

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Southeast Rehabilitation & Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 184 Lincoln Street North Easton, MA 02356	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on a resident group meeting, staff interviews, and document review, the facility failed to ensure grievances and concerns from the Resident Council regarding staff members wearing a name tag for identification were acted upon to resolve the issue. Findings include: Review of the facility's Grievance policy, undated, indicated but was not limited to: Residents have the right to voice grievances without discrimination or reprisal or fear of discrimination or reprisal. Such grievances may include issues with care or treatment that has been received or not received, the behavior of staff or other residents and other concerns regarding the resident's stay at the facility. Review of the Staff Handbook, undated, indicated but was not limited to: All employees must adhere to the following dress code standards: Nametags are to be worn by all employees at all times. Review of Resident Council Minutes, dated 5/16/25, indicated the concern of staff not wearing name tags was identified at the group meeting, with no follow up indicated. Review of Resident Council Minutes, dated 6/25/25, indicated the concern of name badges not being worn was discussed at the group meeting, with a Resident Council Concern Follow-up form completed with a resolution provided to in-service staff all shifts. During an interview with observation on 7/24/25 at 10:25 A.M., the surveyor observed Certified Nursing Assistant (CNA) #8 with no visible name tag. She said she should have her name tag on, and it should be visible, but she had it in her pocket. During an interview with observation on 7/24/25 at 11:35 A.M., the surveyor observed a staff member and asked her name. The surveyor was unable to understand her name and the staff member pulled her name tag from her pocket to show the surveyor. CNA #9 said she keeps her name tag in her pocket and the residents should know her name as she works frequently at the facility. During an interview with observation on 7/24/25 at 12:38 P.M., the surveyor observed a staff member with no name tag visible. Nurse #8 said she did not have her name tag with her, but she should be wearing it. She said she was not sure how a new resident or a visitor would identify her without her name tag. During an interview with an observation on 7/24/25 at 1:04 P.M., the surveyor observed a staff member with no name tag. Nurse #12 said she left her name tag in the car and should be wearing it, so residents are able to identify her. During an interview on 7/24/25 at 12:40 P.M., the Assistant Director of Nurses (ADON) said he expects all staff to be wearing name tags at all times, and it is important for residents to be able to identify the staff by name. On 7/24/25 at 1:00 P.M., the surveyor held a group meeting with 17 residents in attendance. The residents said every month they bring up the concern about staff not wearing name tags, but it continues to be a problem. Residents said it is difficult to identify staff without the name tags, and they should have access to the names of their caregivers. Multiple residents agreed with this statement by offering verbal acknowledgement. Another resident said without knowing who their caregivers are they are unable to file a grievance, complaint or concern because they can't identify the staff. Other residents said it is polite to be able to address your caregivers by their name and that information should be accessible. Residents in attendance at the group meeting nodded and agreed with the statements. The residents said there are multiple staff members during the day not wearing name tags and it just gets progressively worse with each shift. During an interview on 7/28/25 at 1:11 P.M., the Director of Nurses (DON) said staff are educated upon orientation regarding the name tag policy. She said she expects all staff to be wearing name tags. She said she identified staff today (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who were not wearing name tags as it continues to be an ongoing problem, and she was made aware of the problem in June and provided an in-service. She said she does not know why the previous DON did not address the issue identified in May when it was discussed at Resident Council as a concern.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure the residents' environment was clean, comfortable, and homelike. Specifically, the facility failed: To ensure the carpets were clean, free of odor, and without lifting on one unit (unit 200) out of four; To ensure the window unit air conditioners were maintained in a clean and sanitary manner on three out of four units; To ensure the dining room on one out of four units was well lit during dining; To ensure a clean, safe, homelike environment on the 100 unit; To ensure a clean and sanitary environment and tube feeding equipment for Resident #12; and To ensure room [ROOM NUMBER] was maintained in a clean and sanitary manner. Findings include: 1. During the Resident Group meeting on 7/24/25 at 1:00 P.M., 10 out of 17 residents commented on the building's carpeting. The residents said the carpets are old and smell terrible even after they have been cleaned. During a tour of unit 200 on 7/28/25 at 8:00 A.M., the surveyor observed carpeting in two dining room areas to be torn, tattered, and lifting. The surveyor smelled a stale, musty odor that permeated the dining rooms. During an interview 7/29/25 at 8:27 A.M., Certified Nursing Assistant (CNA) #10 said she smelled a stale musty smell that was probably coming from the carpet. She said she knows housekeeping cleans the carpets but there is always an odor emitting from the carpets. During an interview on 7/29/25 at 8:35 A.M., CNA #11 said it smells bad in the dining room and pointed to the carpeting. During an interview on 7/29/25 at 8:37 A.M., the Housekeeping Director said the carpets are cleaned twice a month. He said the carpets need to be replaced because no matter how often they are cleaned there is still a lingering odor. He said he cleaned the carpets on Sunday (two days prior) and there is still a bad odor. During an interview with an observation on 7/29/25 at 8:43 A.M., the Administrator said the carpet is old and he could also smell the musty, stale odor permeating the dining room area. He said the air purifier should be on and that helps reduce the odor because cleaning is not sufficient to reduce the smell. He said he received a quote for the carpeting on the first floor to be replaced but not the second floor. During an interview with an observation on 7/29/25 at 9:09 A.M., Resident #2 said the carpet is dirty and gross. He/She said they have difficulty propelling their wheelchair over the areas where the carpet has bunched and lifted. The Resident pointed to the areas that were bunched in the middle of the dining room area. During an interview with an observation on 7/29/25 at 9:15 A.M., Resident #97 said the carpets are grubby and smell terrible. The Resident pointed to areas of the rug that were stained and had areas of carpet with tattered ripped strings. He/She said they do not like to sit in the dining area due to the odor. Review of the request for the first floor carpeting, dated 6/25/25, indicated but was not limited to the following: (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Justification: Patient and Staff Safety Request: Replace old flooring in the hallway off the lobby and hall of unit 100. Flooring is cupping, lifting, and residents are tripping. The carpet is old, very dirty stained, smells really bad and is coming up. Sections of the carpet are missing, and people are tripping. During an interview on 7/29/25 at 12:50 P.M., the Director of Maintenance said he requested quotes for the major areas, and he said the quote did not include the second-floor carpeting. He said the second-floor dining area needs to be replaced and there are areas of the carpet that are a safety hazard due to the lifting in areas. He said the odor is probably coming from underneath the carpet in the foam padding after years of use. 2. On 7/23/25 at 10:11 A.M., in room [ROOM NUMBER], the surveyor observed Window Air Conditioner (AC) vents/slats that were covered with black dots, spots, and debris. During an interview on 7/23/25 at 10:11 A.M., Resident #8 said the AC is gross and they don't clean it. During the Resident Group meeting on 7/24/25 at 1:00 P.M., residents said the window air conditioning units were dusty, dirty, and had an unknown black substance in them. Residents report they have never seen anyone clean them and are unsure if residents are responsible for cleaning the units in their rooms. The residents said it is most common on the second floor because there are more rooms with window air conditioners installed. On 7/24/25 at 10:08 A.M., the surveyor observed air conditioners installed in windows in resident rooms with dusty air filters, visible debris, and black spots covering the inside of the air conditioner slats that were visible from approximately 3 feet away. The following rooms were observed to have air conditioners containing dust, debris, and black areas: 402, 404, 406, 407, 408, 409, 410, 411, 413, 419, 422, 305, 306, 307, 308, 310, 311, 312, 313, and 221. During an interview on 7/24/25 at 10:48 A.M., Nurse #1 said she had noticed that the air conditioners are dusty and dirty. She said she had told maintenance about the condition of the air conditioners but was unable to recall when. During a tour of the 300 unit on 7/30/25 between 9:15 A.M. and 10:15 A.M. the surveyor observed the following: -The unit had 19 resident rooms: 18 had portable Window AC units and one had a free-standing portable AC unit. -18 of the 19 AC units were dirty with black dots, spots and debris in the vents/slats. -room [ROOM NUMBER] portable AC unit was dripping water from the vents/slats. -room [ROOM NUMBER] had a gap on the right side of the AC unit leaving an open space to the outside. -room [ROOM NUMBER] AC was very loud. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER] had a gap on the left bottom corner of the AC unit leaving an open space to the outside. -room [ROOM NUMBER] AC did not stay running, turned on/off sporadically. -room [ROOM NUMBER] had stained ceiling tiles. -room [ROOM NUMBER] AC was dripping water from the vents/slats. -room [ROOM NUMBER] AC set to 60 degrees, it was not blowing cold air, and the room was warm. During an interview on 7/30/25 at 10:31 A.M., the Director of Maintenance said the window air conditioners are installed in resident rooms around April. He said the filters are cleaned before the units are installed but he is unaware of any process in place to routinely clean or maintain the air conditioning units while in use. He said maintenance will clean any dirty air conditioners or filters that they notice when visiting resident rooms. He said the black spots appear to be mold from usage and rain. He said he believes housekeeping is responsible for cleaning the black areas on the air conditioners because they should be done regularly with bleach. He said he had been unaware of the issue. During an interview on 7/30/25 at 11:04 A.M., the Housekeeping Director said his staff were not cleaning the air conditioners and he can see a significant amount of dust and dirt build up. He said there should be a schedule and process for cleaning the units to keep them clean and free of any build up. During an interview on 7/30/25 at 1:09 P.M., Hospice Staff #1 said she has noticed dusty air conditioners in some resident rooms. She said it cannot be good for residents to be breathing the air from those air conditioners due to all the dust, dirt, and potential mold. During an interview with observations on 7/30/25 at 11:28 A.M., the Administrator said the air conditioners should be free of dust, debris, and black growth. He said the staff are not identifying this as an issue and there should be a process in place for making sure the air conditioners are clean. 3. On 7/23/25 at 8:56 A.M., the surveyor observed unit 400 dining area #1 with three out of six ceiling lights missing. Residents were eating breakfast in dining area #1 and the room appeared noticeably dark. Dining area #2 was viewable from dining area #1 and was observed to be bright and well-lit. During an interview on 7/23/25 at 11:06 A.M., the surveyor observed Resident #3 reading the Daily Chronicle handout in dining area #1. He/she said they sit by the window to get extra sunlight because it is hard to see in this room. On 7/24/25 at 8:36 A.M., the surveyor observed staff members passing breakfast trays and ten residents eating in Dining room [ROOM NUMBER]. Three out of six ceiling lights were missing. During an interview on 7/24/25 at 8:41 A.M., Resident #107 said it is hard to see what you're eating, especially on a cloudy day when they don't have the sun to use for light. During an interview on 7/24/25 at 8:39 A.M., CNA #6 said Dining room [ROOM NUMBER] is darker than the other dining rooms and she doesn't remember when all six ceiling lights last worked. She (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The pale, yellow paint on the walls was scraped in multiple areas revealing green paint beneath. -The windowsill with dirt and debris. -Three round wooden tables had a worn finish and were in need of repair or replacement. During an interview on 7/30/25 at 10:15 A.M., the Administrator acknowledged the observations by the surveyor and said the 100 Unit needed a lot of repair work. 5. Review of Resident #12's July 2025 Medication Administration Record (MAR) indicated the Resident received tube feeding per the physician's order. On 7/24/25 at 1:10 P.M. and on 7/28/25 at 9:30 A.M., the surveyor observed in Resident #12's room brown-colored tube feeding formula drippage on the tube feeding pump (also known as a Kangaroo pump) and pole, the Resident's bedside fan, and bedrail. A small, yellow sign was observed nearby. The sign was dated 10/2/24 and read: Please clean feeding off machine when you drip or spill it. It dries and is hard to get off. On 7/28/25 at 10:10 A.M., Nurse #13 said any spilled tube feeding formula should be wiped up. Nurse #13 said a note was placed in Resident #12's room to remind staff to clean any spillage because it hardens when it dries and is difficult to clean. Nurse #13 said the Resident's room should be clean of tube feeding formula spillage. The surveyor made additional observations of dried tube feeding formula on Resident #12's Kangaroo pump, pole, fan, and bedrail on 7/28/25 at 4:45 P.M., 7/29/25 at 9:21 A.M., and 7/30/25 at 1:15 P.M. During an interview on 7/30/25 at 1:15 P.M., the Infection Control Nurse said tube feeding spillage should be cleaned up because it can grow microorganisms. He said there should be no dried tube feeding spillage in Resident #12's room or on his/her care equipment. During an interview on 7/31/25 at 12:14 P.M., the Director of Nursing (DON) said any tube feeding spills should be cleaned immediately. 6. On 7/23/25 at 9:34 A.M., in room [ROOM NUMBER], the surveyor observed a black, splotchy raised area on the wall behind the headboard of the B bed from the top of the baseboard up to the electrical outlet. On 7/24/25 at 12:29 P.M., in the bathroom of room [ROOM NUMBER] the surveyor observed a missing floorboard with a thick, black raised area. During an interview on 7/30/25 at 11:28 A.M., the Director of Maintenance and Director of Housekeeping observed the wall in room [ROOM NUMBER] and said it looked like something may have spilled on the wall and was not cleaned up.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, and records reviewed, for three Residents (#80, #144, and #135), of 39 sampled residents, the facility failed to ensure that individualized, comprehensive care plans were developed, consistently implemented, and revised as needed. Specifically, the facility failed:1. For Resident #80, to develop and implement a care plan intervention after he/she sustained a fall;2. For Resident #144, to develop and implement a smoking care plan; and3. For Resident #135, to follow the care plan and implement side rails for fall prevention and develop a care plan for post-traumatic stress disorder (PTSD). Findings include: Review of the facility's policy titled Comprehensive Care Plans, undated, indicated but was not limited to: -Policy: the facility is committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life. Recognizing each Resident as an individual, we identify and meet those needs in a resident-centered environment. Care plans are oriented toward preventing avoidable decline in clinical and functional levels, maintaining a specific level of functioning and reflect resident preferences and right to refuse certain services or treatment. -Care plans are a combination of: -Data concerning the resident that is obtained from the physician -Clinical records such as the hospital discharge summary -Evaluations done by professional and other disciplines -The resident and/or family goals for treatment -Acute/chronic events, behaviors and/or illness -Based on the above, the Interdisciplinary Team (IDT) develops a comprehensive Care Plan for each resident that includes measurable objectives and timelines to accommodate preferences, special medical, nursing and psychosocial needs identified in the RAI (Resident Assessment Instrument) and IDT -The Care Plan is evaluated and revised as needed, but at least quarterly. 