STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225224	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Lowell	19 Varnum Street Lowell, MA 01850

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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 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. Based on observations, interviews, and record review, the facility failed to ensure a safe and homelike environment for one Resident (#133), out of 34 total sampled residents. Specifically, the facility failed to ensure Resident #133's sink was not leaking and good repair. Findings include: Review of the facility policy titled 'Homelike Environment', revised February 2021, indicated: - Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. Resident #133 was admitted to the facility in February 2024 with diagnoses including epilepsy (seizure disorder) and a history of a heart attack. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/4/25, indicated Resident #133 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 5/20/25 at 7:05 A.M., Resident #133 said his/her sink had been leaking for approximately two months. The surveyor and Resident #133 observed his/her bathroom sink which was actively dripping water into a plastic basin on the floor directly below. This plastic basin contained approximately an inch of discolored water. Resident #133 said staff were aware because he/she had asked for it to be repaired multiple times since it began leaking. Resident #133 said he/she must empty this basin by him/herself because staff has not done anything to help empty it or to repair the sink. Resident #133 said it's gross and it attracts bugs which he/she hates. During an interview on 5/20/25 at 7:08 A.M., Certified Nurse Assistant (CNA) #3 said she knew Resident #133's sink had been leaking for over a month. CNA #3 said if a sink was broken and in need of repair, it should have been written in the maintenance log so maintenance could follow-up. CNA #3 showed the surveyor the maintenance log, which had maintenance requests that began on 4/21/25. This maintenance log failed to indicate any concerns regarding Resident #133's leaking sink. CNA #3 said it should have been written here but it was not. (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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 7:10 A.M., Unit Manager #2 said if a sink needed to be repaired then a request should have been written in the maintenance log or Unit Manager #2 should have sent an email to maintenance. Unit Manager #2 said she was unaware of any maintenance requests or emails sent regarding Resident #133's concern about leaking sink. During an interview on 5/20/25 at 7:15 A.M., the Maintenance Director said he was not notified about Resident #133's concern about a leaking sink until this morning after the surveyor brought it to Unit Manager #2's attention. The Maintenance Director said he should have been notified by it being put in the maintenance log, but it was not. During an interview on 5/21/25 at 9:44 A.M., the Director of Nursing (DON) said staff should have notified maintenance immediately when the sink began leaking. The DON said over a month is too long to wait to notify maintenance of the need to repair.

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide written documentation related to transfer discharge notices and bed hold upon hospitalizations for three Residents (#129, #144 and #93) out of a total of 34 sampled residents. Findings include: 1. Resident #129 was admitted to the facility in January 2024 with diagnoses including paraplegia and communicating hydrocephalus. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #129 is cognitively intact evidenced by a score of 15 out of a possible 15 in the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #129 is totally dependent on staff for eating, bathing and mobility. Review of the clinical record indicated Resident #129 was transferred to the hospital on 1/18/25, 2/8/25, 3/4/25, 3/18/25 and 4/16/25. The clinical record failed to indicate if a transfer notice or bed hold notice was provided. During an interview on 5/20/25 at 1:37 P.M., the Social Worker said that the notices were not completed. The Social Worker said that the notices will not get done if she is not here. 2. Resident #144 was admitted to the facility in October 2024 with diagnoses including osteomyelitis and blindness. Review of the Minimum Data Set Assessment, dated 4/29/25, indicated Resident #144 is cognitively intact evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. Review of Resident #144's clinical record indicated he/she was transferred to the hospital on 2/12/25. The clinical record failed to indicate if a transfer notice or bed hold notice was provided. During an interview on 5/20/25 at 1:37 P.M., the Social Worker said that the notices were not completed. The Social Worker said that the notices will not get done if she is not here. 3. For Resident #93, the facility failed to provide a transfer discharge notice for 3 hospitalizations. Resident #93 was admitted in January 2021 with diagnoses including anxiety and major depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #93 could not participate in the Brief Interview for Mental Status exam due to severe cognitive impairment. