the Resident was lying in bed with the head of the bed elevated at a 20-degree angle. Resident #12 was observed lying on his/her right side and slouching down with both of his/her feet touching the foot board. CNA #1 was observed to be standing while assisting Resident #12 to eat while the Resident was lying in bed. During an interview at the time, Resident #12 said that he/she was uncomfortable with the way he/she was positioned in bed for the breakfast meal. CNA #1 said that she typically works the 11:00 P.M. to 7:00 A.M. shift and does not assist residents with meals. During an interview on 2/10/26 at 8:39 A.M., Unit Manager (UM) #1 said that the head of Resident #12's bed is expected to be elevated when the Resident was being assisted with meals if eating in his/her bed. UM #1 also said that the risk for Resident #12 not being properly positioned in bed during his/her breakfast meal was aspiration. UM #1 further said that CNA #1 should have positioned Resident #12 with the head of the up prior to assisting the resident with his/her meal. During an interview on 2/10/26 at 4:45 P.M., the Director of Nursing (DON) said that her expectation was that nursing staff should be seated at an eye (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	level with the residents when assisting them to eat during meals and not stand over the residents. The DON also said Resident #12 should be positioned and the head of the bed elevated while in bed during the meals. Refer to F880

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to notify the Provider when test results were outside the parameters ordered, for one Resident (#13), out of a total sample of 27 residents. Specifically, the facility failed to notify the Provider as ordered, when Resident #13's finger stick blood sugar (FSBS) reading was greater than 301 mg/dL (milligrams/ deciliter), putting the Resident at risk of complications related to hyperglycemia. Findings include: Review of the facility policy titled Change in Resident's Condition or Status, last revised 7/2024 included:-The facility professional staff will communicate with physicians, residents and family regarding changes in condition as warranted.-The nurse will notify the resident's provider or on-call provider when there has been a change in resident condition.-Except in medical emergencies, notifications will be made in a reasonable time frame to physicians and family.-The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility's policy titled Obtaining a Fingerstick Glucose Level, last revised 11/2020, included:-The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level.-Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on sliding scale coverage, and/or physician intervention is needed to adjust insulin or oral medication dosages), etc.-Report results promptly to the supervisor and the Attending Physician.-Report other information in accordance with facility policy and professional standards of practice. Resident #13 was admitted to the facility in January 2026 with diagnoses including Type II Diabetes Mellitus, End Stage Renal Disease (ESRD), and Dependence on Renal Dialysis. Review of a Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #13 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15. Review of Resident #13's February 2026 Physician's orders included:-Insulin Lispro Solution (a short-acting, man-made version of human insulin) 100 units/milliliter (unit/ml) Inject as per sliding scale: if 150 - 200 = 1u (unit); 201 - 250 = 2u (units); 251- 300 = 3u (units); 301-999 = 4u (units); If FSBS (Finger Stick Blood Sugar) above 301 give 4 units and notify MD (Medical Doctor)/NP (Nurse Practitioner), subcutaneously four times a day related to Type II Diabetes Mellitus, with meals and at bedtime. Review of the Resident's Medication Administration Record (MAR) for February 2026 indicated the following FSBS levels recorded at 7:00 A.M., 11:30 A.M., 4:30 P.M., and 9:00 P.M.:*7:00 A.M.:-2/5/26 = 368 mg/dL-2/6/26 = 388 mg/dL*11:30 A.M.:2/7/26 = 305 mg/dL*4:30 P.M.:2/5/26 = 466 mg/dL2/6/26 = 460 mg/dL*9:00 P.M.:2/4/26 = 449 mg/dL2/5/26 = 495 mg/dL2/6/26 = 460 mg/dLReview of Resident #13's progress notes dated 2/1/26 through 2/9/26 failed to indicate any notifications to the Physician/NP as required when FSBS levels were greater than 301. During an interview on 2/9/26 at 12:32 P.M., the surveyor and Unit Manager (UM) #2 reviewed Resident #13's clinical record. UM #2 said that any Physician notification communication should have been documented in the progress note section of the medical record. UM #2 said that each time Resident #13's blood sugar was elevated greater than 301 mg/dL, there should have been a progress note written reflecting that the Physician had been notified of the elevated blood sugars. UM #2 said she could not provide any evidence that the Physician had been notified when Resident #13's blood sugar result was greater than 301 mg/dL as ordered.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fitchburg Healthcare	1199 John Fitch Hwy Fitchburg, MA 01420

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain a clean and homelike environment for one Resident (#14) out of a total sample of 27 Residents, on one unit (Two East) out of four units observed. Specifically, the facility staff failed to ensure that Resident#14's enteral tube feeding (nutritional supplement provided through a tube into the stomach) pole (where the feeding pump is attached) and privacy curtain located next to the feeding pump/pole equipment was maintained in a clean and sanitary manner. Findings include: Resident #14 was admitted to the facility November 2022 with diagnoses including cerebral infarction, and gastrostomy (feeding tube, also referred as G-tube) status. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #14:-was severely cognitively impaired as evidenced by a BIMS score of zero out of a total possible score of 15.