1. Review of the facility's policy titled Falls Management, revised April 2024, indicated but was not limited to:-The interdisciplinary team will develop, initiate, and implement an appropriate individualized care plan based on the Fall Risk Evaluation Score. -The interdisciplinary team will meet at the next morning meeting to review any falls and evaluate additional needs for changes in the plan of care. Resident #80 was admitted to the facility in May 2025 with diagnoses including cerebral infarct (stroke) and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 5/8/25, indicated Resident #80 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/23/25 at 10:36 A.M., Resident #80 said he/she recently had a fall in the bathroom. Review of the Fall Incident Report, dated 7/9/25, indicated but was not limited to:-Nursing Description: Patient lost balance while trying to transfer themselves back to the wheelchair in the bathroom. Nurse helped the patient to sit on the floor to prevent injury and called CNA (Certified Nursing Assistant) to help patient back to the chair.-Immediate Action Taken: Skin assessment done; neurological check initiated; and pain assessment. Further review of Resident #80's medical record and care plans indicated the facility failed to develop and implement a fall care plan after the Resident's fall on 7/9/25 in order to minimize future falls. During an Interview on 7/24/25 at 12:48 P.M., the Director of Nursing (DON) said after a resident had a fall the fall care plan should be reviewed, and new interventions should be created and implemented if needed. The DON said Resident #80's fall care plan was not reviewed or revised after his/her fall on 7/9/25. The DON said she expected new fall interventions to be put in place and implemented per facility policy. 2. Resident #144 was admitted to the facility in May 2025 with diagnoses which included unspecified lack of coordination, difficulty walking, mild neurocognitive disorder, seizures, and cannabis use. Review of Resident #144's MDS assessment, dated 5/22/25, indicated Resident #144 had a BIMS score of 12 out of 15, which is indicative of moderate cognitive impairment. Review of Resident #144's Physician's Orders included but was not limited to: -7/23/25, Nicotine Transdermal Patch, 24 hour 7 milligrams/24 hours, apply 1 patch transdermally [sic] one time a day for smoking cessation for 2 weeks and remove per schedule, End Date 8/6/25. Review of Resident #144's Smoking Evaluation and Safety Screen, dated 5/19/25, indicated he/she was a non-smoker and did not wish to smoke while a resident at the facility. Review of Resident #144's Care Plan did not indicate a care plan for smoking or smoking cessation. During an interview on 7/24/25 at 1:36 P.M., Resident #144 said he/she sometimes smokes cigarettes offered to him/her by other residents. Resident #144 said he/she likes the social aspect of smoking and enjoys socializing with the other residents who smoke. During an interview on 7/29/25 at 7:20 A.M., Resident #144 said he/she smoked a cigarette the day before. During an observation and interview on 7/29/25 at 8:40 A.M., the surveyor observed Resident #144 seated in the smoking area. The Resident said he/she already smoked a cigarette. Smoking Attendant #2 and the surveyor reviewed the smoking binder utilized by the smoking attendant and observed Resident #144 was on the list of residents who smoke. During an interview on 7/29/25 at 10:00 A.M., Nurse #10 said Resident #144 was on her list of residents who smoke. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 7/29/25 at 1:10 P.M., the surveyor observed Resident #144 in the smoking area with an unlit cigarette pursed between his/her lips. Resident #144 said another resident allowed staff to provide him/her a cigarette from the resident's supply. Smoking Attendant #1 said Resident #144 typically smokes when he/she is offered a cigarette by another resident from their supply. During an interview on 7/29/25 at 2:35 P.M., Unit Manager (UM) #1 said she completed Resident #144's smoking assessment upon his/her admission to the facility at which time he/she did not smoke. UM #1 said if the Resident wished to smoke, then there should be a smoking care plan. During an interview on 7/31/25 at 12:14 P.M., the DON said any resident who smokes should have a smoking care plan. The DON said Resident #144 should have a smoking care plan in place. 3. Resident #135 was admitted to the facility in June 2020 with diagnoses which included: muscle weakness, psychotic disturbance, mood disturbance, anxiety, and lack of coordination. Review of the medical record indicated Resident #135 had a fall, dated 5/31/24, and sustained a laceration to the left side of the head requiring a hospital visit. Review of the MDS assessment, dated 7/16/25, indicated Resident #135 scored 14 out of 15 on the BIMS indicating Resident #135 was cognitively intact. During an interview on 7/23/25 at 4:25 P.M., Resident #135 said he/she sleeps on the side of his/her bed due to his/her PTSD, and he/she had a bad fall last year and the facility put side rails on his/her bed. Resident #135 said they came around recently and took off the bed's side rails for no reason. Resident #135 said he/she wants the side rails to be put back on his/her bed for security. Review of Resident #135's care plan included but was not limited to the following: -At risk for falls related to weakness and polypharmacy. -5/30/24- Side rails added to bed to assist in preventing falls. Further review of the care plan indicated there was no care plan in place for Resident #135's PTSD. During an interview on 7/29/25 at 9:12 A.M., the Maintenance Director said he got an email and a list to remove side rails. He said there were a couple of residents who were not happy the side rails were being removed. During an interview on 7/29/25 at 9:15 A.M., the DON said there was an audit, and some bed rails were removed, and some residents were not happy. Review of an email from the DON to the Maintenance Director, dated 2/4/25, indicated an audit was performed and Resident #135's bed had side rails in place. Review of the maintenance form titled Side Rails/Bars Assist Bars to be REMOVED, undated, instructed Maintenance staff personal to remove Resident #135's bedside rails. During an interview on 7/30/25 at 12:06 P.M., the DON said she is aware Resident #135 has PTSD, and she does not know why the side rails were taken off, but they could be put back on today.		

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NAME OF PROVIDER OR SUPPLIER Southeast Rehabilitation & Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 184 Lincoln Street North Easton, MA 02356	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interviews, and record review, the facility failed to ensure one Resident (#4), out of a total sample of 39 residents, received the necessary care and treatment to prevent and promote healing of pressure injuries. Specifically, the facility failed to ensure wound care orders were transcribed per wound physician recommendations, to perform wound care per physician's orders, and to adhere to clean technique with proper hand hygiene during dressing changes. Findings include: Review of the facility's policy titled Skin and Wounds, dated as last revised 1/2025, indicated but was not limited to the following:-The necessary treatment and services will be provided to promote healing, prevent infection, and prevent new pressure injuries from developing.-Standard Precautions are used unless otherwise indicated.-Wound treatments are done per MD order. Review of the facility's policy titled The Infection Prevention Program, dated as last revised 3/2024, Section: Hand Hygiene indicated but was not limited to the following:-When to use the Alcohol Hand Sanitizer: before entering the resident's room, before exiting the resident's room, before and after direct resident contact, before putting on and after removing gloves, before and after dressing changes. Review of the facility's contract with the Wound Physician Service, dated 9/3/13, indicated but was not limited to the following:-Facility shall inform the resident's primary care provider of wound care clinician's recommendations within 24 hours of receipt, discuss queries regarding recommendations/clinical practices with the assigned wound care clinician on the day of grand rounds, and to allow the wound care clinician to provide services and procedures to such resident. Resident #4 was admitted to the facility in March 2024 with diagnoses which included muscle weakness, malignant neoplasm, major depressive disorder, bed confinement, and fracture of lumbar vertebra. Review of the Minimum Data Set (MDS) Assessment, dated 5/28/25, indicated he/she scored 9 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment and had unhealed pressure ulcers. Review of the medical record including progress notes, wound notes, pressure ulcer evaluations, and skin checks indicated but were not limited to the following:-4/7/25: Progress Note: New order for Silvadene Cream 1% (antimicrobial cream) three times a day to Deep Tissue Injury (DTI) (pressure injury when tissue deep within the body is damaged due to prolonged pressure often over bony prominences) on left upper buttock.-4/8/25: Skin Check: failed to indicate the new DTI to left buttock.-4/9/25: Wound Physician Note: Unstageable DTI (extent cannot be determined because it's obscured) of the Left Buttock (Site 18). Measuring 5 x 6 x 0.1 centimeter (cm) with moderate serous drainage (clear, watery fluid). Duration >1 day. Treatment Plan for Xeroform Gauze (moist gauze for wound healing) followed by Superabsorbent gelling fiber with silicone border daily.-4/30/25: Wound Physician Note: -Stage 4 Pressure Wound (full thickness skin and tissue loss exposing bone, muscle, or tendon) of the Left Buttock (Site 18). Measuring 6 x 9 x 0.1cm with moderate serous drainage. Treatment Plan for Sodium Hypochlorite Solution (Dakins) (topical wound product, diluted bleach to clean and disinfect wounds, known for its antimicrobial properties) apply twice daily and as needed. Soaked gauze 1/4 strength Dakins followed by Superabsorbent gelling fiber with silicone border twice daily.-Unstageable DTI of the Right Buttock (Site 19). Measuring 6 x 6 x not measurable cm. Treatment Plan for Superabsorbent gelling fiber with silicone border once daily. Review of the Physician's orders and Treatment Administration Record (TAR) indicated but were not limited to the following:-Left Buttock Treatment Order: Normal Saline Wash (NSW), pat dry, pack with gauze Dakin solution, foam dressing twice daily. (4/30/25) The facility failed to include the strength of the Dakin solution in the physician's order for the Left Buttock and failed to implement the treatment order to the Right Buttock. Review of the weekly skin checks from April 2025 through May 2025, indicated the Resident was out of the facility from 5/5/25 through 5/13/25, and new skin impairments had been identified on 5/14/25 to the right and left buttock and left heel. No descriptions or measurements were included. No other skin impairments had been identified on the weekly skin checks. Review of the Wound Physician Note, dated 5/14/25, indicated:-Stage 4 Pressure Wound of the Left Buttock (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	superabsorbent border dressing every day and evening shift. (7/18/25)-Right Buttock: Cleanse with wound cleanser spray, pat dry. Pack wound with kerlix gauze soaked with Dakins Solution, leaving a wick for removal. Cover with 5x5 superabsorbent border dressing every day and evening shift. (7/18/25)-Left Heel: Skin Prep to left heel every day and evening shift for skin protection. (7/25/25) On 7/30/25 at 12:19 P.M., the surveyor observed Nurse #5 perform Resident #4's wound care which included but was not limited to the following:-Nurse #5 had just finished putting dressings on the Right and Left Feet and called the surveyor in to observe the dressing changes to the Right and Left Buttock.-Nurse #5 said the Right foot treatment she applied was NSW, followed by Xeroform, an ABD pad (absorbent non-adherent dressing), and Kerlix wrap. She said the Left Heel treatment she applied was NSW followed by xeroform, and a border dressing.-Both the Right and Left foot dressings were dated 7/30/25 and initialed by Nurse #5. -Right Buttock dressing was removed, area sprayed with wound cleanser, Kerlix gauze packing was removed in one long piece.-Nurse #5 removed her gloves and applied new gloves - no hand hygiene (HH) was performed between glove change.-Nurse #5 Sprayed and cleansed with wound cleanser wound spray and wiped area with non-sterile 4x4 gauze from large package.-Nurse #5 removed her gloves and applied new gloves - no HH was performed between glove change.-Nurse #5 poured Dakins 1/2 strength solution on a pile of non-sterile 4x4 gauze (removed from same package used to clean the area), the stack of 4x4 gauze was pushed into wound bed.-Nurse #5 covered the wound with border foam dressing.-Nurse #5 removed her gloves and applied new gloves - no HH was performed between glove change. -Left Buttock dressing was removed, Kerlix gauze packing was removed in one long piece.-Nurse #5 cleansed area with wound cleanser spray.-Nurse #5 removed her gloves and applied new gloves - no HH was performed between glove change.-Nurse #5 poured Dakin 1/2 strength solution onto a pile of non-sterile 4x4 gauze (removed from the same package used for Right Buttock and to cleanse the Left Buttock), the stack of 4x4 gauze was pushed into wound bed.-Nurse #5 covered the wound with border foam dressing.-Nurse #5 removed her gloves and applied new gloves - no HH was performed between glove change. -Lower Left buttock/upper thigh area had Moisture Associated Skin Damage in multiple small areas. Nurse #5 said they were newly re-opened.-Nurse #5 cleansed the area with wound cleanser spray.-Nurse #5 removed her gloves and applied new gloves - no HH was performed between glove change.-Nurse #5 applied Silver sulfadiazine cream to the areas.