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the Minimum Data Set indicated Resident #93 had hospitalizations on 12/13/24, 1/15/25, and 3/7/25. Review of the medical record failed to indicate that a transfer/discharge notice had been provided to Resident #93 and/or his/her representative. During an interview on 5/20/25 at 1:37 P.M., the Social Worker said that the notices were not completed. The Social Worker said that the notices will not get done if she is not in the building.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interviews and record review, the facility failed to identify and complete a Significant Change in Status (SCSA) Minimum Data Set assessment (MDS) for one Resident (#115), when he/she was discharged from hospice services, out of a total sample of 34 residents. Findings include: Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2024, indicated a SCSA comprehensive assessment must be completed by the end of the 14th calendar day following determination that a significant change has occurred. Resident #115 was admitted to the facility in January 2024 with diagnoses including Huntington's disease (an inherited condition that affects movement, thinking, and mood) and hypertension (high blood pressure). Review of the most recent Minimum Data Set (MDS) assessment, dated 2/25/25, indicated Resident #115 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS also indicated Resident #115 was receiving hospice services. Review of Resident #115's nursing progress notes, dated 4/30/25, indicated: - Per hospice team - pending dc (discharge) from hospice services. - Per DON (Director of Nursing) - Administrator informed nursing team of client will be off hospice services either today or tomorrow. Review of Resident #115 census summary indicated Resident was discharged from hospice services beginning 4/30/25. Review of Resident #115 nursing progress notes, dated 5/17/25 and 5/18/25, indicated Resident was receiving hospice services, when he/she was not. Review of Resident #115 plan of care related to nutritional status, revised on 10/31/24, indicated: - On hospice with goal of comfort and care. This care plan had not been updated since before the Resident was discharged from hospice services on 4/30/25. Review of Resident #115's medical record on 5/19/25 at 2:15 P.M. failed to indicate a SCSA assessment had been completed, which was 19 days after Resident was discharged from hospice services. During an interview on 5/19/25 at 2:17 P.M., Unit Manager #2 said Resident #115 was discharged from hospice services on 4/30/25. During an interview on 5/19/25 at 2:19 P.M., the MDS Nurse said a SCSA needs to be completed after any resident is discharged from hospice services as required by the RAI guidelines. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 5/19/25 at 2:35 P.M., the MDS Nurse said Resident #115 should have had a SCSA completed since he/she was discharged from hospice services on 4/30/25, but one was not completed. During an interview on 5/19/25 at 2:38 P.M., the Director of Nursing (DON) said she expects the MDS Nurse to follow RAI guidelines. The DON said a SCSA should have been completed for Resident #115 because he/she was discharged from hospice services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews and record review, the facility failed to ensure staff provided appropriate care and services for one Resident (#140) with a gastrostomy tube (a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication), out of 34 sampled residents. Specifically, the facility failed to ensure nursing changed the water flush bag (a bag containing water that is connected to and delivers water for hydration through a gastrostomy tube) every 24 hours as necessary to prevent infection and maintain the integrity of the feeding system. Findings include: Review of the facility policy titled 'Enteral Nutrition Feedings (tube feeding), revised 7/26/13, indicated: - An open system (bag and tubing) may hang up to 24 hours unless compromised. Resident #140 was admitted to the facility in June 2024 with diagnoses including diabetes and sepsis. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/11/25, indicated Resident #140 was rarely/never understood and had severe cognitive impairment as evidenced by a Staff Assessment for Mental Status. This MDS also indicated Resident #140 received 501 ml (milliliters) or more of average fluid intake per day by tube feeding. On 5/19/25 at 12:22 P.M., the surveyor observed Resident #140 in bed receiving his/her tube feeding and water flush through an enteral feeding pump with the water flush settings at flush 220 ml every 6 hours. The water flush bag was dated 5/17/25 at 4:20 A.M., which was 56 hours and 2 minutes before this observation. Review of Resident #140's physician's orders indicated: - Enteral feed order, flush enteral tube q (every) 6 hours with 220 ml of water, initiated 3/17/25. Further review of Resident #140's physician's