-was dependent on staff for Activities of Daily Living (ADLs). -has a feeding tube. On 2/9/26 at 9:01 A.M., the surveyor observed multiple areas of dried brown material splattered over the base of Resident #14's feeding tube pole and privacy curtain. On 2/10/26 at 8:12 A.M., the surveyor observed multiple areas of dried brown material remained splattered over the base of Resident #14's feeding tube pole and privacy curtain. On 2/11/26 at 7:42 A.M., the surveyor observed that multiple areas of dried brown material remained splattered over the base of Resident #14's feeding tube pole and privacy curtain. On 2/11/26 at 7:46 A.M., the surveyor and Unit Manager (UM) #3 observed Resident #14's soiled feeding tube pole and privacy curtain. During an interview at the time, UM #3 said that the Resident's equipment should be kept clean and that the nursing staff are responsible for cleaning the tube feeding equipment once they notice that it has been soiled. UM #3 also said that the facility staff should notify the housekeeping staff to clean the privacy curtains when they are visibly soiled and they had not. UM #3 said that Resident #14's room was unsanitary and undignified. During an interview on 2/11/26 at 7:56 A.M., the Staff Development Coordinator (SDC) said that the soiled items in Resident #14's room would be an infection control concern and that the staff should have addressed the Resident's soiled items timely. During an interview on 2/11/26 at 10:50 A.M., the Administrator said the facility did not have a policy on environmental rounds or cleaning of Residents' rooms. The Administrator also said that the management team at the facility performed random rounds of Resident rooms daily during the week and they had not been made aware of Resident #14's room, but if they had been they would have cleaned it immediately. The Administrator said that the facility had a process to perform environmental rounds on all Resident rooms quarterly throughout the year.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interviews, and record review, the facility failed to ensure all residents residing on one Unit (Three West) out of four total resident units observed, including Resident #113, were free from physical restraints implemented for staff convenience pertaining to restricting wandering residents. Specifically, the facility failed to ensure:-that all residents residing on the Three [NAME] unit were assessed for safety and the residents' ability to self-release a Do Not Enter sign [strap] secured across the residents' doorways, when six and ten residents rooms were observed on three different occasions with the Do Not Enter sign secured across the doorways to the individual rooms, and one resident was observed ducking under the strap to exit his/her room, putting the residents at risk of social isolation and non-assessment of the physical restraint use.-for Resident #113, identified with progressive decline in intellectual functioning, that he/she was able to release the Do Not Enter sign [strap] secured across the doorway when facility staff requested he/she demonstrate releasing the device and the Resident was unable to release the device to exit his/her room. Findings include: Review of the facility policy titled Use of Restraints, dated November 2017 and revised January 2024, indicated the following:-Restraints shall only be used to treat the resident's medical symptom(s) . -Physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement . -The definition of a restraint is based on the functional status of the resident and not the device. -Prior to placing a resident in restraints, there shall be a pre-restraining evaluation . -If the resident cannot remove a device in the same manner in which the staff applied it given that the resident's physical condition and this restricts his/her typical ability to change position or place, that device may be considered a restraint. Resident #113 was admitted to the facility in April 2020 with diagnoses including unspecified symptoms and signs involving cognitive functions and awareness and Altered Mental Status. Review of Resident #113's Active Care Plan, reviewed 12/8/25, indicated the following: -When not participating in activity program, [Resident] prefers to . walk around the unit and socialize with staff and peers (initiated 8/3/21). -The Resident had chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought process related to brain deterioration, memory loss, and Dementia (initiated 5/5/21) -The Resident walked with continual supervision/one assist as needed (initiated 8/29/20). On 2/5/26 at 11:43 A.M., the surveyor observed the following on the Three [NAME] Unit: -Each resident room doorway was equipped with a Do Not Enter sign that could be secured across the doorway. -Ten resident rooms had the Do Not Enter signs secured across their doorways. -Resident #113 stood in the doorway of his/her room, looking into the hallway and the Do Not Enter sign was observed secured across the doorway in front of the Resident. -Resident #113 said he/she felt dizzy and Certified Nurses Aide (CNA) #3 approached the Resident. -CNA #3 invited the Resident for activities and lunch and the Resident agreed. -CNA #3 released the Do Not Enter sign from the doorway by sliding one side of the sign up and out of a grooved device attached to one side of the door frame. -Resident #113 exited the room. On 2/10/26, between 9:42 A.M. and 9:48 A.M., the surveyor observed the following on the Three [NAME] Unit: -Each resident room doorway was equipped with a Do Not Enter sign that could be secured across the doorway. -Six resident rooms had the Do Not Enter signs secured across the room doorways. -One Resident was observed to exit his/her room by bending forward at the waist and ducking under the Do Not Enter sign. -Resident #113 stood in the doorway of his/her room, with the Do Not Enter sign secured across the doorway in front of the Resident. -At 9:48 A.M., Resident #113 leaned forward, with the front of his/her body touching the Do Not Enter sign and looked to his/her left down the hallway. -Resident #113 then asked aloud why he/she lived there and said he/she wanted to go home. On 2/10/26 at 10:03 A.M., the surveyor observed that ten resident rooms had the Do Not Enter signs secured across (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the room doorways. During an interview on 2/10/26 at 1:58 P.M., CNA #3 said the Do Not Enter signs engaged across resident doorways had been implemented approximately four to six months earlier. CNA #3 said the Do Not Enter signs were installed to keep residents who wandered out of other resident rooms. CNA #3 said the Do Not Enter signs did not have any kind of breakaway feature and that to release the signs, you would have to lift the side of the sign that was inserted into the grooved device on the doorway. CNA #3 said that a lot of the residents could remove the Do Not Enter signs and that some residents would duck under the signs to get out of their rooms. During an interview on 2/10/26 at 2:13 P.M., Unit Manager (UM) #1 said the Do Not Enter signs were implemented about six months prior. UM #1 said the signs were installed to keep residents out of other residents' space. UM #1 said there were no individual resident assessments completed at the time the Do Not Enter signs were installed to determine whether implementing the signs could result in residents not being able to exit their rooms. UM #1 said that Resident #113 was able to remove the Do Not Enter signs on his/her own. Resident #113 was observed at this time standing in the doorway of his/her room, behind the secured Do Not Enter sign. UM #1 asked Resident #113 if he/she wanted to come out of the room and the Resident said yes. The Resident used two hands to grasp the middle of the Do Not Enter sign and pulled up then slightly toward his/her body, then bent forward. Resident #113 then said, I don't know how. UM #1 was observed to release the Do Not Enter sign for the Resident and the Resident #113 exited his/her room. During an interview on 2/10/26 at 4:48 P.M., the Director of Nursing (DON) said when facility staff added a device for a resident, such as a seatbelt or an alarm, a restraint assessment would be completed to determine whether or not the resident could remove the device and whether the device might be considered a restraint. The DON said if the device was determined not to be a restraint, the resident would be monitored weekly to ensure there was no change resulting in restraint. The DON said restraint assessments were not initiated for any residents when the Do Not Enter signs were installed on the Three [NAME] Unit. The DON said the purpose for the Do Not Enter signs was to keep residents who wandered out of other residents' rooms. The DON said that the facility's interdisciplinary team (IDT) had decided to obtain and install the Do Not Enter signs and that the IDT had not discussed the possibility that the signs could have been restraints.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that a person-centered care plan relative to eating assistance and supervision was implemented for one Resident (#110) out of a total sample of 27 residents. Specifically, for Resident #110, the facility failed to implement continual supervision by one (staff) and assist of one staff as needed to set up meals as required, when the Resident experienced a significant weight decline and was care planned for feeding assistance and supervision. Findings include:Review of the facility policy titled Resident Meal Service and Dining, revised 7/2024, included but was not limited to: Residents are served food and beverages in a manner that provides nourishing and attractive meals, dignity, and social interaction based on the resident preferences to the degree possible. -The facility staff strives to provide a pleasant dining experience and create an environment(s) where residents eat that are homelike and conducive to dining. This may include but not limited to:>Staff is available to provide supervision and assistance to residents throughout the meal services as needed. Review of the facility policy titled Nutrition, revised 7/2024, included but was not limited to: *Residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. >The nutritional status of the resident is assessed upon admission, quarterly, annually, when a significant change occurs, and/or more frequently as deemed necessary by the interdisciplinary team (IDT). >The Registered Dietician Nutritionist (RDN) collaborates with the IDT and/ or resident/ resident representative to develop a resident-focused, interdisciplinary plan of care to outline nutrition-related goals and individualized interventions to address the specific needs of the resident. >The IDT facilitates communication of the implementation and evaluation of nutrition interventions amongst the team.>Nutrition interventions are evaluated for effectiveness as warranted.>The IDT monitors care planned nutrition interventions ongoing. >The RDN identifies residents needing frequent monitoring/evaluation (i.e. [that is], more frequent than quarterly) by the RDN. Examples of residents that may need frequent monitoring by the RDN may include but are not limited to residents:>Nutritional status is reassessed upon a significant change of condition in (i.e., weight change).>The care plan is updated as needed. Review of the facility policy titled Care Plans, Comprehensive Person-Centered, revised 1/2024, included but was not limited to: *A comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial and functional needs that are developed for each resident. >The care plan interventions are derived from information gathered as part of the comprehensive assessment.>The resident comprehensive care plan will identify problem areas and their causes as warranted and developing interventions that are targeted and meaningful to the resident. >Evaluation of residents is ongoing, and care plans are revised as information about the residents and the residents' conditions changes. >The IDT team reviews and updates the care plan when there has been a significant change in the residents' conditions, when there is a change and at least quarterly, in conjunction with the required quarterly minimum data set (MDS) assessment. Resident #110 was admitted to the facility in November 2020 with diagnoses including Duodenal Ulcer, Moderate Protein Calorie Malnutrition, Type 2 Diabetes Mellitus, Muscle Wasting Atrophy, Gastroesophageal Reflux Disease (GERD), Iron Deficiency Anemia, and Gastritis. Review of Resident #110's Weight Summary from 9/10/25 (weight 104.0 pounds [lbs.]) through 1/21/26 (weight 88.6 lbs.) indicating a significant weight loss. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #110:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15. -has poor appetite. -required set up or clean up assistance with eating. Review of Resident #110's Activity of Daily Living (ADL) Care Plan, revised 11/24/25, indicated:-the Resident has an ADL self-care deficit as evidenced by need (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with ADLs, Dementia, impaired mobility, unable to initiate, sequence or complete a task. >eating: the Resident requires continual supervision of one (staff)/ assist of one as needed. Review of Resident #110's Care Plan Meeting Notes, dated 11/11/25, indicated:-the Resident's Healthcare Proxy (HCP- person assigned to make medical decisions on behalf of a person if they are unable to communicate or make decisions for themselves) had a concern about the Resident's weight loss and shared that the Resident eats better when his/her meals are cut up, the crust cut off the sandwiches etc. Review of Resident #110's Nutrition Care Plan, revised 1/22/26, indicated:-Significant weight decline.