-Nurse #5 removed her gloves and applied new gloves - no HH was performed between glove change. During wound care Nurse #5 failed to clarify the strength of Dakins Solution to be used, failed to perform wound care per orders utilizing a pile of loose 4x4 gauze to pack the wound instead of the one long piece of Kerlix, failed to adhere to clean technique and perform HH during wound care, and applied a dressing to the Left Heel without an order for a dressing. During an interview on 7/30/25 at 2:48 P.M., Nurse #5 said she usually does HH when she enters the room and when she exits, but not between glove changes. She said the 1/2 strength Dakins is the only one she had ever seen in the building and was unaware the Wound Physician wanted 1/4 strength to be used, as she did not do the wound rounds or write the orders. She said the order should have a strength since there are different ones, but it does not. Additionally, she said she used regular 4x4 gauze to pack the wound because the Kerlix is in the supply room and they are both gauzes, so she did not think it was a problem. She said she did not know why the order was changed to Kerlix from the regular gauze. Nurse #5 said the left heel had no dressing on it when she went in and she didn't know why, so she put the dressing back on. She said she did not realize the wound had been healed and the order discontinued and changed to just skin prep last week. During an interview on 7/30/25 at 2:53 P.M., the Infection Control Nurse/Wound Nurse said the wound should have been packed with one long piece of Kerlix and not the loose gauze. He said you should never use loose gauze or a pile of 4x4 in a big wound like that because a piece could get stuck or left in the wound. He said the wound should be packed and a tail left to easily remove the packing in one long piece. He said he does the weekly wound rounds and writes the orders. He said the wound Doctor writes the orders on his report and they copy them exactly as he orders into the electronic orders. He (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said if we don't have what he wants we would call to get a new order, or a temporary order until the supplies are delivered, then we would write those orders and write a progress note. He said he believes the facility only has the 1/2 Strength Dakins Solution, but the order should contain the strength ordered and it does not, so we have been using the wrong solution for months. During an interview on 7/31/25 at 10:45 A.M., the Director of Nurses said all new skin pressure areas should be documented in the medical record, an order written to be followed by the wound physician, and then nurses should follow the wound care orders. She said she was unsure why the treatment orders in April and May were not written as ordered or why the Dakins Solution did not have a strength in those orders. She said the Dakins Solution should have a strength in the order and that is what should be used; since there was no strength in the order it should have been clarified. She said if the primary care physician declined wound physician orders, it should have been documented in the medical record and it was not. She said the Assistant Director of Nurses (ADON) was doing wound round before the current wound nurse took over. She said HH should be done before starting wound care, between every glove change, if hands are soiled, and after wound care. Additionally, she said treatments should be done per physician's orders, the wound should not be packed with loose gauze it should have been packed with the Kerlix with a tail for easy removal and the left heel wound was resolved and the nurse should not have put a dressing on it, she should be following the orders. During an interview on 7/31/25 at 11:09 A.M., the ADON said he was doing wound rounds before the current wound nurse took over. He said he was unsure why the treatment orders on 4/30/25 and 5/21/25 were not transcribed as ordered. He said the final version he gets from the wound doctor is exactly what is to be written in the electronic record. He said the Dakins Solution should have had a strength in the order all along and it did not. He said HH should be done before and after wound care and with glove changes and the wound should have been packed with Kerlix because that is what was ordered. Additionally, he said the expectation is treatments are done per the orders.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record reviews, and interviews, the facility failed to ensure an environment that was free from accidents and hazards for nine Residents (#111, #4, #12, #68, #54, #13, #43, #80, and #144), out of a total sample of 39 residents. Specifically, the facility failed:1. For Resident #111, to ensure the Resident's previous elopement was investigated and had effective interventions in place to prevent a second elopement from the facility;2. For Residents #4 and #12, to ensure fall prevention/injury mitigation interventions were implemented;3. For Resident #68, to ensure new interventions were developed and implemented following a fall;4. For Resident #54, to ensure he/she was supervised while smoking, not lighting cigarette butts off the ground to smoke, and ensure the smoking area was free of disposed cigarette butts on the ground;5. For Residents #13 and #43, to ensure he/she was supervised while smoking and was not sharing a cigarette with another resident; and6. For Residents #80 and #144, to complete smoking evaluation and safety screens prior to the Resident smoking on facility property. Findings include:1. Review of the facility's policy titled Elopement, dated July 2015, indicated but was not limited to the following: -Elopement is defined as the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way. -The facility strives to promote resident safety maintaining a process to screen all residents for risk of elopement, implement preventive strategies for those identified at risk, institute measures for resident identification at the time of admission, and conduct missing resident procedures, as warranted. -Document relevant information in the Resident's medical chart, incident report, and DPH report, as warranted. Resident #111 was admitted to the facility in January 2025 with diagnoses including hemiplegia and hemiparesis following cerebral infarction, dementia, and epilepsy. Review of Resident #111's Minimum Data Set (MDS) assessment, dated 7/18/25, indicated he/she scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment, required supervision or touching assistance for walking 150 feet in a corridor or similar space, and used a walker as a mobility device. Review of a nursing progress note, dated 6/25/25, indicated Resident #111 was seen walking off facility property and walking across the main road. Once back to the facility the Resident verbalized, he/she wanted to leave the facility. Review of Resident #111's care plan initiated on 7/1/25, six days after his/her elopement indicated but was not limited to the following: Focus: Resident is at risk to try and leave the nursing facility, moves without regard to safety, pacing, roaming, /wandering in/out of peer rooms, eloped outside on 6/25/25 Goal: Resident will not leave the facility unescorted daily x 90 days. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions: -If resident is seen at an exit, encourage to come with staff. -Establish and maintain daily routine to meet physical needs. -Encourage in participation in positive meaningful activity programs of choice. -6/25/25 encourage resident to walk to/sit on back patio. On 7/29/25 at 2:10 P.M., the surveyor observed Resident #111 walking across the parking lot headed towards the main street with no sidewalks. The Resident walked approximately .3 miles with a walker on a 95-degree day after receiving a heart monitor placed at an appointment. The surveyor observed cars pulled over on the street and saw two staff members coming out of the facility walking towards the street. During an interview on 7/29/25 at 2:30 P.M., Receptionist #1 said there were only two residents outside that she was aware of. She said the residents have access to leave the property through the smoking area, but they know they are not supposed to. During an interview on 7/29/25 at 2:40 P.M., the surveyor saw the Admissions Director outside. She said she had heard that Resident #111 eloped from the building and was going to look for him/her. She said the Resident is a known elopement risk. During an interview on 7/29/25 at 2:53 P.M., Receptionist #1 said staff called the building and informed her they observed Resident #111 walking down the street. She said she was at lunch between 1:30 P.M. and 1:45 P.M. and the Resident may have gone out then. She was unsure how the Resident eloped from the building. She said Unit Secretary #1 was sitting at the desk during her lunch break. During an interview on 7/29/25 at 3:31 P.M., Unit Secretary #1 said she was sitting at the reception desk and did not see any residents leave. She said she was not at the desk the entire time and can't account for the time she wasn't at the desk. She said she is aware of a binder that contains residents who are at risk for elopement but is unsure of which residents are in the binder. She said she did not know if Resident #111 was an elopement risk. During an interview on 7/29/25 at 3:33 P.M., the Director of Nurses (DON) said Resident #111 eloped from the building and there was an investigation initiated, elopement policy and procedure was not followed, and Dr. Hunt (the emergency code paged overhead when a resident is missing) was not initiated. She said she was unsure if the Resident had eloped previously. During an interview on 7/30/25 at 2:44 P.M., the DON said the previous DON's last day was on 6/20/25. She said she was informed of the elopement from 6/25/25 on 7/1/25 and initiated a care plan and completed a wandering assessment. She said it was a generic care plan because she was unaware of the elopement details. There should have been an investigation of the Resident's elopement, assessments completed, and care plans initiated on the day of his/her 6/25/25 elopement and the process was not followed. The DON said she was unable to find any evidence that an investigation had been completed to identify risks for future elopements or that education was provided to staff. She said these steps should have been taken to keep the Resident safe. She said (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the only education offered to staff regarding incident reports and elopement was conducted on 7/23/24. Review of the Inservice Attendance form, dated 7/23/24, indicated: -Inservice topic, Elopement -Content: Incident reports and elopement evaluations must (sic) if a resident elopes from the premises. -There were 10 signatures on the attendance form including the speaker on the content. During an interview on 7/30/25 at 3:16 P.M., the Assistant Director of Nurses (ADON) said he is responsible when the director is unavailable. He said he was aware of Resident #111's elopement on 6/25/25. He said he was unsure if an investigation was completed, he collected statements and was unable to recall if education was provided. He said he would have conducted the in-services. During an interview on 7/30/25 at 3:30 P.M., Nurse #5 said she was the nurse working 6/25/25 when the Resident eloped. She said she did not receive any education and was not asked to write a statement or provide additional details regarding the elopement. She said her note indicates she informed the DON but was unable to recall who she spoke to. During an interview on 7/30/25 at 3:30 P.M., Additional Staff #12 said he recalls he was at the front desk on 6/25/25. He said he received a call from a staff member that they saw Resident #111 walking across the property. He said he ran out to ensure Resident's safety and he said he/she was standing close to the road on the corner, and he put himself between the Resident and the street to ensure no passing cars would hit the Resident. He said there are no sidewalks, and the Resident was close to the street. He said he did not provide any additional details to assist with an investigation, and he received no education on the elopement process. He said he has worked at the building for approximately six years and received education when he was first hired but not since then. During an interview on 7/30/25 at 4:37 P.M., Activities Assistant #1 said she recalls seeing Resident #111 in the front parking lot on 6/25/25 and actively walking to the street. She said she told the nurse, and the nurse called the front desk and spoke to Additional Staff #12. She said there were no other staff members with him/her until Additional Staff #12 got to him/her and he/she was approximately 300 feet from the entrance at the very corner of the property near a speed limit sign on the street. She said it was hard to watch because she said people drive so fast down the street and there are no sidewalks. She said she was nervous because she didn't want the Resident to be hit by a car or fall. She said she did not receive any education, nor was she asked additional details. During an interview on 7/30/25 at 3:11 P.M., the Administrator said he believed that the DON was investigating the previous elopement but did not ensure its completion. He said it should have been investigated and resident specific interventions put in place to prevent the Resident from a second elopement. He said staff should have been educated on the elopement process and procedure including informing staff of Resident #111's risk for elopement. During an interview on 7/30/25 at 5:15 P.M., the DON said the 6/25/25 elopement should have been investigated and personalized interventions developed to prevent future elopements. She said staff were not educated on the Elopement policy following the first elopement which left them unaware of (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	how to prevent the second elopement. She said the change in DON is likely a reason this was missed. 2. Review of the Falls Management Policy, last reviewed August 2018, indicated but was not limited to the following: -The interdisciplinary team will develop, initiate, and implement an appropriate individualized care plan. A. Resident #4 was admitted to the facility in March 2024 with diagnoses which included muscle weakness, malignant neoplasm, intervertebral disc disorder, compression fracture, and fall. Review of the MDS assessment, dated 5/28/25, indicated he/she scored 9 out of 15 on the BIMS, indicating he/she had moderate cognitive impairment. Review of the medical record indicated Resident #4 suffered a fall on 5/2/25 and 5/3/25. Review of the incident reports and nursing progress notes indicated but were not limited to the following: -5/2/25, Resident #4 was observed on the floor on the side of his/her bed after trying to go to the bathroom. He/she indicated they slid off the bed and could not stop it. He/she had an air mattress in place due to wounds. -5/2/25, foam bumpers were added to the bed under the fitted sheet to prevent sliding off the bed. -5/3/25, Resident #4 was observed face down on the floor. Bed was in low position. Resident #4 was unable to describe what had occurred. -5/4/25, on the overnight shift he/she complained of right elbow pain. -5/4/25, an X-Ray was ordered by the provider, the X-ray showed a fracture of the right distal humeral metaphysis, the provider ordered resident be transferred out for further evaluation. -5/13/25, Resident was readmitted to the facility from the hospital. Ortho recommended conservative treatment. Low Bed, Foam Bolsters, and floor mats on both sides of the bed. Review of the Comprehensive Care Plan indicated but was not limited to the following: PROBLEM: At risk for fall related injury. GOAL: He/She will not sustain a fall related injury by utilizing fall precautions. INTERVENTIONS: -Foam Bumpers under fitted sheet to prevent sliding off the bed. -Floor mat right and left side to prevent injury from fall. The surveyor observed Resident #4 in bed with an air mattress and bolsters in place without floor (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mats on the right and left side as indicated in the care plan as follows: -7/23/25 at 9:40 A.M., floor mat on the right side of bed only. -7/23/25 at 1:50 P.M., floor mat on the right side of bed only. -7/29/25 at 9:15 A.M., no floor mats next to the bed. -7/29/25 at 1:37 P.M., no floor mats next to the bed. -7/30/25 at 9:15 A.M., no floor mats next to the bed. -7/30/25 at 11:00 A.M., no floor mats next to the bed. -7/30/25 at 12:19 P.M., floor mat on the right side of bed only. During an interview on 7/30/25 at 2:53 P.M., the Infection Control Nurse said Resident #4 used to have two mats, and the care plan says they should have two, but he/she only has one, because he thinks it was a trip hazard for the roommate, so it was removed. During an interview on 7/30/25 at 3:00 P.M., Nurse #5 said after the fall when Resident #4 broke their arm the floor mats were added to prevent injury. She said they used to have two, but she thinks they removed the left one because it was dangerous for the roommate. During an interview on 7/31/25 at 10:45 A.M., the DON said Resident #4's care plan was written for two mats, so he/she should have two mats. She said she was unaware that one had been removed and would need to investigate it. During an interview on 7/31/25 at 11:09 A.M., the Assistant Director of Nurses (ADON) said if Resident #4's care plan is for two mats, he/she should have two floor mats and did not know why he/she only had one. B. Resident #12 was admitted to the facility in April 2024 with diagnoses which included paraplegia, dementia, anxiety, and impulse disorder. Review of Resident #12's MDS assessment, dated 4/24/25, indicated the Resident had memory problems and was severely impaired in making decisions regarding tasks of daily life and never/rarely made decisions. Review of Resident #12's active Physician's Orders indicated but was not limited to the following: -Floor mats to both sides of bed, 8/10/21. Review of Resident #12's July 2025 Medication Administration Record (MAR) indicated the floor mats were placed on both sides of the bed per the physician's order. Review of Resident #12's care plan indicated but was not limited to the following: -Resident is at risk for falls related to paraplegia, 7/28/25 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Floor mat to both sides of bed, 6/29/20. On 7/24/25 at 1:10 P.M. and 7/28/25 at 9:30 A.M., the surveyor observed one floor mat in place on the Resident's left side and no floor mat on the Resident's right side. During an interview on 7/28/25 at 10:10 A.M., Nurse #13 reviewed Resident #12's physician's orders and said the orders stated the Resident should have two floor mats in place. During an interview on 7/31/25 at 12:14 P.M., the DON said she expected floor mats to be implemented per physician's orders and Resident #12 should have two floor mats as ordered. 