orders failed to indicate any instructions regarding the frequency of water flush bag changes. Review of Resident #140's nursing progress notes, dated 5/17/25 to 5/19/25, failed to indicate any rationale for the water flush bag not being changed since 5/17/25. During an interview on 5/20/25 at 6:55 A.M., Nurse #2 and the surveyor observed Resident #140's water flush bag, which was now dated 5/19/25 at 6:30 P.M. (indicating the water flush bag was not changed for 62 hours and 10 minutes). Nurse #2 said water flush bags must be changed every 24 hours. Nurse #2 said she was assigned Resident #140 on night shift on 5/18/25 and 5/19/25. Nurse #2 said she did not change the water flush bag on 5/18/25 because it was the evening shift nurses responsibility to change it when she connected a new tube feeding container to the enteral feeding pump. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 12:43 P.M., Nurse #3 said she was assigned Resident #140 on the evening shift for 5/17/25 and 5/18/25. Nurse #3 said water flush bags must be changed every 24 hours. Nurse #3 said she poured more water into the water flush bag to make sure there was enough water in the bag for the scheduled flushes and connected a new tube feeding container to the enteral feeding pump, but she did not change the water flush bag on 5/17/25 or 5/18/25 because it was the night shift nurses responsibility. During an interview on 5/20/25 at 2:18 P.M., the Assistant Director of Nursing said there were no additional facility policies that specifically addressed water flush bags, but water flush bags should be changed every 24 hours. During an interview on 5/21/25 at 8:25 A.M., Unit Manager #2 said Resident #140's water flush bag should have been changed every 24 hours when a new tube feeding container was connected to the enteral feeding pump. During an interview on 5/21/25 at 9:44 A.M., the Director of Nursing (DON) said Resident #140's water flush bag should have been changed every 24 hours when a new tube feeding container was connected to the enteral feeding pump.

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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. Based on observations, interviews and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#125) out of sample of 34 residents. Specifically, for Resident #125, the facility failed to provide oxygen to the Resident as indicated in the physician's orders. Findings include: Review of facility policy, titled Oxygen Administration, dated as revised October 2010, indicated the following: -Verify that there is a physician's order for this procedure. Review the physician's orders for facility protocol for oxygen administration. -Steps in the procedure: 9. Place appropriate oxygen device on the resident (i.e. mask, nasal cannula and/or nasal catheter). Resident #125 was admitted to the facility in July 2023 with diagnoses that included Chronic Diastolic Heart Failure, primary pulmonary hypertension and sleep apnea. Review of Resident #125's most recent Minimum Data Set (MDS) Assessment, dated 4/15/25, indicated a Brief Interview for Mental Status (BIMS) exam score of 15 out of 15, indicating that the resident was cognitively intact. Further review of the MDS failed to indicate the use of oxygen therapy. Review of Resident #25's physician's orders indicated the following: -O2 (oxygen) at 2L (liters) continuously via Nasal Cannula, dated 4/16/24. Review of Resident #125's active care plan indicated the following: -Cardiac disease related to CAD (coronary artery disease), Hypertension (high blood pressure), CHF (congestive heart failure), with interventions that included to administer oxygen as ordered, dated as revised 8/2/23. On 5/19/25 at 8:24 A.M., Resident #125 was observed sleeping in bed. The Resident was receiving oxygen at 3 liters per minute via a face mask. On 5/19/25 at 1:29 P.M., Resident #125 was observed awake in bed. The Resident was receiving oxygen at 3 liters per minute via a face mask. On 5/20/25 at 7:00 A.M., Resident #125 was observed sleeping in bed. The Resident was receiving oxygen at 3 liters per minute via a face mask. On 5/21/25 at 7:56 A.M., Resident #125 was observed lying in bed. The Resident was receiving oxygen at 3 liters per minute via a face mask. Resident #125 declined to be interviewed by the surveyor, or speak to his/her oxygen use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 8:30 A.M., Nurse #1 said that oxygen should be delivered as indicated in the physician's orders. She said if the order is to receive oxygen via nasal cannula, then the resident should not be using a mask. During an interview on 5/21/25 at 9:06 A.M., the Director of Nurses said that oxygen should be administered based on the physician's order, including both the flow rate and means of which it is delivered to the resident.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure physician visits were completed timely, completed as required for new admissions, and were alternated between the physician and the nurse practitioner for seven Residents (#26, #27, #144, #8, #129, #120 and #89) out of a total of 34 sampled residents. Specifically: 1. For Residents #26, #27 and #144, the facility failed to ensure they were seen by the physician as required after admission to the facility. 