-by mouth (PO) at times 50 percent (%).-Edentulous (lacking teeth) - tolerates regular textured food.-Provide feeding assistance as needed. Review of Resident #110's February 2026 Physician's orders, indicated:-Regular diet regular texture, Thin Liquids consistency, Fortified Hot Cereal, initiated 2/16/22.-Frozen Nutritional Treat (or magic cup) two times a day related to moderate protein - calorie malnutrition 4 oz with lunch and dinner, initiated 11/20/23.-Ensure Plus (or equivalent) two times a day, give 8-ounce (8 oz) twice a day (BID) with lunch and dinner due to (d/t) potential for alteration in nutrition, initiated 1/22/26. Review of Resident #110's Care Card, dated 2/10/26, included but was not limited to:>Continual supervision of one (staff) and/or assist of one as needed.Review of Resident #110's Dietician Progress Note dated 1/22/26, indicated: -Weight 88.6, -7.5% change, has had a significant weight decline in six months from 105 to current 89, (weight) loss of 15%. -NP and family made aware. Review of Resident #110's Medical Nutrition Therapy assessment dated [DATE], indicated the following: *Physical and Functional Data:>Independent>Supervision>Extensive Assist>% of weight change in 90 days: 14%. On 2/5/26 at 9:22 A.M., the surveyor observed Resident #110 reclining in with the head of bed in the upright position and a bedside table with a breakfast tray in front of him/her. The surveyor observed that the breakfast meal was untouched and there was no staff member present in room at the time. On 2/6/26 at 8:10 A.M., the surveyor observed a staff member enter Resident #110's room and placed a breakfast tray on the Resident's bedside table. The staff member was observed setting the Resident's tray up for the meal and then exited the room. The surveyor observed the Resident lying in his/her bed with his/her eyes closed, and the breakfast meal included an English muffin with butter, a cup of cranberry juice and a cup of mandarin oranges. The surveyor did not observe a staff member present in the room with the Resident. On 2/6/26 at 8:31 A.M., the surveyor observed Resident #110 lying in bed with his/her eyes closed, and the breakfast meal remained untouched on the bedside table in front of the Resident. The surveyor did not observe any staff members returning to the room to assist after the meal was set up for the Resident. On 2/6/26 from 12:22 P.M. through 12:45 P.M., the surveyor observed Resident #110 lying in bed and a lunch meal on the bedside table in front of the Resident. The surveyor observed that the lunch meal included fish, mixed vegetables, pasta, a magic cup, a carton of milk, a cup of coffee, cranberry juice and Ensure Plus with a straw. The surveyor observed that Resident #110 was not provided with assistance or supervision by staff during the meal and the lunch tray remained untouched. On 2/6/26 at 12:49 P.M., the surveyor observed Unit Manager (UM) #1 enter Resident #110's room to retrieve the untouched lunch tray and placed the tray in the meal truck located in the hallway. During an interview on 2/6/26 at 1:01 P.M., UM #1 said that Resident #110 required cueing from staff during meals and that usually cues [sic] the Resident to eat his/her meals. During an interview on 2/6/26 at 1:09 P.M., UM #1 said that he had reviewed Resident #110's care plans, and the care plan indicated the Resident required continual supervision of one and/or assist of one as needed (PRN) with meals. UM #1 said he determined that the assistance of one as needed means that staff would check on the Resident and provide cues during meals. UM #1 said that he typically checks on the Resident during meals and cues him/her because UM #1 has a good rapport with the Resident, but he had not checked in on the Resident during the breakfast or lunch meals today to ensure that the Resident was eating but he should have. UM #1 also said that all the Certified Nurse Aide's (CNAs) working on the unit today were not familiar with Resident #110. UM #1 further said that the risk of the Resident not getting continual supervision or assist of a staff member during meals was that the Resident could continue (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to lose weight, which could lead to decreased immunity, muscle loss and nutritional deficiencies. On 2/10/26 from 8:21 A.M. through 8:37 A.M., the surveyor observed Resident #110 lying in his/her bed with a breakfast tray on the bedside table and no staff member present in the Resident's room to assist or supervise the breakfast meal at the time. During an interview on 2/10/26 at 10:55 A.M., the Registered Dietician (RD) said that Resident #110 has been on her weight loss list for a couple of months. The RD said that she noticed the weight loss in November 2025 and December 2025 as the Resident had lost 12 pounds. The RD said that she placed the Resident on weekly weights and added supplemental Ensure Plus, magic cup, and fortified cereal to the Resident's diet and the Resident had gained two pounds. The RD also said that the Resident could eat his/her meals but sometimes required assistance and at times staff to assist with feeding him/her during meals. The RD further said that the risk of continual weight loss for Resident #110 would be impaired nutrition which can lead to decreased nutritional status such as pressure injury, and loss of muscle mass. During an interview on 2/10/26 at 4:43 P.M., the Director of Nursing (DON) said if Resident #110 was care planned for continual supervision during meals, then nursing staff should provide supervision during the meals. The DON also said that a staff member should always be with the Resident during meals to provide supervision and assistance needed during mealtimes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure activities of daily living (ADL's- activities related to personal care which includes washing, dressing, and oral hygiene) were provided for one Resident (#136) out of a total sample size of 27 residents. Specifically, for Resident #136, the facility failed to provide assistance with oral hygiene when the Resident required assistance to complete oral hygiene due to weakness and hemiparesis (weakness of one side of the body), placing the Resident at risk for dental complications. Findings include: Review of the facility policy titled Activities of Daily Living (ADL), Supporting, revised 11/2024, included but was not limited to:ˆ Residents will be provided with care, treatment and services as appropriate to maintain or improve as able their ability to carry out activities of daily living (ADLs). -Residents who are unable to carry out activities of daily living independently will receive the services necessary for activities of daily living. -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: >Hygiene (bathing .and oral care). Resident #136 was admitted to the facility in July 2025 with diagnoses including muscle wasting and atrophy, hemiparesis, muscle weakness and Anoxic Brain Damage (damage due to loss of oxygen supply to the brain). Review of Resident #136's person-centered ADL care plan revised 1/26/26, indicated: -has an ADL self-care deficit due to weakness with interventions including oral care assist/dependent.