3. Review of the Falls Management Policy, last reviewed August 2018, indicated but was not limited to the following: -A fall risk evaluation will be conducted on each resident/patient upon admission, with the quarterly MDS cycle, and when a significant change in status occurs (including a fall). -The interdisciplinary team will develop, initiate, and implement an appropriate individualized care plan based on the Fall Risk Evaluation Score. A score of 0-9 indicated no to low risk, while a score of 10+ indicates moderate to high fall risk. Resident #68 was admitted in December 2023 with diagnoses which included Neurocognitive disorder with Lewy Body dementia (a disorder caused by clumps of a certain protein in the brain), dementia, unspecified with mood disturbance, Type 2 diabetes mellitus, atrial fibrillation, aphasia, cerebral infarct with right sided weakness, and hypertension. Review of the medical record indicated Resident #68 had BIMS score of 3 out of 15, indicating severe cognitive impairment. Review of the Nursing Progress Notes indicated the following: -4/8/25 at 3:00 A.M., observed on the floor next to his/her bed. -4/15/25 at 1:15 A.M., observed on the floor next to his/her bed wrapped in the blankets. -5/6/25 at 11:15 P.M., observed on the floor next to his/her bed. -6/5/25 he/she was observed sitting on the floor. Review of the Fall Risk Evaluation dated 6/2/25 indicated a score of 13, assessing the Resident to be at moderate to high risk for falls. Review of the Comprehensive Care Plan indicated but was not limited to the following: -4/8/25-non-skid socks -4/15/25-Resident moved closer to the nurses' station to be monitored. Resident evaluated for side rails to help with bed mobility turning and repositioning (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/8/25-floor mats to both sides -6/5/25-Resident moved back to his old room to reduce confusion Review of the nursing progress note, dated 7/10/25, indicated Resident #68 was observed on the floor at approximately 2:50 A.M. sitting on the floor close to his/her bed. He/she was unable to explain what happened. Review of the Fall Risk Evaluation, dated 7/10/25, indicated that following the fall, the Resident was assessed a score of 21, which placed the Resident at Moderate to High Fall Risk. Review of the Care Plan failed to indicate additional individualized interventions were added following the 7/10/25 fall to reduce the risk of falling and mitigate the risk of injury. During an interview on 7/31/25 at 3:15 P.M., the DON said that Resident #68 remained a significant fall risk in spite of the interventions listed in the care plan. The DON said that the falls occurred solely at night and that interventions listed in the care plan had not been effective in preventing the Resident's falls and he/she remained at risk for falls and potential injury. 4. Resident #54 was admitted to the facility in July 2022 with diagnoses which included: muscle weakness, peripheral vascular disease, psychoactive substance abuse. Review of the MDS assessment, dated 6/12/25, indicated Resident #54 scored 15 out of 15 on the BIMS, indicating Resident #65 was cognitively intact. In addition, section J1300 indicated tobacco use. Review of Resident #54's current care plan indicated but was not limited to the following: a. Resident #54 chooses not to follow the facility rules/policies regarding smoking, despite numerous attempts at education, initiated 7/14/23. -Resident will not sustain safety related injury due to noncompliance x90 days. -Discuss with resident his/her objections, reasons, fears, ideas. Initiated 7/14/23. Inform resident about risk of noncompliance, initiated 7/14/23. b. Resident #54 wishes to smoke and is assessed for supervision level: Independent. - Focus on observation of hands during weekly skin check to ensure there are no burns, date initiated 1/3/24. -Monitor resident safety during smoking., initiated 1/3/24. On 7/29/25 at 2:45 P.M., the surveyor observed Smoking Attendant (SA) #1 sitting in the main dining room by the door which leads to the designated smoking area. SA #1 opened the coded door to allow the surveyor to enter the designated smoking area, and the surveyor made the following observations: -Resident #54 sitting in a wheelchair holding a lit cigarette butt in his/her left hand. The cigarette was observed to be burning down to the filter. SA #1 approached Resident #54 and removed the lit (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cigarette from his/her hand and said, "You have to put out that cigarette before you burn your hand." -The surveyor observed Resident #54 to have a raised red area on the left distal second digit and to have numerous burn holes in his/her pants. -Numerous cigarette butts were observed on the ground throughout the smoking area. -SA #1 was sweeping up cigarette butts on the ground and disposing them in the ash tray. During an interview on 7/29/25 at 3:00 P.M., SA #1 said, "Resident #54 does not have any cigarettes, so he/she goes around and picks up cigarette butts off the ground and lights them. I know Resident #54 has a lighter and I asked him/her for it and Resident #54 declined to give it to me." SA #1 said he wrote up Resident #54 this morning for having a lighter and informed the Administrator. SA #1 said the residents keep disposing of the cigarette butts on the ground instead of the ash tray provided. He said he informs the Administrator, but the residents don't listen. SA #1 said it's after 2:30 P.M., it's not even smoking time. The next smoking time is 3:30 P.M., and none of the residents out here smoking are even on the list, they just come out here to smoke. During an interview on 7/29/25 at 3:10 P.M., Resident #54 said he/she burned his/her finger a couple weeks ago; it's fine now. During an interview on 7/29/25 at 3:12 P.M., the Administrator said he was aware Resident #54 has a lighter in his/her possession. He said he can't search Resident #54's room until he returns to the room. The Administrator said the SA #1 is supposed to be outside in the smoking area anytime there is a resident out there and SA #1 should be supervising Resident #54 until we are able to retrieve the lighter. The Administrator said he was aware of the area on Resident #54's left hand second digit and said it has been there for a long time. During an interview on 7/29/25 at 4:55 P.M., the DON said she was not aware of a burn on Resident #54's left second digit or that he/she had a lighter in his/her possession. The surveyor and the DON went to Resident #54's room and the DON observed Resident #54's left hand. Resident #54 said he/she did it a few weeks ago and rolled over in bed. Resident #54 declined to allow the DON to view his/her pants for burn holes. During an interview on 7/29/25 at 5:05 P.M., Nurse #5 said she did know about the burn on Resident #54's hand. She said she did see a blackened area on the left second digit but thought it was just ashes from smoking. During an interview on 7/30/2025 at 10:10 A.M., the DON said Resident #54 does have an area on the left second digit, and he will see the wound physician this week. 5A. Resident #13 was admitted to the facility in June 2025 with diagnoses which included: Lack of coordination and nicotine dependence. Review of the MDS assessment, dated 6/12/25, indicated Resident #54 scored 15 out of 15 on the BIMS, indicating Resident #13 was cognitively intact. Review of Resident #13's current care plan indicated but was not limited to the following: (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13 wishes to smoke and is assessed for supervision level: Independent. -Resident #13 will smoke safely at designated area at scheduled times through next review period, initiated 3/12/25. -Resident #13 will not offer cigarettes or light to other residents who are supervised without staff permission, initiated 3/12/25. -Resident #13 will follow center policy and procedures, initiated 3/12/25. -Monitor resident's safety during smoking, initiated 3/12/25. Review of Resident #13's Smoking Evaluation and Safety Screen, dated 6/2/25, indicated but was not limited to the following: -Smoking safety measures: What is needed to ensure the resident is safe during smoking? (check all that apply). Box A is checked indicating routine supervision during scheduled smoking activity. On 7/29/25 at 2:45 P.M., the surveyor observed Smoking Attendant (SA) #1 sitting in the main dining room by the door which leads to the designated smoking area. SA #1 opened the coded door to allow the surveyor to enter the designated smoking area, and the surveyor made the following observations: -Resident #13 was smoking a cigarette which was being passed back and forth with Resident #43. -Resident #13 was holding a box of cigarettes in his/her hand. -Resident #13 placed the box of cigarettes on the outside windowsill. -Surveyor observed the box of cigarettes to be empty. 5B. Resident #43 was admitted to the facility in June 2023 with diagnoses which included: stroke with right dominant side muscle weakness and lack of coordination. Review of the MDS assessment, dated 7/25/25, indicated Resident #43 scored 15 out of 15 on the BIMS, indicating Resident #43 was cognitively intact. In addition, section J1300 indicated no tobacco use. Review of Resident #43's current care plan indicated but was not limited to the following: Resident #43 wishes to smoke and is assessed for supervision level: Independent. -Resident #43 will smoke safely at designated area at scheduled times through next review period, initiated 3/12/25. -Resident #43 will not offer cigarettes or light to other residents who are supervised without staff permission, initiated 3/12/25. -Resident #43 will follow center policy and procedures, initiated 3/12/25. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor resident's safety during smoking, initiated 3/12/25. Review of Resident #43's Smoking Evaluation and Safety Screen, dated 7/7/25, indicated but was not limited to the following: -Smoking safety measures: What is needed to ensure the resident is safe during smoking? (check all that apply). Box A is checked indicating routine supervision during scheduled smoking activity. On 7/29/25 at 2:45 P.M., the surveyor observed SA #1 sitting in the main dining room by the door which leads to the designated smoking area. SA #1 opened the coded door to allow the surveyor to enter the designated smoking area, and the surveyor made the following observations: -Resident #43 was smoking a cigarette which was being passed back and forth with Resident #13. During an interview on 7/29/25 at 3:00 P.M., SA #1 said Resident #13 is not supposed to have their own supply of cigarettes, but he/she gets them. SA #1 said Residents #13 and #43 should not be sharing cigarettes. SA #1 said it's after 2:30 P.M., it's not even smoking time. The next smoking time is 3:30 P.M. and none of the residents out here smoking are even on the list, they just come out here to smoke. 6A. Resident #80 was admitted to the facility in May 2025 with diagnoses including stroke cerebral infarct (stroke) and peripheral polyneuropathy (a condition where multiple nerves in the periphery of the body are damaged or diseased, often causing numbness, tingling, pain, and weakness). Review of the MDS assessment, dated 5/8/25, indicated Resident #80 was cognitively intact as evidenced by a BIMS score of 14 out of 15. During an interview on 7/23/25 at 10:36 A.M., Resident #80 said he/she smoked cigarettes when he/she could get them. Resident #80 said he/she would get cigarettes off other residents. Review of Resident #80's Smoking Evaluation and Safety Screen, dated 5/1/25, indicated he/she was a current smoker, had not smoked in two months, did not have smoking material in their room or on their person, and did not wish to smoke. All questions related to safety and smoking observations were left unanswered. Review of the Smoking Policy and Procedure, signed by Resident #80 on 5/1/25, indicated but was not limited to:-Residents must purchase their own cigarettes, etc. Residents will not be permitted to purchase cigarettes for other residents, nor will they be permitted to give any of their own cigarettes to other residents. -All residents who smoke will be assessed on admission, quarterly, and with change of status to determine equipment needs. Review of the Resident #80's Physician's Orders indicated but was not limited to:-Nicotine Transdermal Patch 21 milligrams/24 hours, apply one patch transdermal one time a day for smoking cessation and remove per schedule. (5/2/25) Review of Resident #80's nursing notes indicated but was not limited to:-7/25/25 Nicotine Patch discontinue due to Resident smoking During an interview on 7/30/25 at 8:13 A.M., SA #2 said if there is a new resident out in the smoking area, he would ask them their name and would check to see if they are on the smoking list. He said he (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, record review and interview, the facility failed to ensure two Residents (#104 and #43) were free from significant medication errors when they were not administered the medication as prescribed, placing him/her at risk for adverse reactions. Specifically, the facility failed:1. For Resident #104, to administer Amlodipine Besylate Tablet 10 milligrams (mg) (for blood pressure) per physician's order; and2. For Resident #43, to administer Eliquis 5mg (blood thinner). Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice dated as revised April 11, 2018, indicated but was not limited to the following:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers. 1. Resident #104 was admitted to the facility in October 2021 with diagnoses which included hypertension (high blood pressure) and heart disease. On 7/24/25 at 9:20 A.M., the surveyor observed Nurse #8 administer medications to Resident #104 as follows: -Nurse #8 poured the following medications into the medication cup for Resident #104: Omeprazole 20 mg, Plavix 75mg, Enteric Coated (EC) Aspirin 81mg, and Clonazepam 0.5mg.-Nurse #8 signed the medications off as administered on the electronic medication administration record (eMAR).-Nurse #8 scrolled through the eMAR and signed off an order for Amlodipine Besylate 10mg prior to locking the computer screen. (This medication was not poured)-The medications she poured were administered. Review of the Physician's Orders indicated but were not limited to the following:-Amlodipine Besylate Tablet 10mg by mouth one time a day for hypertension. During an interview on 7/24/25 at 1:28 P.M., Nurse #8 said she did not realize she did not administer the Amlodipine, which was to treat high blood pressure. 2. Resident #43 was admitted to the facility in June 2023 with diagnoses which included Atrial Fibrillation (irregular heart rate) and cerebral infarct (stroke). On 7/24/25 at 9:30 A.M., the surveyor observed Nurse #8 administer medications to Resident #43 as follows: -Nurse #8 poured the following medications into the medication cup for Resident #43: Acetaminophen 1000mg, Aspirin 81mg, Colace 100mg, Baclofen 5mg, Benzotropine Mesylate 0.5mg, Depakote Solution 500mg, Toprol XL 25mg, Lexapro 20mg, Protonix, Risperidone 1mg, Lidoderm Patch, Salonpas Patch, and Iron 325mg.-Eliquis 5mg was not poured and marked not available with a note indicating the medication was on order.-The poured medications were administered to Resident #43, he/she refused the Salonpas Patch. Review of the physician and nursing progress notes failed to indicate the provider was notified the Eliquis was not available and was not administered. During an interview on 7/24/25 at 1:28 P.M., Nurse #8 said if a medication is not available they should call the pharmacy to check on the delivery and then call the provider to get an order to hold it, to give it later, or obtain an order for something else. She said she did not call the provider that morning about the Eliquis, she just wrote a note and then called the pharmacy to see when it will be delivered. During an interview on 7/24/25 at 5:00 P.M., the Director of Nurses said if a significant medication is not available the nurse should call the provider and get an order to hold it, give it later, or for something else, whatever the provider tells them to do should be written in a physician's order. They should call the pharmacy to re-order the medication and check the emergency kit to see if we have the medication. A progress note should also be written. Additionally, she said all medications should be administered per physician orders and double checked when signing off the eMAR.