2. For Residents #8, #89, #120 and #129, the facility failed to ensure they were seen by the physician as required. Findings include: Review of Physician Visits policy, dated 2001 indicated: Policy Statement: The attending physician must make visits in accordance with applicable state and federal regulations. 1. The attending physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history and the presence of medical conditions or problems that cannot be handled readily by phone. 2. The attending physician must visit his/her patients at least once every thirty days for the first ninety days following the resident's admission and then at least every sixty days thereafter. 3. Non-physician practitioners may perform required visits, sign orders and sign certifications/re-certifications as permitted by state and federal law. 4. After the first 90 days, if the attending physician determines that a resident need not be seen by him/her every thirty days, an alternate schedule of visits may be established, but not to exceed every sixty days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety days following admission, unless restricted by law or regulation. 5. The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. 1a. Resident #26 was admitted to the facility in February 2025 with diagnoses including vascular dementia and epilepsy. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she was moderately cognitively impaired as evidenced by a score of nine out of a possible 15 on the Brief Interview for Mental Status Exam. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's progress notes indicated Resident #26 had been seen once by the physician upon admission, on 2/28/25, and had no other visits by the physician or the nurse practitioner, every 30 days, as required. 1b. Resident #27 was admitted to the facility in February 2025 with diagnoses including diffuse traumatic brain injury and epilepsy. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #27 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status score of 9 out of 15, and required assistance with bathing, dressing and toileting. Review of Resident #27's physician progress notes indicated he/she was seen once upon admission by the physician on 2/28/25, and had no other visits, every 30 days, as required. 1c. Resident #144 was admitted to the facility in October 2024 with diagnoses including osteomyelitis and blindness. Review of the Minimum Data Set Assessment, dated 4/29/25, indicated Resident #144 is cognitively intact evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. Review of Resident #144's physician progress notes indicated he/she was not seen by the physician until 1/15/25 (approximately three months after his/her admission) and then by the nurse practitioner on 4/28/25. 2a. Resident #8 was admitted to the facility in June 1999 with diagnoses including schizophrenia and intracranial injury. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #8 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 3 out of a possible 15, and required assistance with bathing. Review of Resident #8's physician progress notes from July 2024 through May 2025 indicated he/she had been seen by the nurse practitioner on 10/15/24 and 1/15/25 and only had one visit from the physician on 1/15/25. 2b. Resident #89 was admitted to the facility in July 2022 with diagnoses including chronic obstructive pulmonary disease and chronic kidney disease. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #89 is cognitively intact evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status Exam. Review of Resident #89's physician progress notes July 2024 and May 2025 indicated Resident #89 was seen by the Nurse Practitioner on 8/28/24, 9/24/24, 10/1/24, 10/8/24, 11/11/24, 11/12/24, 12/13/24, 1/15/24 and 2/19/25, and Resident #89 was seen once by the physician on 1/15/25. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2c. Resident #120 was admitted to the facility in January 2024 with diagnoses including traumatic subdural hemorrhage immobility syndrome (paraplegic). Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #120 is cognitively intact evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status exam (BIMS). During an interview on 5/19/25 at 8:06 A.M., Resident #120 said that he/she had not been seen by the nurse practitioner or physician in a while. Review of Resident #120's physician progress notes between June 2024 and May 2025 indicated he/she had been seen by the nurse practitioner on 6/11/24, 8/13/24, 8/28/24, and 1/15/25 and by the physician on 6/14/24 and 1/15/25. 2d. Resident #129 was admitted to the facility in January 2024 with diagnoses including paraplegia and communicating hydrocephalus. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #129 is cognitively intact evidenced by a score of 15 out of a possible 15 in the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #129 is totally dependent on staff for eating, bathing and mobility. During an interview on 5/19/25 at 10:15 A.M., Resident #129 said he/she had not seen the nurse practitioner or physician in a while. Review of Resident #129's progress notes from June 2024 through May 2025 indicated he/she was seen by the physician on 1/15/25, 2/13/25, 3/10/25, and 4/18/25, and had visits from the Nurse Practitioner on 2/19/25 and 3/28/25. During an interview on 5/19/25 at 10:18 A.M., Unit Manager #1 said that each unit has their own nurse practitioner, and they come in weekly. Unit Manager #1 said that physician and nurse practitioner notes are located in the electronic record. During an interview on 5/19/25 at 2:25 P.M., the Assistant Director of Nursing (DON) said that the physician notes had been pulled directly from the physician's office and then should be uploaded by Medical Records. The ADON said that Residents should be seen every three months by the physician or nurse practitioner. During an interview on 5/20/25 at 10:21 A.M., Nurse Practitioner #1 said that residents are visited by the attending physician upon admission and that nurse practitioners alternate visits after. Nurse Practitioner #1 said notes are written after residents are seen and are accessible to staff electronically from their office. Nurse Practitioner #1 said resident visit frequencies are based on the regulation and that she did not think new admissions were being seen as required every 30 days for the first 90 days. (continued on next page)

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	225224	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Lowell	19 Varnum Street Lowell, MA 01850

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25 at 9:34 A.M., Physician #1 said that residents are seen within 48 hours of admission by the physician and then visits are alternated with the nurse practitioners as required. Physician #1 said notes are written after each visit and then uploaded by staff into the record. Physician #1 said that there might be some residents who were missed for visits as an oversight.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record reviews for two Residents (#62 and #126) out of five residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. Two out of three nurses observed made two errors out of 26 opportunities resulting in a medication error rate of 7.69%. Specifically, 1.) For Resident #62, the nurse administered the incorrect dose of atorvastatin calcium (a medicine used to treat high cholesterol). 2.) For Resident #126, the nurse failed to ensure an order for aspirin included a dosage prior to administration. Findings include: Review of the facility policy titled 'Administering Medications', revised April 2019, indicated: - Medications are administered in accordance with prescriber orders. - The individual administering medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 1.) Resident #62 was admitted to the facility in April 2019 with diagnoses including hypertension (high blood pressure) and hyperlipidemia (high cholesterol). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/25/25, indicated Resident #62 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of 15. On 5/20/25 at 8:23 A.M., the surveyor observed Nurse #4 prepare and administer the following medication to Resident #62: - One atorvastatin calcium 10 mg (milligram) tablet. Review of Resident #62's active physician order, initiated 5/15/25, indicated: - Atorvastatin calcium oral tablet 20 mg, give 1 tablet by mouth one time a day. During an interview on 5/20/25 at 11:31 A.M., Nurse #4 said she administered one atorvastatin calcium 10 mg tablet to Resident #62 but should have administered two tablets because the dose was recently increased to 20 mg. During an interview on 5/20/25 at 2:08 P.M., the Director of Nursing (DON) said Nurse #4 should not have administered atorvastatin calcium 10 mg because the physician's order is for 20 mg. 2.) Resident #126 was admitted to the facility in April 2024 with diagnoses including hyperlipidemia and atrial fibrillation (irregular heart rhythm). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 4/29/25, indicated Resident #126 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15. On 5/20/25 at 9:00 A.M., the surveyor observed Nurse #7 prepare and administer the following medication to Resident #126: - One chewable aspirin 81 mg tablet. Review of Resident #126's active physician order, initiated 4/26/24, indicated: - Aspirin oral tablet chewable, give 1 tablet by mouth in the morning. This order failed to indicate a dosage. During an interview on 5/20/25 at 11:39 A.M., Nurse #7 said all medications require a dosage to be included in the physician order. Nurse #7 said the aspirin should not have been administered without clarifying the physician order to include a dosage because the correct dosage could not be verified. During an interview on 5/20/25 at 2:08 P.M., the Director of Nursing (DON) said all medications require a dosage to be included in the physician order. The DON said there should have been a dosage included in Resident #126's physician's order for aspirin but there was not.