-encourage proper hygiene. Review of Resident #136's active Certified Nurse Aide (CNA) Care Kardex (brief overview of a Resident's care needs) indicated: -Mouth care: Assist/Dependent Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #136: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15 points. -had not demonstrated rejection of ADL care. -required partial/moderate assistance for oral hygiene. On 2/5/26 at 9:30 A.M., the surveyor observed Resident #136 awake and lying in his/her bed and wearing sleepwear. During an interview at the time, Resident #136 said that he/she was not offered or provided with routine oral hygiene by the staff, required assistance for care due to his/her weakness and could sometimes do his/her own oral care if the CNA set up the supplies for him/her on the over the bed table. The Resident smiled at the surveyor and a thick white substance was observed on the Resident's upper and lower gum line. Resident #136 said he/she had not received assistance with oral hygiene since being admitted to the facility. On 2/9/26 at 3:22 P.M., the surveyor observed Resident #136 awake and lying in bed. During an interview at the time, Resident #136 said that he/she had already received assistance for washing up that morning, but the CNA had not offered to set up the toothbrush supplies for him/her. Resident #136 also said that he/she was not provided assistance with oral hygiene over the weekend. Resident #136 was able to smile upon the surveyor's request, and a thick white substance was observed covering the upper and lower gumline of the Resident's mouth. On 2/10/26 at 10:10 A.M., the surveyor observed Resident #136 awake and lying in bed. During an interview at the time, Resident #136 said he/she had been washed up for the day but was not provided with oral hygiene supplies to brush his/her teeth. Resident #136 said he/she would like to brush his/her teeth every day, but the staff do not offer to help. During an interview on 2/10/26 at 12:39 P.M., Unit Manager (UM) #4 said that oral hygiene should be offered to all residents twice a day with morning and evening care unless otherwise specified by the resident. UM #4 said she was familiar with Resident #136 and his/her care needs. UM #4 said that Resident #136 has weakness and required a set-up of supplies for oral hygiene care. UM #4 said Resident #136 did not have the ability to set up oral hygiene supplies for himself/herself. During an interview on 2/10/26 at 12:10 P.M., CNA #4 said she was assigned to Resident #136. CNA #4 said that Resident #136 was totally dependent on the CNA to get washed-up because the Resident was weak. CNA #4 said that Resident #136 did not refuse care when care was (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fitchburg Healthcare	1199 John Fitch Hwy Fitchburg, MA 01420

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered. CNA #4 said that oral hygiene should be done twice a day, in the morning and in the evening for the Resident. CNA #4 said Resident #136 was able to brush his/her teeth as long as the CNA set him/her up with supplies and loaded toothpaste on the toothbrush. CNA #4 said that she did not assist Resident #136 with oral hygiene today because she got too busy. During an interview on 2/10/26 at 12:53 P.M., Social Worker (SW) #2 said that oral care should be provided by the CNA staff during daily care for the residents in the facility. The surveyor and SW #2 observed Resident #136's teeth and SW #2 said that the white plaque build-up on the Resident's teeth was extensive and did not appear to have received oral hygiene. Resident #136 said that he/she had not been provided with oral hygiene assistance since his/her admission to the facility. During an interview on 2/10/26 at 2:29 P.M., Minimum Data Set (MDS) Nurse #1 said that oral hygiene was important for Resident #136 because not being provided with oral hygiene could result in infection or tooth loss. Please Refer to F791

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide respiratory care and services in accordance with professional standards of practice for one Resident (#27) out a total sample of 27 residents. Specifically, the facility failed to: -For Resident #27, obtain a Physician's order for a baseline oxygen flow rate, oxygen titration liter flow range and portable oxygen flow rate when the Resident was diagnosed with chronic obstructive pulmonary disease (COPD) and chronic respiratory failure, placing the Resident at risk for respiratory complications related to oxygen use. Findings include: Review of the facility policy titled Oxygen Administration, last revised 1/2024 included: The purpose of this procedure is to provide guidelines for safe oxygen administration. >Verify there is a Physican's order in place for oxygen administration. >Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. >Document the rate of oxygen flow, route. Review of the AARC Clinical Practice Guideline for Oxygen Therapy, dated 8/8/14 at https://www.aarc.org/wp-content/uploads/2014/08/08.071063.pdf indicated the following in part: -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations.-There is a potential in some spontaneously breathing hypoxemic (low oxygen level) patients with hypercapnia (high carbon dioxide level) and chronic obstructive pulmonary disease (COPD) that oxygen administration may lead to an increase in PaCO2 (carbon dioxide).-Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction in home oxygen therapy. Resident #27 was admitted to the facility in September 2025 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypoxia and Obstructive Sleep Apnea (OSA). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #27: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a total possible score of 15. -received oxygen therapy. Review of Resident #27's active Physician orders indicated: -titrate oxygen via nasal cannula (NC - flexible tube placed in the nose to deliver oxygen) to maintain oxygen saturation above 90% every shift, start date 9/23/25. -portable oxygen while out of the room every shift, start date 9/10/25. -No prescribed baseline oxygen flow rate relative to oxygen titration and portable oxygen use. Review of Resident #27's December 2025, January 2026, and February 2026 Treatment Administration Records (TAR) and Medication Administration Records (MAR) indicated that the Resident was administered oxygen every day.Further Review of the December 2025, January 2026, and February 2026 TARs and MARs failed to indicate documentation of the oxygen flow rate that was being administered to the Resident. On 2/5/26 at 10:00 A.M., the surveyor observed Resident #27 seated in a wheelchair in his/her room with a NC in place and the oxygen flow rate set at 3 liters per minute (LPM) on the oxygen concentrator. During an interview at the time, the Resident said that he/she did not adjust the oxygen flow rate up or down, only the staff did that. On 2/9/26 at 9:05 A.M., the surveyor observed Resident #27 seated in a wheelchair at his/her bedside with a NC in place and oxygen set at 1 LPM on the oxygen concentrator. During an interview on 2/9/26 at 12:37 P.M., the Assistant Director of Nurses (ADON) said he was the Nurse assigned to Resident #27. The ADON said Resident #27 was on continuous oxygen but sometimes could go without the oxygen. The surveyor and the ADON observed the Resident's portable oxygen device which was attached to the Resident's wheelchair and delivering oxygen via NC at 3 LPM. The surveyor and the ADON also observed the Resident's Physician orders for oxygen that did not include a prescribed oxygen flow rate. The ADON said that a prescribed flow rate for oxygen administration was important to have in place for Resident #27 because administering too much oxygen could send the Resident's carbon dioxide levels too high and administering too little oxygen could cause the Resident to become short of breath. During an interview on 2/9/26 at 1:11 P.M., the Director of Nursing (DON) said that an oxygen flow rate in Resident #27's oxygen orders should have been included. The DON further said that the flow rate of (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen administered should also be documented on the Resident's TAR, that way the staff would know if the Resident's need for oxygen was increasing. The DON said that an increased need in oxygen would indicate a decline in the Resident's condition and the Doctor could then be notified for additional work-up to be done in-house or send the Resident to the hospital.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, interview, and record review, the facility failed to administer medications per professional standards of practice resulting in two significant medication errors for one Resident (#136) out of a total sample of 27 residents. Specifically for Resident #136, the facility staff failed to hold (not administer) administration of: -Amlodipine Besylate (used to treat high blood pressure) medication for six days between 1/1/26 - 1/31/26 as ordered, for a Systolic Blood Pressure (SBP) less than 110 millimeters of Mercury (mmHg), placing the Resident at risk for cardiac compromise. -Enalapril Maleate (used to treat high blood pressure) medication for five days between 1/1/26 - 1/31/26 per Physician's order, for a SBP less than 110 mmHg, placing the Resident at risk for cardiac complications. Findings include: Resident #136 was admitted to the facility in July 2025 with diagnoses including Atrial Fibrillation (A-fib), Hypertension (HTN), and sudden cardiac arrest. Review of Resident #136's person-centered Cardiovascular Care Plan, initiated 7/28/25 and revised 1/26/26 indicated: -has an altered cardiovascular status of A-fib, HTN and history of sudden cardiac arrest with interventions including monitoring vital signs (temperature, respiratory rate, heart rate and blood pressure) as ordered. Review of Resident #136's active Physician orders indicated: -Amlodipine Besylate 5 mg tablet by mouth one time a day related to HTN, hold if SBP less than 110 mmHg, start date 8/22/25. -Enalapril Maleate 20 mg tablet by mouth one time a day related to HTN, hold if SBP less than 110 mmHg, start date 11/5/25. Review of Resident #136's January 2026 Medication Administration Record (MAR) indicated: *Amlodipine Besylate 5 mg tablet by mouth was administered to the Resident outside of the Physician ordered parameters on the following days: -1/1/26 at 9:00 A.M.: SBP 107 mmHg-1/21/26 at 9:00 A.M.: SBP 108 mmHg -1/22/26 at 9:00 A.M.: SBP 98 mmHg-1/23/26 at 9:00 A.M.: SBP 99 mmHg-1/24/26 at 9:00 A.M.: SBP 102 mmHg-1/28/26 at 9:00 A.M.: SBP 108 mmHg*Enalapril Maleate 20 mg tablet by mouth was administered to Resident #136 outside of the Physician ordered parameters as follows: -1/1/26 at 9:00 A.M.: SBP 107 mmHg-1/21/26 at 9:00 A.M.: SBP 108 mmHg-1/22/26 at 9:00 A.M.: SBP 98 mmHg-1/23/26 at 9:00 A.M.: SBP 99 mmHg-2/24/26 at 9:00 A.M.: SBP 102 mmHg During an interview on 2/11/26 at 8:38 A.M., Unit Manager (UM) #4 said that Resident #136 had SBP parameters relative to Amlodipine Besylate and Enalapril Maleate medication administration. UM #4 said that both medications should be held if the Resident's SBP was less than 110 mmHg. The surveyor and UM #4 observed Resident #136's January 2026 MAR and UM #4 said that she was unaware that the medications had been administered outside of the Physician ordered parameters, but they should not have been. UM #4 said that Resident #136's blood pressure can run low sometimes and that was probably why the Physician had ordered the parameters. UM #4 said that Resident #136 was at risk for his/her blood pressure bottoming out, which meant that the Resident's blood pressure could drop lower when the Amlodipine Besylate and Enalapril Maleate medications were administered outside the ordered parameters. During an interview on 2/11/26 at 8:49 A.M., the Director of Nursing (DON) said that all Nurses should follow the Physician ordered parameters for medication administration. The DON said that Resident #136 receiving the Enalapril Maleate and Amlodipine Besylate medications outside of the Physician ordered parameters could cause risk for his/her blood pressure to bottom out which means he/she could pass out, get dizzy, fall, or at worse cause death.