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure the nurse responsible for liquid controlled substance medications stored in the refrigerator were only accessible to that nurse in two of two medication rooms reviewed. Findings include: Review of the facility's policy titled Medication Storage Room/Medication Cart Policy, dated February 2018, indicated but was not limited to the following:-Medications are stored primarily in a locked mobile cart which is accessible only to licensed personnel.-Drugs requiring refrigeration are stored separately in a refrigerator that is used exclusively for medications and medication adjuncts. Review of the facility's policy titled Narcotics (Massachusetts and Rhode Island), dated [DATE], indicated but was not limited to the following:-Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling and record keeping in the facility.-Person responsible for removing medication from count should sign the index. On [DATE], the surveyor observed the medication storage rooms as follows:-At 12:50 P.M., Borderland Unit, with Nurse #5, the surveyor asked who had the keys to the narcotic storage box in the fridge. Nurse #5 said both medication nurses have a key to the box.-At 2:00 P.M., [NAME] Unit, with Nurse #7, the surveyor asked who had the keys to the narcotic storage box in the fridge. Nurse #7 said both medication nurses have a key to the box. During an interview on [DATE] at 12:50 P.M., Nurse #5 said both medication nurses had a key to the lock box. She said she was unsure why and said the Ativan in the box is logged into her narcotic book, so she is responsible for it. During an interview on [DATE] at 1:22 P.M., Nurse #11 said she too had a key to the lock box on the Borderland Unit. She opened the box to show the surveyor. Additionally, she said the Ativan belongs to a resident on the other side and is logged into the other book. The liquid Ativan for Resident #116 was actively in use. During an interview on [DATE] at 2:00 P.M., Nurse #7 said they both have a key to the box, although she was unsure why, because the liquid Ativan in the box was for the other nurse's residents. Nurse #7 opened the box showing the surveyor she could access the medications. She then locked the drawer again. She said the two bottles of Ativan in the box were not hers and were logged into the other medication nurse's narcotic book. -The liquid Ativan for Resident #76 had been discontinued and not used since [DATE].-The liquid Ativan for Resident #164 had been discontinued, he/she had expired [DATE]. During an interview on [DATE] at 5:00 P.M., the Director of Nurses said the only nurse who should have access to the box is the one responsible for counting the medication. She said the other nurse should not be able to access the medications. During an interview on [DATE] at 1:25 P.M., Nurse #1 and Nurse #9 said they always both have had a key to the same box, but only the person whose book the medication is logged into should have had access to the medications.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to follow prescribed diets and follow therapeutic menus to ensure the residents' daily nutritional and special dietary needs were met as prescribed by the physician. Specifically, the facility failed to:1. Follow prescribed menus for the correct percentage of milk; and2. Failed to prepare the correct therapeutic substitutions for three of three meals observed. Findings include:Review of the facility's policy titled Food and Dining Service, dated 4/2015, indicated but was not limited to the following:-The objective of food service is to supply to residents/patient a diet comparable with his needs.-The responsibility of determining the resident/patients' dietary needs are the physician, the nurse in charge, and the dietician. The type of diet is prescribed by the physician.Therapeutic diets:-Prepared and served as prescribed by attending physician.-Planned by a qualified registered dietician.-Necessary substitutions are made by the dietician and/or the Food Service Manager.-Substitutions are documented on appropriate form and kept on file in the dining service department. 1. Review of 152 lunch tickets for 1/29/25 which were provided to the surveyor by [NAME] # 2 indicated the following:Whole milk- 391% milk - 12% milk -5Milk (No indication of the percent fat)- 54 During an observation with interview on 1/29/25 at 11:45 A.M., the surveyor observed tray distribution on the 100 Unit and all trays being served with milk were given blue 1% cartons on the tray from the cooler on top of the meal truck. The surveyor observed the cooler and there was only 1% in the cooler. Multiple staff members serving lunch on the 100 unit said all the residents that get milk receive a blue carton out of the cooler.On 1/29/25 the surveyor observed multiple lunch trays and unit kitchenettes and made the following observations:-Unit 100: Six trays observed in which the diet slips indicated whole milk, and the resident received a carton of 1% milk. The cooler on top of the meal truck contained only blue 1% cartons of milk. The unit kitchenette had ten cartons of 1% milk and a half gallon of 1% milk. No whole milk was observed.-Unit 300: Three trays observed in which the diet slips indicated whole milk, and the resident received a carton of 1% milk. The cooler on top of the meal truck contained only blue 1% cartons of milk. The unit kitchenette had one half gallon of whole milk located in rear of the refrigerator. There were no cartons of any kind of milk.-Unit 200: Six trays observed in which the diet slips indicated whole milk, and the resident received a carton of 1% milk. The cooler on top of the meal truck contained only blue 1% cartons of milk. The kitchenette had five cartons of 1% milk. No whole milk was observed.On 1/29/25 at 1:05 P.M., the surveyor observed the main kitchen's milk supply and made the following observations:-Three crates of blue 1% cartons of milk-Two crates of with nine half gallon whole milk-No 2% milkDuring an interview on 7/30/2025 at 9:15 A.M., the Food Service Manager (FSM) said every truck goes up with a cooler of blue 1% cartons milk and there should be half gallons of whole milk in the cooler. She said if there are no half gallons of whole milk in cooler, the nurses on the floor should get whole milk from the refrigerator and pour glasses of whole milk on the floor. She said she is not aware of what the nurses are doing on the floors.During an interview on 7/30/2025 at 5:04 P.M., the Corporate Dietitian said she was not aware the nursing staff was serving only 1% milk to all the residents, she said if the dietary diet indicates whole milk, the resident should be receiving whole milk. 2A. Review of 152 lunch tickets for 1/29/25 which were provided to the surveyor by [NAME] # 2 indicated the following:37 mechanical soft diets18 pureed diets Therapeutic diets:Low sodium-1Vegan- 2Vegetarian -1Renal-2 A. On 7/29/25 at 11:15 A.M., the surveyor entered the kitchen to observe lunch service and made the following observations of the tray line:-One pan of peas-One pan of Swedish meatballs-One pan of gravy-Cook was serving ground meatballs with tongs, delivering varying amounts of the ground Swedish meatballs to resident plates.-Regular diets were served spaghetti, instead of the planned noodles.-Peas were served with 4 oz ladle, filled with different amounts throughout the meal service.-High protein diets, [NAME] #1 was serving three Swedish meatballs, until he was corrected by [NAME] #2 to serve five Swedish meatballs.-Large portion diets, (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] #1 was serving three meatballs, until corrected by [NAME] #2-Large protein, he said he doubles the protein and would give five meatballs, instead of the standard three meatballs Review of the therapeutic menus indicated the following substitutions were to be made:Mechanical soft diet:3 oz. of ground Swedish meatballs (FSM confirmed should have been four, not three)Peas: canned (instead of the frozen served) Vegetarian:Swedish meatballs: vegetarian Swedish meatballs (Instead of regular meatballs) Vegan:No therapeutic diet available Low sodium:Low salt gravy (Only one pan of gravy) During an interview on 7/31/25 at 1:01 P.M., the Regional Dietitian and the Food Service Manager (FSM) reviewed the gravy packet used for 1/29/25 lunch meal and said it is not low sodium gravy, it is a lower salt gravy. The Regional Dietitian said they should be using low salt gravy. B. On 7/30/2025 at 8:00 A.M, the surveyor observed breakfast tray line and made the following observations:-Bacon was not served, instead sausage substituted.-Puree meal was eggs and toast with cinnamon. Not the prescribed puree meal of cinnamon French toast and bacon.-Resident #1 with puree diet meal ticket indicated he/she did not like eggs, [NAME] #1 served double portion pureed toast with cinnamon. During an interview on 7/30/25 at 8:10 A.M., [NAME] #1 said there was no bacon, so he substituted for sausage. [NAME] #1 said he did not puree French toast; he pureed toast and added some cinnamon. During an interview on 7/30/2025 at 9:15A.M., the Food Service Manager (FSM) said the cooks should be following the therapeutic menus and have the food available on the tray line, bacon should have been served for breakfast today, and yesterday noodles should have been served not the spaghetti. She said Resident #1 should not have been served double pureed toast with cinnamon, he/she should have been served pureed French toast. The surveyor viewed the food storage with the FSM and there were bags of noodles available, and in the refrigerator there were two boxes of bacon. FSM said the serving size for Swedish meatballs should have been four meatballs, not three.During an interview on 7/30/2025 at 5:00 P.M., [NAME] #1 and [NAME] #2 both said they were not aware of therapeutic menus and did not know where to find them. [NAME] #1 and [NAME] #2 said they follow the regular menu posted on the bulletin board, and they don't record any substitutions they make to the menu. [NAME] #2 said if a resident is CCHO diet they would just cut the dessert in half or substitute it for a sugar free alternative. [NAME] #1 said he was not aware of any renal diet restrictions. Both Cooks said they make substitutions as they go.Interview on 7/30/2025 at 5:04 P.M., the Corporate Dietitian said the cooks should be aware of the therapeutics diets and following them. She said if there is food that is not available, or they can't find the food item, they should be communicating with the FSM. C. On 7/31/2025 at 12:30 P.M., the surveyor observed lunch tray line and made the following observations:-Only one vegetable option available-mixed vegetables, which included corn. Mechanical soft diet indicates no corn. -There was no Shepard's pie made with cream of corn for mechanical soft diets.-There were no vegetarian or vegan meals prepared.-There was no ground beef prepared for dysphagia diets.-Multiple mechanical soft diets plated with mixed vegetables containing corn, plated and loaded on the truck until the issue with the corn was recognized. -Cook #2 in middle of tray service pulling trays and cooking ground beef for dysphagia diets, heating up canned green beans for mechanical soft diets, making a single serving of macaroni and cheese for a vegan diet meal ticket, and dietary staff adding hummus to prepared salad for vegan meal ticket.-Resident #140's meal tray and diet ticket which indicated low sodium diet. The lunch tray had mashed potatoes with gravy bowl in the middle and turkey covered in gravy. The therapeutic substitution was low salt gravy. -Resident with vegan meal ticket was served macaroni and cheese and yogurt. During an interview on 7/31/2025 at 12:45 P.M., Corporate Dietitian and FSM said the foods for the therapeutic substitutions were not made ahead of time. Corporate Dietitian said they realized mechanical soft diets could not eat the mixed vegetables with corn, so they substituted with canned green beans. FSM said the meal ticket for vegan meal was served macaroni and cheese because they believe he/she is not vegan but a vegetarian. Corporate Dietitian said the therapeutic substitutions should have been prepared ahead of meal service.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interview, observation, and record review, the facility failed to have available a vegan menu which was prepared in advance and followed to meet the needs of one Resident (#59), out of a total sample of 39 residents. Findings include: Review of the facility's policy titled Food and Dining Service, dated 4/2015, indicated but was not limited to the following: -The objective of food service is to supply the residents/patients a diet comparable with their needs. -The responsibility of determining the resident/patients' dietary needs is that of the physician, the nurse in charge, and the dietician. The type of diet is prescribed by the physician. Therapeutic diets: -Prepared and served as prescribed by attending physician. -Planned by a qualified registered dietician. -Necessary substitutions are made by the dietician and/or the Food Service Manager. -Substitutions are documented on appropriate form and kept on file in the dining service department. Review of the Food Committee Meeting Minutes, dated 6/27/25, indicated but was not limited to the following comments from a resident on a vegan diet: -My food is overcooked and there is little variety. I would like to see whole potatoes versus processed, lentils, cabbage, and hummus with salads. -Resident also requests to see the packaging of his/her vegan meat substitutes to make sure it is acceptable. -Resident states he/she gets too much rice and hash browns. -Resident complains regularly of receiving non-vegan items on tray. Review of Resident #59's Nutrition Evaluation, dated 5/2/25, indicated the diet to be consistent carbohydrate diet (CCHO), no added salt (NAS), and Vegan. Resident #59 follows a vegan diet, and no meat and dairy products. History of not trusting food to be vegan. Did not want to discuss diet with this writer. Can be combative with staff, throws tray if he/she does not get the right food. Review of Resident #59's Physician's Orders indicated a prescribed diet of CCHO, NAS, regular consistency texture, thin liquids consistency, for diabetes and hypertension, and VEGAN. Initiated 11/12/24. Review of the facility's therapeutic menus indicated there was a preplanned therapeutic menu for a vegetarian diet, but no preplanned therapeutic menu for a vegan diet. During an interview on 7/30/25 at 5:00 P.M., [NAME] #1 and [NAME] #2 both said they were not aware of therapeutic menus and did not know where to find them. On 7/31/25 at 12:15 P.M., the surveyor observed during lunch tray service [NAME] #2 instruct a Dietary Aide to make a salad and add hummus. The Dietary Aide was observed unwrapping a pre-made salad and adding an unmeasured scoop of hummus to the salad. The salad was then placed on Resident #59's tray, which had been pulled off the line waiting for the salad to be prepared. During an interview on 7/31/25 at 12:25 P.M., [NAME] #3 who was plating the lunch trays could not tell the surveyor the difference between a vegan and a vegetarian therapeutic diet. During an interview with the Regional Dietitian present on 7/31/25 at 12:41 P.M., Resident #59 said he/she is sick of getting salads and hummus for lunch. Resident #59 took the cover off the lunch meal and said, I am not eating this. Resident #59 said he/she doesn't always trust what the kitchen sends up as vegan and would like to see the packages. Resident #59 said he/she has never eaten meat, and he/she knows if it's meat or not. Resident #59 continued with frustration and said, The other day they were served three hash browns for breakfast which was not healthy. Resident #59 said they try to serve him/her mashed potatoes all the time, but he/she knows they are made with milk. He/she said they served him/her sweet potatoes, carrots and leftover onion and peppers, which he/she said, doesn't even go together, and there is no protein. During an interview on 7/31/25 at 4:34 P.M., the Regional Dietitian said there is no policy for therapeutic diets, the cooks just follow the menu as written. She said she will have to look at the therapeutic menus to ensure a vegan diet is included.