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure diagnostic test results were maintained in the clinical record for one Resident (#120) out of a total of 34 sampled residents. Specifically, the facility failed to ensure the results of an ultrasound were reviewed and reported to the attending physician and filed in his/her clinical record. Findings include: Review of the Lab and Diagnostic Test Results Clinical Protocol policy dated November 2018 indicated: - When test results are reported to the facility, a nurse will first review the results. -A physician can be notified by phone, fax, voicemail, e-mail, pager or a telephone message. -Facility staff should document information about when, how and to whom the information was provided and the response. This should be done in the progress notes section of the medical record and not on the lab results report. Resident #120 was admitted to the facility in January 2024 with diagnoses including traumatic subdural hemorrhage immobility syndrome (paraplegic). Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #120 is cognitively intact evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status exam (BIMS). During an interview on 5/19/25 at 8:05 A.M., Resident #120 said he/she was having pain in his/her genitals and staff were aware. Review of the physicians' orders indicated an order, dated 5/13/25, for an ultrasound on his/her genitals. Review of the medical record indicated the ultrasound was obtained on 5/13/25. Review of the clinical record failed to include the results of Resident #120's ultrasound. During an interview on 5/20/25 at 8:11 A.M., seven days after the ultrasound was ordered, Unit Manager #1 was unable to locate Resident #120's test results in the clinical record and accessed the results electronically from the diagnostic center and printed out a copy. Unit Manager #1 said that she had not reviewed the results of the ultrasound or notified the attending physician of the ultrasound results. Unit Manager #1 said Resident #120 had the ultrasound done after he/she had reported pain in his/her genitals. During an interview on 5/20/25 at 9:39 A.M., Nurse #8 said that Resident #120 had reported gential pain yesterday. Nurse #8 said she thought Resident #8 had an ultrasound to his/her genitals because he/she was reporting pain. (continued on next page)

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 9:53 A.M., the Director of Nursing (DON) said that ultrasound results should be reviewed by staff and reported to the attending physician the day the results are in. The DON said that nurses can access the results on the computer if they're not automatically uploaded into the electronic health record. The DON was not aware that Resident #120's ultrasound results were not in his/her clinical record or reviewed until the surveyor inquiry on 5/20/25.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews, and record reviews, the facility failed to accurately document in the medical record for one Resident (#11) out of 34 total sampled residents. Specifically, for Resident #11, the nurses inaccurately documented insulin was administered when it was not. Findings include: Review of the facility policy titled 'Charting and Documentation', revised July 2017, indicated: - Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Resident #11 was admitted to the facility in July 2018 with diagnoses including diabetes, stage four chronic kidney disease, and congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/18/25, indicated Resident #11 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #11 received insulin daily. During an interview on 5/21/25 at 8:41 A.M., Resident #11 said his/her blood sugars are unstable and his/her insulin needs to be held if his/her blood sugar is below 200. Resident #11 said he/she is very involved in his/her insulin management and is happy because nursing always holds his/her insulin when needed. Review of Resident #11's active physician orders indicated: - All insulin to be held if fasting blood sugars are 200 and below, every shift, initiated 5/17/24. - Novolin 70/30 relion (a type of insulin) subcutaneous (under the skin) suspension 100 unit/ml (milliliter), inject 25 unit