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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, interview, and record review, the facility failed to ensure that medication was stored in a safe and sanitary manner in the medication carts on one (2 West) of four medication carts observed.Specifically, the facility failed to ensure that staff was not storing medications in an unsafe and unsanitary manner when:-staff stored one pre-poured medication cup containing resident medications in the top drawer of the 2 [NAME] medication cart.-and a second medication cup containing pre-poured, unlabeled medications was also observed in the top drawer of the 2 [NAME] medication cart. Findings include:Review of the facility policy titled, Storage of Medication, dated September 2018, included but was not limited to:-Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration.-The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements, including requirements of good manufacturing practices established by the United States Pharmacopeia. Medications are to remain in these containers and stored in a controlled environment. On 2/5/26 at 8:14 A.M., the surveyor and Nurse #1 observed the two [NAME] medication carts as follows:-Nurse #1 opened the medication cart and there was a medication cup containing an unidentified/unlabeled tablet, five large white tablets inside the medication cart. During an interview at the time, Nurse #1 said the five large white tablets were Tylenol medication that was pre-poured by the previous shift because the facility had large bottles of Tylenol medications and it was easy to just pre-pour some of the Tylenol medications for easy administration.-a second medication cup that contained two large purple capsules, one small white tablet, and one large white tablet. During an interview at the time, Nurse #1 said the medication belonged to a resident. Nurse #1 said she had poured the resident's medications to administer but the resident said he/she would take his/her medication after he/she returned from a smoking break. Nurse #1 said she put the medication back in the top drawer but did not label the medication cup with the resident's name. Nurse #1 further said the medications were the resident's scheduled medications as follows:-Phospha 250 Neutra tablet (phosphorus medication containing potassium phosphate and sodium phosphate).-Loratadine tablet (antihistamine medication used for allergy symptoms).-Potassium Chloride capsules (medication used to prevent or treat low levels of potassium).Nurse #1 said she had pre-poured the medications between 7:30 A.M. to 8:00 A.M. after she had taken report from the 11:00 P.M. to 7:00 A.M. (night) shift nurse. During a follow-up interview on 2/5/26 at 2:15 P.M., Nurse #1 said the resident's medication was not scheduled to be administered until 10:00 A.M. Nurse #1 said she should not have pre-poured the medications. During an interview on 2/5/26 at 2:45 P.M., the Director of Nursing (DON) said it was not the facility practice to pre-pour medications for residents. The DON also said that her expectation was that Nurses were not supposed to pre-pour medications when the medications were not due to be administered.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interviews, and record review, the facility failed to provide assistance for one Resident (#136) out of a total sample of 27 residents, in accessing routine dental services. Specifically, the facility failed to evaluate whether Resident #136 wished to obtain access to routine dental care, placing the Resident at risk for delayed routine dental services and impaired oral health. Findings include: Review of the facility policy titled Ancillary Physician Services, revised 3/2025 included the following: -Routine ., Dental and Audiology services are available to meet the resident's health needs. >Routine ., Dental and Audiology services are provided to our residents through: -A contract agreement . -Referral to the residents personal . -Referral to a community . or -Referral to other health care organizations that provide . >Residents have the right to select .Dental and Audiologist of their choice when services are needed. >Resident insurance will be billed . >Social Services or nursing representatives will assist residents with appointments ., and for reimbursement of services under the state plan, if eligible. Resident #136 was admitted to the facility in July 2025 with diagnoses including Dysphagia (difficulty swallowing) and Diabetes. Review of the Resident's Minimum Data Set (MDS) Assessment, dated 11/7/25, indicated: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 points out of a total possible score of 15 points. -has not demonstrated rejection of care. During an interview on 2/5/26 at 9:30 A.M., the surveyor observed Resident #136 awake and lying in his/her bed. Resident #136 said that he/she was not offered or provided with routine oral hygiene by the staff and required assistance for care due to his/her weakness and could sometimes do his/her own oral care if the CNA set up the supplies for him/her on the over the bed table. The Resident was observed with a thick white substance on the upper and lower gum line when he/she smiled at the surveyor. Resident #136 said he/she would love to see a Dentist but was not sure how to book a routine cleaning at the facility. Review of Resident #136's medical record failed to indicate that the Resident was offered dental services to meet his/her needs and had accepted or declined routine dental services. During an interview on 2/10/26 at 12:53 P.M., Social Worker (SW) #1 said a Dental Provider is contracted with