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and test tray results, the facility failed to provide food to residents that was palatable and served with an appetizing presentation for one of two test trays. Findings include: On 7/29/25 at 11:44 A.M., the surveyor requested a test tray. The test tray arrived on the [NAME] Unit at 11:45 A.M. At 12:12 P.M. the surveyor conducted the test tray with Rehab Staff #3 with the following results: -Visual presentation was poor. There were three dry meatballs on top of a bed spaghetti with thin liquid brown gravy on the bottom of the plate. The peas were two different colors, and the pale peas looked dried out. -Swedish meatballs were 131.5 degrees Fahrenheit (F), the meatball taste was adequate, but they were dry and missing the gravy. -Spaghetti was 188.4 F, the flavor was bland with no gravy sticking to the spaghetti and half the spaghetti was dry with no gravy. -Gravy was a very thin liquid that collected on the bottom of the plate, flavor was very mild and there was not enough gravy to coat the meatballs and spaghetti. -Peas were 131.9 F, the peas were two different colors with different textures. -Coffee was 155.5 F and palatable. -Dessert cake with whipped cream was at room temperature and was palatable. During interviews on 7/29/25, after the completion of the test tray, residents made the following comments: -Resident #160 said he/she could not even taste the gravy, the meatballs were okay, and he/she didn't like the peas. -Resident #152 was on a mechanical soft diet, and the hamburger helper was watery. -Resident #26 said the gravy was watery. -Resident #30 was on mechanical soft diet and said there was very little gravy. -Resident #41 said there was no gravy. The results of the test tray validated the residents' complaints of unpalatable and unappetizing food.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observations, interviews, and record review, the facility failed to provide adaptive equipment for two Residents (#80 and #109), out of a total sample of 39 residents. Specifically, the facility failed:1. For Resident #80, to provide hollow-handled silverware (adaptive eating utensils) during meals; and2. For Resident #109, to provide a rocker knife (adaptive knife cuts food with a rocking motion) during meals. Findings include:1. Resident #80 was admitted to the facility in May 2025 with diagnoses including cerebral infarction (stroke) and neuropathy.Review of the Minimum Data Set (MDS) assessment, dated 5/8/25, indicated Resident #80 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15.During an interview on 7/24/25 at 12:41 P.M., the surveyor observed Resident #80 eating lunch and continuously repositioning their spoon. Resident #80 said he/she had a hard time holding his/her spoon because they had not received their hollow-handled spoon. Resident #80 said it was uncomfortable for him/her to hold regular silverware because of their neuropathy.Review of Resident #80's meal ticket indicated Adaptive Equipment: Hollow-Handled Utensils.Review of the Occupational Therapy Notes, dated 7/8/25, indicated but was not limited to:-Resident trialed built-up utensils on this date. Patient completed self-feeding assessment seated at edge of bed. Patient reports increased ease with use of built-up utensils. Patient has chronic hand pain due to neuropathy. Notified the kitchen regarding built-up utensils.On 7/25/25 at 8:35 A.M., the surveyor observed Resident #80 in bed eating his/her breakfast cereal with a non-hollow-handled spoon. Resident #80 had a hollow-handled knife and fork on their tray.On 7/28/25 at 8:41 A.M., the surveyor observed Resident #80 in his/her wheelchair eating breakfast. Resident #80 was observed holding a non-hollow-handled fork eating fruit. Resident #80 had a non-hollow-handled knife and a spoon on his/her tray. Review of Resident #80's meal ticket indicated Adaptive Equipment: Hollow-Handled Utensils.During an interview on 7/30/25 at 8:19 A.M., Certified Nursing Assistant (CNA) #1 said when the meal trucks would come from the kitchen, the nurse would check the tray for accuracy of meal, allergies, and to ensure the resident would have proper silverware. CNA #1 reviewed Resident #80's tray and said Resident #80 did not have a hollow-handled spoon on their tray but should have one to help them with eating. Review of Resident #80's meal ticket indicated Adaptive Equipment: Hollow-Handled Utensils.During an interview on 7/30/25 at 8:23 A.M., Unit Manager (UM) #1 said when the meal trays arrived from the kitchen the nurse would review every tray to ensure the resident received the correct diet and appropriate utensils. UM #1 said Resident #80 had a hollow handled knife and fork on his/her tray but had not received a hollow handled spoon.During an interview on 7/30/25 at 8:39 A.M., the Occupational Therapist said Resident #80 was working with Occupational Therapy (OT) to improve his/her functional ability prior to going home. The Occupational Therapist said Resident #80 had trialed the hollow handled utensils with OT related to their diagnosis of neuropathy. The Occupational Therapist said once the trial of the hollow handled utensils was completed then the Occupational Therapist would notify dietary department that the resident required hollow handled utensils, and dietary would add it to their meal ticket and the nurse would check the meal ticket was accurate when it would be delivered from the kitchen.2. Resident #109 was admitted to the facility in November 2017 with diagnoses including dementia.Review of the MDS assessment, dated 7/11/25, indicated Resident #109 had a moderate cognitive deficit as evidenced by a BIMS score of 8 out of 15.Review of Resident #109's current Physician's Orders indicated but was not limited to:-May have rocker knife with meals, 4/21/2022 -No Added Salt diet, Regular Consistency texture, Thin (Regular) Liquids consistency No Fish, Rocker knife with meals, 12/4/2023Review of Resident #109's Registered Dietitian's Nutrition Assessment, dated 4/10/25, indicated but was not limited to:-Adaptive EquipmentReview of Resident #109's history of weight loss, last revised 7/21/25, indicated but was not limited to:-Rocker knife with meals, initiated 4/21/22During an interview on 7/28/25 at 1:04 P.M., the surveyor observed (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #109 seated in his/her wheelchair in their room eating lunch. Resident #109 said the nurse had to cut his/her chicken because he/she was unable to cut the chicken without their rocker knife. Review of Resident #109's meal ticket indicated Adaptive Equipment: Rocker knife. Resident #109's meal tray did not have a rocker knife on it. During an interview on 7/29/25 at 9:19 A.M., the surveyor observed Resident #109 cutting his/her pancakes with a regular handled knife. Resident #109 said it was hard to cut the pancakes without the rocker knife. Review of Resident #109's meal ticket indicated Adaptive Equipment: Rocker knife. Resident #109's meal tray did not have a rocker knife on it. During an interview on 7/29/25 at 9:25 A.M., Nurse #3 and CNA #7 reviewed Resident #109's breakfast tray. CNA #7 said the kitchen would usually send adaptive equipment and Resident #109 usually had a rocker knife on his/her tray. Nurse #3 said Resident #109 did not have a rocker knife on his/her tray but should have. During an interview on 7/31/25 at 11:13 A.M., the Corporate Dietitian said there were adaptive utensils in the kitchen. She said the residents' meal ticket would indicate the type of adaptive equipment needed and the staff member assembling the tray would place it on the tray. She said she does not know why the adaptive equipment was not placed on Resident #80's and Resident #109's trays by the dietary staff but they should have been. During an interview on 7/31/25 at 12:52 P.M., the Director of Nursing said adaptive equipment should be on each resident's tray as indicated on their meal ticket.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to maintain an infection prevention and control program which included a complete and accurate system of surveillance to identify any trends or potential infections. Findings include: Review of the facility's policy titled Infection Prevention Program, last reviewed January 2025, indicated but was not limited to: -This facility follows the professional standards set forth as recommended by the Centers for Disease Control and Prevention (CDC)/Occupational Safety and Health Administration (OSHA). Policies and procedures of the facility are developed and based on current CDC/OSHA recommendations. -This facility has developed and maintains an Infection Prevention Program that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of infection. The goal of the Infection Prevention Program is to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. -The facility has a system in place for the prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff, and visitors. -Elements of the Infection Prevention program include but are not limited to monitoring and documenting infections, tracking, analyzing outbreaks of infections, managing resident health initiatives, and provision of early, uniform identification and reporting of infections. -Perform surveillance and investigation of infections to prevent, to the extent possible, the onset and spread of infection. -Promote antibiotic stewardship and ensure residents receive the right antibiotic at the right dose, at the right time and for the right duration. -Analyze trends and clusters of infection and any increase in the rate of infection or resistant organisms, in a timely manner. -Maintain the monthly infection reports by unit to record each resident infection. -Monitor community associated infections in residents admitted to the facility and attempt to obtain results and diagnosis of infection when residents are transferred back from an acute care hospital. Review of the facility's policy titled General Infection Control Nursing Policies, last reviewed January 2025, indicated but was not limited to: -Infection surveillance will be targeted toward high risk of infection for the population served. -Healthcare Associated Infections (HAIs) will be defined as any infection that is not present or incubating at the time of admission and presents with clinical signs of infection 72 hours after (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission. -Community-Associated Infections (CAIs) will be defined as any infection present or incubating at the time of admission. Any infection that is present within 72 hours of admission will be considered a community associated infection. -Surveillance. Material for infections and long-term care will be utilized for recording infections and determining infection rates. Review of the facility's policy titled Surveillance for Healthcare-Associated Infections (HAIs), last reviewed January 2025, indicated but was not limited to: -Surveillance is defined as the ongoing systematic collection analysis, interpretation, and dissemination of data. -The facility will closely monitor all residents who exhibit signs/symptoms of infection. The nurse or nursing assistant will notify the Infection Preventionist of suspected infections, who will record the information on the infection control log. -The Infection Preventionist or designee will monitor the residents with infections and/or potential infections by completing the "Monthly Infection Report by Unit." -The Infection Preventionist will review the infection report monthly for trends and new bacteria in the facility. Review of the Infection Surveillance Logs for April 2025, May 2025, and June 2025 indicated residents symptomatic of an illness who were not treated with an antibiotic were not recorded/documented on the surveillance sheets. Review of the April 2025 Infection Surveillance Logs failed to indicate: -5 of 5 residents with urinary tract infections failed to include culture results identifying the organism/bacteria, one of which was positive for extended-spectrum beta-lactamase producing bacteria (ESBL- bacteria that produce enzymes that break down certain antibiotics, making them ineffective). -Resident #151 was admitted to the facility in May 2025 with diagnoses including Methicillin Resistant Staphylococcus Aureus Infection (MRSA, a type of staphylococcus infection that is resistant to many common antibiotics), was placed on contact precautions, and was treated with Mupirocin External Ointment (topical antibiotic that is used to treat bacterial skin infections). -Resident #55 was readmitted to the facility in May 2018 with diagnoses including shingles (contagious viral infection that causes a painful rash), was placed on contact precautions, and was treated with Acyclovir (antiviral medication primarily used to treat infections caused by herpes simplex virus). Review of the May 2025 Infection Surveillance Logs failed to indicate: -Resident #151 was on contact precautions and being treated for MRSA, for which he/she tested (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	positive; -Resident #55 was on contact precautions and being treated for shingles; and -5 of 5 residents with urinary tract infections failed to include culture results identifying the organism/bacteria. Resident #87 was readmitted to the facility in June 2025 with diagnoses including Influenza A, was placed on droplet precautions, and was being treated with Oseltamivir (antiviral medication). Resident #151 was having loose stools and was tested for Clostridioides difficile (a bacterium that can cause severe diarrhea and colitis [inflammation of the colon]). Further review of the June 2025 Infection Surveillance Logs failed to indicate: -Resident #87 was on droplet precautions (implemented to prevent the spread of infections that are transmitted through respiratory droplets) and being treated for Influenza A, for which he/she tested positive; and -Resident #151 was having loose stool. During an interview on 7/29/25 at 2:20 P.M., the Infection Preventionist (IP) said he had just started at the facility and was unable to find any Infection Surveillance Logs other than what was given to the survey team on 7/23/25. The IP said Residents #151, #87, and #55 should all have been on the Infection Surveillance Logs and culture results for any culture tests should be listed on the Surveillance Logs to quantify bacteria and spread of infection. During an interview on 7/29/25 at 2:52 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) reviewed the April, May, and June 2025 line listings. The ADON said he was responsible for completing Infection Surveillance Logs and did not fill in the cultured test results obtained in the facility or in the hospital. The DON said the facility did not have an accurate surveillance process.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program. Findings include: Review of the facility's policy titled Infection Control Prevention Program - Antibiotic Stewardship, last reviewed January 2025, indicated but was not limited to the following:- It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's infection prevention and control program. The goal of this program is to reduce inappropriate antimicrobial use, improve patient care outcomes and reduce possible consequences of antimicrobial use.- The facility uses the Updated McGeer criteria to define infections.- When symptoms of an infection are identified, the following measures will be implemented: -Nursing staff shall notify MD (physician)/APRN (nurse practitioner) and responsible party; -Symptoms will be reviewed with the MD/APRN and further testing will be obtained per MD/APRN order; test results will be reviewed with the MD/APRN when available; -All orders will include dose, duration, and indication of antibiotic; -The duration of the ABT (antibiotic) therapy will be defined and/or regularly reviewed by the prescriber; and -Antibiotics will be reassessed 48-72 hours after initiation to ensure the antibiotic is still indicated or adjustments should be made. Review of the facility's policy titled Surveillance for Healthcare-Associated Infections (HAIs), last reviewed January 2025, indicated but was not limited to:- This facility will closely monitor all residents who exhibit signs/symptoms of infection.- The nurse or nursing assistant will notify the IP of suspected infections, who will record the information of the Infection Control Log.