subcutaneously in the morning, hold insulin if fasting glucose is 200 or below, initiated 12/5/24. - Novolin n relion (a type of insulin) subcutaneous suspension, inject 18 units subcutaneously in the evening, insulin to be held if fasting blood sugar 200 and below, initiated 12/4/24. - Novolog (a type of insulin) solution 100 unit/ml, inject 8 unit subcutaneously in the evening, insulin to be held if fasting blood sugar 200 and below, initiated 3/5/25. Review of Resident #11's Medication Administration Record (MAR), dated April 2025, indicated: - On 4/1/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 90. - On 4/4/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 77. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/6/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 114. - On 4/8/25 at 9:00 A.M., a nurse administered 25 units of novolin 70/30 insulin, when blood sugar was 198. - On 4/11/25 at 9:00 A.M., a nurse administered 25 units of novolin 70/30 insulin, when blood sugar was 133. - On 4/11/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 134. - On 4/14/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 194. - On 4/21/25 at 5:00 P.M., Nurse #4 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 160. - On 4/27/25 at 5:00 P.M., a nurse administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 163. Review of Resident #11's Medication Administration Record (MAR), dated May 2025, indicated: - On 5/1/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 97. - On 5/2/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 191. - On 5/6/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 90. - On 5/8/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin, when blood sugar was 177. - On 5/13/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 177. - On 5/16/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin, when blood sugar was 90. - On 5/17/25 at 5:00 P.M., Nurse #6 administered 18 units of novolin n insulin, when blood sugar was 194. - On 5/19/25 at 5:00 P.M., a nurse administered 18 units of novolin n insulin and 8 units of novolog insulin, when blood sugar was 152. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's nursing progress notes, dated 4/1/25 to 5/19/25, failed to indicate any clarifying information on insulin being administered or held on the above noted dates in the April 2025 and May 2025 MARs. During an interview on 5/21/25 at 7:59 A.M., Nurse #4 said Resident #11's insulin should always be held if his/her blood sugar reading was below 200. Nurse #4 said she had always held Resident #11's insulin when his/her blood sugar was below 200. Nurse #4 said insulin should not be documented as administered if it was not. During an interview on 5/21/25 at 8:25 A.M., Unit Manager #2 said Resident #11's insulin should always be held if his/her blood sugar reading was below 200. Unit Manager #2 said she was surprised that Resident #11's insulins were documented as administered when his/her blood sugars were below 200 because Resident #11 is very involved and aware of his/her insulin orders. Unit Manager #2 said she believed it was documented inaccurately. Unit Manager #2 said insulin should not be documented as administered if it was not. During a telephone interview on 5/21/25 at 8:50 A.M., Nurse #6 said he was aware that Resident #11's insulin needed to be held if his/her blood sugars were below 200. Nurse #6 said during April 2025 and May 2025 he always held his/her insulin if Resident #11's blood sugars were below 200. Nurse #6 further said that Resident #11 was very involved in his/her insulin management and always wanted to see the blood sugar reading. Nurse #6 said Resident #11 got excited if it was under 200 and would never allow any nurse to administer insulin if it were below 200. Nurse #6 said he must have documented Resident #11's insulin inaccurately. Nurse #6 said insulin should not be documented as administered if it was not. During an interview on 5/21/25 at 9:44 A.M., the Director of Nursing (DON) said Resident #11 would not allow insulin to be administered if his/her blood sugar was below 200 and felt the documentation was inaccurate. The DON said insulin should not be documented as administered if it was not.