the facility and comes into the facility to provide routine dental care for the residents. SW #1 said that a Dental Provider consent form should be completed by a facility SW together with all long-term care residents or their representative. SW #1 said that Resident #136 has been covered by a Medicaid Health Insurance Plan since his/her admission and did not have a completed Dental Provider form in his/her medical record. During an interview on 2/10/26 at 1:25 P.M., the Director of Nursing (DON) said that the Dental Provider form to select dental services should be part of the admission packet and reviewed by the facility Social Worker(s). During an interview on 2/10/26 at 2:29 P.M., MDS Nurse #1 said the Dental Provider form should have been reviewed by a SW with Resident #136 as soon as the facility knew that the Resident was here for long-term care on 11/2/25. MDS Nurse #1 said that the facility reviewed the Dental Provider forms during each MDS review, but the Resident's form had accidently been missed. MDS Nurse #1 said that a delay in routine dental services placed Resident #136 at risk for infection and loss of teeth.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice for one Resident (#12) out of a total sample of 27 residents. Specifically, for Resident #12, the facility staff failed to appropriately follow Enhanced Barrier Precautions (EBP's - the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), when providing high contact care for the Resident, increasing the risk of organism transmission to the Resident, staff, and other residents within the facility. Findings include:Review of the facility policy titled Infection Control Guidelines for Nursing Procedures, revised 7/2024, included but was not limited to: *To provide guidelines for general infection control while caring for residents.-Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing resident's infections which may include:>Prevention of the transmission of multi-drug-resistant organisms (MDROs). Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). -EBP is indicated for nursing home residents with any of the following:>Infection or colonization with an MDRO when contact precautions do not otherwise apply. >Use of gown and gloves during high-contact resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing.>Examples of high contact resident activities: dressing, transferring, changing linens. Resident #12 was admitted to the facility in January 2018 with diagnoses including retention of urine and History of Methicillin-Resistant Staphylococcus Aureus (MRSA) in the urine. Review of the Minimum Data Set (MDS) Assessment, dated 12/15/25, indicated Resident #12:-was severely cognitively impaired as evidence by a Brief Interview for Mental Status (BIMS) score of three out of total possible score of 15. -has an impairment on one side of his/her upper extremity.-has impairment of both lower extremities.-was dependent on staff for eating. Review of Resident #12's Physician Orders dated 2/10/26, indicated:-Enhanced Barrier Precaution (long-term) due to history of MRSA, initiated 6/16/25. Review of Resident #12's Comprehensive Person-Centered Care Plan initiated 6/16/25, indicated:-Enhanced Barrier Precautions (long-term) due to history of MRSA. On 1/10/26 at 7:55 A.M., the surveyor observed a sign posted outside of Resident #12's door that indicated: *STOP ENHANCED BARRIER PRECAUTIONS >EVERYONE MUST: -clean their hands including before entering and when leaving the room. >providers and staff must also: -wear gloves and a gown for the following high contact resident care activities: -transferring. -changing linens. On 2/10/26 at 8:04 A.M., the surveyor observed Certified Nurse Aide (CNA) #1 assisting Resident #12 with his/her breakfast meal while the Resident was lying flat on the right side of the bed and slouched down facing CNA #1. During an interview at the time, the Resident said that the position he/she was lying in was uncomfortable. CNA #1 was observed leaving the Resident's room and alerted CNA #2 to assist in repositioning the Resident. CNA #1 and CNA #2 entered Resident #12's room without either CNA performing hand hygiene and donning PPE prior to repositioning Resident #12 in bed. During an interview on 2/10/26 at 8:11 A.M., CNA #2 said that Resident #12 was not on any form of precautions and she did not wear a gown or gloves when she assisted in repositioning the Resident in bed. During an interview on 2/10/26 at 8:14 A.M., CNA #1 said that she typically works the night (11:00 P.M. - 7:00 A.M.) shift on a different unit, on a per diem basis and did not use PPE to provide care for the Resident unless the Resident had a bowel movement. During an interview on 2/10/26 at 8:19 A.M., Unit Manager (UM) #1 said that Resident #12 was on EBP for MRSA in the urine. UM #1 said that staff were expected to wear gown and gloves when care was provided to the Resident including handling bed linens. UM #1 said the risk of staff not wearing PPE was transmission of infections to other residents. On 2/10/26 at 8:27 A.M., the surveyor and UM #1 observed CNA #1's left hand resting on the bed while she fed Resident #12. During an interview at the time, UM #1 said that any contact with the Resident and or his/her bedding required staff to wear gloves and gown, but CNA #1 and #2 did (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not. During an interview on 2/10/26 at 4:45 P.M., the Director of Nursing (DON) said that Resident #12 had a history of MRSA in his/her urine and CNA #1 and CNA #2 should have donned a gown and gloves when touching Resident #12's skin and bed linens to reposition the Resident in bed.