- Document in the narrative nurses notes every shift of presence or absence of symptoms. Review of the revised 2024 McGeer criteria indicated but was not limited to the following: Syndrome: Urinary Tract Infection (UTI) without indwelling catheter Criteria: Must fulfill both 1 and 21. At least one of the following signs or symptoms: Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate Fever or leukocytosis, and >1 of the following:- Acute costovertebral angle pain or tenderness- Suprapubic pain- Gross hematuria- New or marked increase in incontinence- New or marked increase in urgency- New or marked increase in frequency If no fever or leukocytosis, then >= 2 of the following:- Suprapubic pain- Gross hematuria- New or marked increase in incontinence- New or marked increase in urgency- New or marked increase in frequency 2. At least one of the following microbiologic criteria- 50,000 cfu/ml of no more than 2 species of organisms in a voided urine sample- 20,000 cfu/ml of any organism(s) in a specimen collected by an in-and-out catheter Review of the facility's April 2025, May 2025, and June 2025 antibiotic surveillance tracking forms indicated but was not limited to: April 2025:- Resident #128, Category: UTI; Date of onset: 4/17/25; Symptoms: FO (foul odor); Final Status: CAI; Counted: No The April antibiotic surveillance tracking form did not have enough symptoms documented to indicate a McGeer infection for UTI had been met in accordance with the facility's pre-defined criteria, however an antibiotic was prescribed for 10 days. Review of Resident #128's medical record indicated:- Collect urine for urine analysis (UA) and culture and sensitivity (C+S), 4/13/25 Further review of Resident #128's medical record failed to indicate:- nursing progress note of why a urine was obtained on 4/13/25;- nursing progress notes of why an antibiotic was initiated on 4/17/25; and- a clinical rationale by the prescribing physician for the initiation of an antibiotic even though the symptoms did not meet pre-defined criteria. During an interview on 7/29/25 at 2:20 P.M., the Infection Preventionist (IP) said as part of the antibiotic stewardship program the nurses needed to write a progress note which included but was not limited to signs and symptoms of why a urine culture was obtain or signs of infection. He said the Physician or Nurse Practitioner needed to write a note addressing the antibiotic and why it was initiated, and then 48-72 hours after initiation of the antibiotic it needed to be reassessed to ensure it was effective and was still indicated or if adjustments needed to be made. During an interview on 7/31/25 at 2:32 P.M., the Director of Nursing said it was her expectation for the nurses, Physicians, and Nurse Practitioners to follow Antibiotic Stewardship.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pneumococcal immunizations for three eligible Residents (#4, #9, and #109), out of a total sample of five residents. Findings include: Review of the facility's policy titled Procedures for Pneumococcal Vaccination, last revised December 2024, indicated but was not limited to: Each resident or their responsible party will be asked on admission if they have previously had any pneumococcal vaccinations and their age at the time of vaccination. The records that accompany the residents also will be used to determine immunization status.- The pneumococcal conjugate vaccine will be offered to all eligible residents, and the risks and benefits will be provided to the resident or resident's legal representative prior to administration of the vaccine. The resident or resident's legal representative has the right to refuse the vaccine.- Adults aged 50 years or older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive a pneumococcal conjugate vaccine (either PCV15, PCV20, or PCV21). If PCV15 is administered, this should be followed by a dose of PPSV23 in a year or more.- Adults aged 19-49 with certain underlying medical conditions or other risk factors who have not previously received pneumococcal conjugate vaccine or whose previous vaccination status is unknown should receive 1 dose of PCV (either PCV15, PCV20, or PCV21). When PCV15 is used, it should be followed by a dose of PPSV23 in a year or more. Review of the Centers for Disease Control and Prevention (CDC) guidance titled Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025, indicated but was not limited to the following: Pneumococcal Vaccination Age 50 years or older who have: Previously received both PCV13 and PPSV23, but no PPSV23 was received at age [AGE] years or older: 1 dose of PCV20 or 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine dose. a. Resident #4 was admitted to the facility in August 2021 and is currently [AGE] years old. Review of the immunization history for Resident #4 indicated but was not limited to: PPV23 pneumococcal vaccination, administered 11/25/19 Review of Resident #14's Resident Pneumonia Vaccine Education Documentation Form, signed 9/17/202 (missing the last number), indicated but was not limited to: The pneumococcal vaccine will be offered to all eligible residents and the risks and benefits will be provided to the resident or the resident's legal representative prior to administration of the type of vaccine.- There are 2 pneumonia vaccines recommended for persons over 65. These vaccines should be given one year apart.- The Resident had the PPSV23 in the past (Month/Year): Left Blank During an interview on 7/30/25 at 11:45 A.M., the Infection Preventionist said Resident #4 was not up to date with their pneumococcal vaccine and was overdue for the PCV20 pneumococcal vaccine and should have received it. b. Resident #9 was admitted to the facility in June 2023 and is currently [AGE] years old. Review of the immunization history for Resident #9 indicated but was not limited to: PPV23 pneumococcal vaccination, administered 2/15/22. During an interview on 7/30/25 at 11:45 A.M., the Infection Preventionist said Resident #9 was not up to date with their pneumococcal vaccine and was overdue for the PCV20 pneumococcal vaccine and should have received it. c. Resident #109 was admitted to the facility in November 2017 and is currently [AGE] years old. Review of the immunization history for Resident #109 indicated but was not limited to: PPV23 pneumococcal vaccination, administered 2/12/13-Prevna13 pneumococcal vaccination: not eligible Review of Resident #109's Resident Pneumonia Vaccine Education Documentation Form, signed 11/8/17, indicated but was not limited to: The pneumococcal vaccine will be offered to all eligible residents and the risks and benefits will be provided to the resident or the resident's legal representative prior to administration of the type of vaccine.- There are 2 pneumonia vaccines recommended for persons over 65. These vaccines should be given one year apart.- The Resident had the PCV13 in the past (Month/Year): Left Blank During an interview on 7/30/25 at 11:45 A.M., the Infection Preventionist said Resident #109 was not up to date with their pneumococcal vaccine and was overdue for the PCV20 pneumococcal vaccine and should have received it.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to provide education, assess for eligibility, offer and administer COVID-19 vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations for five Residents (#4, #9, #71, #87, and #109), out of a total sample of five residents reviewed for immunizations and for five employees, out of five employee records reviewed. Findings include: 1. Review of the facility's policy titled Vaccine, last revised December 2024, indicated but was not limited to: -It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 by offering our residents immunization to COVID-19. -It is the policy of this facility, in collaboration with the medical director, to have an immunization program against COVID-19 disease in accordance with national standards of practice. -COVID-19 vaccines will be offered as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the resident has already been immunized during this time period, or resident/responsible party refuses to receive the vaccine. Review of CDC guidance titled Stay Up to Date with COVID-19 Vaccines, revised 6/6/25, indicated but was not limited to the following: - CDC recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 years and older. This includes people who have received a COVID-19 vaccine, people who have had COVID-19, and people with long COVID. - Getting the 2024-2025 COVID-19 vaccine is especially important if you: -Never received a COVID-19 vaccine -Are ages 65 years and older -Are at high risk for severe COVID-19 -Are living in a long-term care facility -Want to lower your risk of getting Long COVIDa. Resident #87 was admitted to the facility in July 2020. Review of the electronic Immunization Record indicated he/she received the 2023-2024 COVID-19 vaccination. Further review of Resident #87's medical record failed to indicate the facility offered the current (2024-2025) COVID-19 vaccine to the Resident. b. Resident #4 was admitted to the facility in August 2021. Review of the electronic Immunization Record indicated he/she received the 2023-2024 COVID-19 vaccination. Further review of Resident #4's medical record failed to indicate the facility offered the current (2024-2025) COVID-19 vaccine to the Resident. c. Resident #9 was admitted to the facility in June 2023. Review of the electronic Immunization Record indicated he/she received the 2023-2024 COVID-19 vaccination. Further review of Resident #9's medical record failed to indicate the facility offered the current (2024-2025) COVID-19 vaccine to the Resident. d. Resident #71 was admitted to the facility in May 2021. Review of the electronic Immunization Record indicated he/she received the 2023-2024 COVID-19 vaccination. Further review of Resident #71's medical record failed to indicate the facility offered the current (2024-2025) COVID-19 vaccine to the Resident. e. Resident #109 was admitted to the facility in November 2017. Review of the electronic Immunization Record indicated he/she received the 2023-2024 COVID-19 vaccination. Further review of Resident #109's medical record failed to indicate the facility offered the current (2024-2025) COVID-19 vaccine to the Resident. During an interview on 7/29/25 at 2:52 P.M., the Assistant Director of Nursing (ADON) said the facility had not offered or provided education about the 2024-2025 COVID-19 vaccine to long term care residents that resided at the facility. During an interview on 7/29/25 at 2:52 P.M., the Director of Nursing (DON) said the COVID-19 vaccine should be offered on admission and yearly after that. 2. Review of the facility's policy titled COVID-19-Employee Vaccination Policy, last revised 3/2025, indicated but was not limited to: -The facility educates and offers all staff the COVID-19 vaccine. -Staff will be required to complete the employee Consent and Education form, indicating either consent or declination to the current COVID-19 2024-2025 vaccine. -The COVID-19 vaccines will be offered as per CDC and/or FDA guidelines unless the individual has already been fully immunized or such immunization is medically contraindicated, or the staff member declines based on a religious belief or other personal reasons. Review of the staff medical record for immunization information for Nurse #14, Nurse #3, (continued on next page)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Occupational Therapist #1, Certified Nursing Assistant (CNA) #15, and CNA #16 failed to indicate the facility assessed the staff's eligibility, offered them the COVID-19 vaccine, provided them with education, and had proof that the vaccination was offered and accepted or declined. During an interview on 7/24/25 at 1:25 P.M., the Director of Human Resources reviewed the five employee files and said she was unable to locate any documentation or proof that the five staff members had been provided education on the new 2024-2025 COVID vaccination or offered the vaccination. During an interview on 7/29/25 at 11:08 A.M., the DON said when a new employee was hired, they should have been educated on the COVID-19 vaccine and have proof of the education as well as whether the vaccine was offered and accepted or declined.		

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on record review and interview, the facility failed to ensure that signed written informed consent for the administration of psychotropic medications (drugs that affect mental processes used to treat a variety of mental health conditions) were obtained from the Health Care Proxy (HCP), which included providing the resident/resident representative with information related to the risks and benefits of the medications, prior to administering them for one Resident (#4), out of five sampled residents selected for unnecessary medication review. Findings include: Review of the facility's policy titled Psychotropic Medication-Informed Consent-Massachusetts Only, dated February 2016, indicated but was not limited to the following:-Prior to administering psychotropic medication, the facility shall obtain the informed written consent of the resident, the resident's HCP or the residents guardian. Informed written consent shall be obtained on a form approved by the Department of Public Health (DPH). The written consent form shall be kept in the resident's medical record. Resident #4 was admitted to the facility in March 2024 with diagnoses which include major depressive disorder, insomnia, psychotic disorder, and chronic pain syndrome. Review of the Minimum Data Set (MDS) Assessment, dated 5/28/25, indicated he/she scored 9 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment. Additionally, he/she had been administered antipsychotic, antidepressant, and anticonvulsant medications. Review of the medical record indicated he/she had a HCP on file. Additionally, the Physician had invoked the HCP on 3/7/24, indicating Resident #4 lacked the capacity to make, or to communicate, health care decisions. Review of the Physician's Orders indicated but were not limited to the following:-Gabapentin Oral Capsule (anticonvulsant, used to treat seizures, also used for chronic neuralgia pain and off-label for anxiety or other related disorders) 300 milligrams (mg) by mouth three times a day related to chronic pain syndrome. -Risperdal Oral Tablet (antipsychotic) give 0.25 mg by mouth in the morning for psychosis. -Sertraline HCL Tablet (antidepressant) give 150 mg by mouth one time a day for depression. -Trazodone HCL Tablet (antidepressant) 100 mg by mouth at bedtime related to major depressive disorder. Review of the Medication Administration Records (MAR) for March 2025 through July 2025 indicated he/she received the medications as ordered. Review of the Informed Consent for Psychotropic Administration Forms in the medical record indicated the following:-Medication: Gabapentin. Classification: Miscellaneous. Purpose: Mood Stabilizer. The box to consent for the administration was left blank. The box to refuse consent for the medication was left blank. The form was signed by Resident #4 and dated 3/5/25 (363 days after their HCP was invoked).-Medication: Risperdal. Classification: Antipsychotic. The box to consent for the administration was left blank. The box to refuse consent for the medication was left blank. The form was signed by Resident #4 and dated 3/5/25.-Medication: Sertraline. Classification: Antidepressant. The box to consent for the administration was left blank. The box to refuse consent for the medication was left blank. The form was signed by Resident #4 and dated 3/5/25.-Medication: Trazodone. Classification: Antidepressant. The box to consent for the administration was left blank. The box to refuse consent for the medication was left blank. The form was signed by Resident #4 and dated 3/5/25. Review of the Physician and Nursing progress notes failed to indicate informed consent had been obtained by the HCP. The facility failed to ensure the Informed Consent for Psychotropic Administration Forms were reviewed and signed by the invoked HCP. During an interview on 7/30/25 at 2:22 P.M., Nurse #5 said the consents should have been signed by Resident #4's HCP since it was activated. She said she was unsure why she had Resident #4 sign the consents in March 2025. During an interview on 7/31/25 at 10:45 A.M., the Director of Nurses (DON) said the consents should have been signed by the activated HCP and not Resident #4. During an interview on 7/31/25 at 11:09 A.M., the Assistant Director of Nurse (ADON) said the consent forms should have been signed by the HCP and not Resident #4.		

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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. Based on observation, interview, and record review, the facility failed to notify the Physician or the Nurse Practitioner (NP) of recommendations or changes in condition for two Residents (#80 and #109), out of a total sample of 39 residents. Specifically, the facility failed:1. For Resident #80, to notify the Physician/NP of a fall; and2. For Resident #109, to notify the Physician/NP of a significant weight loss. Findings include: Review of the facility's policy titled Condition: Significant Change, dated April 2015, indicated but was not limited to:-Professional staff will communicate with physician, resident/patient, and family regarding changes in condition to provide timely communication of resident/patient status change which is essential to quality care management. -The physician, resident/patient and/or responsible party will be notified by the nurse in the event of a change in condition.-The notification shall be documented in the clinical record. 1. Resident #80 was admitted to the facility in May 2025 with diagnoses including cerebral infarct (stroke) and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 5/8/25, indicated Resident #80 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. During an interview on 7/23/25 at 10:36 A.M., Resident #80 said he/she recently had a fall in the bathroom. Review of the Fall Incident Report, dated 7/9/25, indicated but was not limited to:-Agencies/People Notified: No Notifications Found. Further review of Resident #80's medical record failed to indicate the Physician/NP was notified of Resident #80's fall. During an interview on 7/30/25 at 8:23 A.M, Unit Manager #1 said the Physician or NP should be notified of a resident's fall. She said the notification must be documented on the Fall Incident Report and in a Nursing Note. Unit Manager #1 reviewed Resident #80's medical record, including the 7/9/25 Fall Incident Report, and said there was no documentation the Physician or NP were notified of Resident #80's fall. During an interview on 7/30/25 at 11:07 A.M., NP #1 said if a resident had a fall, the nurse would assess the resident and then call and notify either her or the Physician, and then she would write a note addressing the fall. She reviewed Resident #80's medical record and said she had not been notified of his/her fall but should have been. During an interview on 7/31/25 at 12:52 P.M., the Director of Nursing (DON) said her expectation was for the NP or Physician to be notified of all falls and for the notification to be documented in the resident's medical record and in the Fall Incident Report. 2. Review of facility's policy titled Weights, date August 2015, indicated but was not limited to:-If a significant weight loss/gain is identified (more than 5% in 30 days or over 10% in six months) the Interdisciplinary Team, Dietician, Physician, and Family are notified. Resident #109 was admitted to the facility in November 2017 with diagnoses including dementia and congestive heart failure. Review of the MDS assessment, dated 7/11/25, indicated Resident #109 had a moderate cognitive deficit as evidenced by a BIMS score of 8 out of 15. Review of Resident #109's Registered Dietitian's Nutrition Assessment, dated 4/10/25, indicated but was not limited to:-11% weight loss since January 2025. During an interview on 7/31/25 at 12:12 P.M., Nurse #11 said when a weight loss is identified for a resident the nurse would notify the Physician or NP and document it in a nursing note, then the NP would write a note addressing the weight loss. Nurse #11 reviewed Resident #109's medical record and said she did not see any documentation of the NP or Physician notification, but they should have been notified. During an interview on 7/31/25 at 2:24 P.M., NP #1 said when either her or the Physician were notified of a resident losing weight, they would address it in a note as well as any interventions put in place. NP #1 reviewed Resident #109's medical record and said she was not notified of Resident #109's 11% weight loss but should have been. During an interview on 7/31/25 at 12:52 P.M., the DON said her expectation was for the NP or Physician to be notified of a significant weight loss and for the notification to be documented in the resident's medical record.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, for five Residents (#9, #90, #109, #12, and #14), of 39 sampled residents, the facility failed to ensure care was provided to residents in accordance with professional standards of practice. Specifically, the facility failed: 1. For Resident #9, to follow the physician's order for air mattress settings; 2. For Resident #90, to administer Pyridoxine Hydrochloride (Vitamin B6) per physician's orders; 3. For Resident #109, to obtain his/her weight per physician's orders; 4. For Resident #12, to implement hand rolls per physician's orders; and 5. For Resident #14, to administer an inhaler per physician's orders. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Review of the facility's policy titled Support Surfaces, undated, indicated but was not limited to: -Support surfaces will be used for all residents in the facility. A support surface refers to a specialized device for pressure redistribution designed to manage pressure, shear, moisture, or friction forces on tissue. Examples are alternating and low air loss mattresses (specialty support surfaces). -A physician's order is required for the use of specialty support surfaces. The order shall include the type of mattress, the mode, and setting. -Specialty support surfaces will be checked each shift for proper functioning and/or inflation. 1. Resident #9 was admitted to the facility in June 2023 with diagnoses including pressure ulcer of the right lower back stage four (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) and left hip stage three pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue). Review of the Minimum Data Set (MDS) assessment, dated 4/25/25, indicated Resident #9 had moderate cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Further review of the MDS indicated Resident #9 had two pressure areas and utilized a pressure reducing device on his/her bed. Review of Resident #9's current Physician's Orders indicated but was not limited to: -Specialty air mattress. Check settings and function every shift set at standard for resident's weight (211.4 pounds). During an interview on 7/23/25 at 9:22 A.M., Resident #9 said he/she had an air mattress because of a pressure area on their back. Resident #9 said he/she was not aware of what the settings for the mattress should be. On the following dates and times, the surveyor observed Resident #9 lying in bed on an air mattress set to 260 pounds: -7/23/25 at 9:22 A.M. and 10:48 A.M. -7/23/25 at 12:30 P.M. and 4:07 P.M. -7/24/25 at 12:10 P.M. -7/28/25 at 8:21 A.M. -7/29/25 at 9:54 A.M. and 3:29 P.M. -7/30/25 at 8:18 A.M. and 12:35 P.M. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon further review of the control panel for Resident #9's air mattress positioned at the foot of his/her bed, the surveyor observed a piece of paper tape indicating that their air mattress should be &ldquo;Set at 220.&rdquo; During an interview on 7/31/25 at 12:28 P.M., Nurse #6 said Resident #9's air mattress was set to his/her weight. Nurse #6 said Resident #9's last weighed 210 pounds on 3/3/25. Nurse #6 inspected Resident #9's air mattress and said it was set to 260 pounds but should be set to 220 pounds per physician's orders. During an interview on 7/31/25 at 12:44 P.M., Unit Manager #1 said the expectation was for nurses to follow the physician orders and set Resident #9's air mattress setting to 220 pounds. Unit Manager #1 said the nurse would check the function and settings of Resident #9's air mattress every shift and should have adjusted the settings as needed. During an interview on 7/31/25 at 12:52 P.M., the Director of Nursing (DON) said depending on the reason for a specialty air mattress they are either set for comfort level or per the resident's weight which would be indicated in a physician's order. The DON said Resident #9's air mattress should have been set to his/her weight as indicated in the physician's order. 2. Review of Lippincott Nursing Procedures, Eighth Edition, [Philadelphia: Wolters Kluwer, [2019], indicated but was not limited to the following: Safe Medication Administration Practices, General:-To promote a culture of safety and to prevent medication errors, nurses must avoid distractions and interruptions when preparing and administering medications and adhere to the five rights of medication administration: identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route. Recent literature identifies nine rights of medication administration, which in addition to the five rights includes the right documentation, the right action (or appropriate reason for prescribing the medication), the right form, and the right response. Review of the facility's policy titled Medication Administration-Oral, dated June 2015, indicated but was not limited to:-Procedures: Drugs for oral administration are available on tablets, enteric coated tablets, capsules, syrups, elixirs, oils, liquids, suspensions, powders, and granules. Some require special preparations before administration.-Stay with the resident until he/she has swallowed the medication. Resident #90 was admitted to the facility in April 2025 with diagnoses of dementia, pneumonia, and dysphagia (swallowing difficulty). Review of the most recent MDS, dated [DATE], indicated Resident #90 was cognitively intact as evidenced by a BIMS score of 13 out of 15. Review of Resident #90's current Physician's Orders indicated but was not limited to:-May crush all appropriate medications according to guidelines, dated 7/22/25-Pyridoxine Hydrochloride 12.5 milligram tab one time daily by mouth, dated 7/22/25 On 7/28/25 at 8:13 A.M., the surveyor observed Nurse #1 preparing medications for Resident #90. On 7/28/25 at 8:22 A.M., the survey entered Resident #90's room and observed him/her in bed with a white round pill on his/her left chest wall laying on top of their johnny (hospital gown). (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/28/25 at 8:26 P.M., Resident #90 said he/she takes their medications crushed in applesauce and the nurse was just in his/her room to administer their medications. Resident #90 said he/she was unaware of the pill on his/her johnny and was not sure what pill was on their chest. During an interview on 7/28/25 at 8:32 A.M., Nurse #1 said she had administered medications to Resident #90 around 8:15 A.M. and he/she takes their medications crushed in applesauce. Nurse #90 observed the pill on Resident #90's chest and it was his/her Vitamin B6. Nurse #1 said she must have forgotten to crush it. During an interview on 7/31/25 at 12:52 P.M., the DON said her expectation was for the nurse to stay with a resident until all medications are taken and they are given per physician's orders. 3. Resident #109 was admitted to the facility in November 2017 with diagnoses including dementia and congestive heart failure. Review of the MDS assessment, dated 7/11/25, indicated Resident #109 had a moderate cognitive deficit as evidenced by a BIMS score of 8 out of 15. Review of Resident #109's Registered Dietitian's Nutrition Assessment, dated 4/10/25, indicated but was not limited to:-11% weight loss since January 2025. Review of Resident #109's current Physician's Orders indicated but were not limited to: -Weekly weight, 4/9/2025 Review of Resident #109's weights indicated but was not limited to: -4/3/2025 127.0 pounds -5/2/2025 137.2 pounds -7/1/2025 132.2 pounds Review of Resident #109's Treatment Administration Record (TAR) for April 2025, May 2025, June 2025, and July 2025 failed to indicate Resident #109 was weighed weekly per physician's orders. During an interview on 7/31/25 at 12:12 P.M., Nurse #11 said Resident #109 had an order for weekly weights, but she could not find any documented in his/her chart. Nurse #11 said once a weight was obtained the weight would go onto a weekly weights sheet and documented under vital signs in the Electronic Medical Record (EMR). During an interview on 7/31/25 at 12:52 P.M., the DON said weights should be done per physician's orders and documented on the resident's TAR and under the resident's vital signs in their EMR. 4. Resident #12 was admitted to the facility in April 2024 with diagnoses which included right and left-hand contractures, paraplegia, severe dementia, anxiety, and impulse disorder. Review of Resident #12's MDS assessment, dated 4/24/25, indicated the Resident had memory (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problems and was severely impaired in making decisions regarding tasks of daily life and never/rarely made decisions. Review of Resident #12's active Physician's Orders indicated but was not limited to the following: -Nurse, wash and soak hands with lukewarm water, every shift inspect and dry and apply moisturizing lotion before applying hand rolls to both hands and remove with evening care. Check skin as well. Review of Resident #12's July 2025 Medication Administration Record (MAR) indicated the Resident received hand treatments per the physician's order. During an interview on 7/28/25 at 10:10 A.M., the surveyor observed Resident #12 with a hand roll in each hand. Nurse #13 said the Resident had hand rolls in place during the day. On 7/29/25 at 10:37 A.M., the surveyor observed Resident #12's right hand with no hand roll in place and no hand roll nearby. The Resident's left hand was under sheets and not observed. On 7/30/25 at 9:23 A.M., the surveyor observed Resident #12 had no hand rolls in either hand. No hand rolls materials were observed on the Resident's bed. During observation and interview on 7/30/25 at 1:15 P.M., the surveyor and Infection Control Nurse observed Resident #12 with no hand rolls in place and no hand roll materials nearby. The Infection Control Nurse reviewed the Resident's physician's order and said the Resident should have hand rolls placed in both hands. During an interview on 7/31/25 at 12:14 P.M., the DON said Resident #12 should have hand rolls in place per physician's order. 5. Review of the facility's policy titled Self-Administration of Medications, dated July 2015, indicated but was not limited to: -Residents are afforded the right to self-administer their own medications, upon request, and after determination the practice is safe. If the resident elects to self-administer his/her own medications, an evaluation of their cognitive, physical and visual ability to perform this task is conducted to ensure accurate and safe medication management; -If unable to safely perform this task, the licensed staff, or trained medication aides/technicians, as allowed by State law, will administer medications; -Upon admission, readmission, annually, quarterly and change of condition, provide the resident/responsible party with a two-part document entitled SELF-ADMINISTRATION OF MEDICATIONS INFORMED CONSENT AND EVALUATION; -Evaluate the resident's cognitive, physical, and visual ability to self-administer medications; -If approved, obtain a physician's order for self-administration of medications; -Update the care plan for self-medication to include where the medication will be stored, documentation of self-administration, and location of the drug administration; (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Mark the Medication Administration Record (MAR) for each medication being self-administered for daily compliance monitoring purposes. (Indicate that the resident has self-administered). Resident #14 was admitted to the facility in June 2023 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), adjustment disorder with mixed anxiety and depressed mood, and alcohol dependence. Review of Resident #14's MDS assessment, dated 6/6/25, indicated the Resident was cognitively intact as indicated by a BIMS score of 15 out of 15. Review of Resident #14's current Care Plan indicated but was not limited to the following: -Resident #14 has an Activities of Daily Living (ADL) deficit related to: changing cognitive status, cognitive impairment, disease process/condition, revised 6/13/25; -Resident will participate in ADLs as able, revised 6/19/25; -Resident will receive staff intervention in ADL activities, revised 6/19/25; -Needs intervention in the following areas: Dressing (continual supervision to assist), Eating (set up), toilet use (supervision), grooming (continual supervision to assist), bathing (continual supervision to assist), mouth care (supervision); -Resident #14 has a diagnosis of COPD, revised 6/13/25; -Provide active treatment as ordered, including administering nebulizers, inhalers, oxygen, and performing respiratory assessments, initiated 5/8/25. Review of the Resident's current Physician's Orders indicated but was not limited to the following: -Albuterol Sulfate Inhalation Aerosol Solution, 2 puff inhale orally two times a day for wheeze, 7/27/23. Review of Resident #14's MAR for July 2025 indicated the Resident was administered albuterol per physician's orders at 0900 and 2100. During an interview with observation on 7/30/25 at 9:36 A.M., the surveyor observed an albuterol inhaler on Resident #14's bedside table. The Resident said he/she keeps the inhaler in his/her bedside drawer and he/she believed the inhaler should be used twice per day or as needed. The surveyor observed the inhaler label which indicated: 2 puffs inhale orally two times a day. The Resident took the inhaler out of the box, shook it briefly, and inhaled one short puff before placing it back into the box onto his/her bedside table. During an interview on 7/30/25 at 1:29 P.M., Nurse #5 said the Nurse Practitioner decides if a resident is appropriate to self-administer medication. If a resident is deemed appropriate, then a physician's order is placed for self-administration of medication. The Nurse said Resident #14 was her resident and he/she did not have orders to self-administer medication or inhalers. During an interview on 7/30/25 at 2:15 P.M., Nurse #5 said Resident #14 has orders for an albuterol (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inhaler once in the morning and once at night and she had not administered it to him/her yet that day. Nurse #5 said she did not know that the Resident had an inhaler in his/her possession and was self-administering. Nurse #5 said the Resident should not be self-administering his/her albuterol inhaler. During an interview on 7/31/25 at 12:14 P.M., the DON said she would expect a resident who self-administers medication to have been evaluated and educated on self-administration. The DON said Resident #14's self-administration of Medication assessment did not indicate the Resident could self-administer his/her albuterol inhaler; therefore, nursing should administer his/her albuterol inhaler.		

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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 observation, interview, and record review, the facility failed to provide a portable oxygen (O2) cannister for a resident requiring two liters of continuous O2 for one Resident (#71), out of total sample of 39 residents. Findings include: Review of the facility policy titled Oxygen Administration Nasal Cannula, dated 11/2020, indicated but was not limited to the following: -to deliver low flow oxygen, per the physician's order. (Generally, 1 to 6 liters per minute and 24 to 45% concentration). -Oxygen source (Oxygen concentrator, high pressure oxygen cylinder, or portable liquid oxygen tank). -Set the oxygen leader flow to the prescribed leaders flow per minute. Resident #71 was admitted to the facility in March 2022 with diagnoses which included: Chronic obstructive pulmonary disease (COPD), Congested heart failure (CHF) (chronic respiratory failure with hypercapnia, chronic sleep apnea, and intellectual disability. Review of the Minimum Data Set (MDS) assessment, dated 5/30/25, indicated Resident #71 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #71 was cognitively intact. Further review of MDS indicated in section J1100A Shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring) Answer: YES, and section O0110c1B oxygen therapy: Yes. Review of physician orders indicated the following: -Oxygen (O2) continuously via nasal cannula (NC) set at 2 Liters/minute. Every shift Check pulse oximeter and Liters per Minute (LPM). Initiated 10/20/24. Review of Resident #71's care plan indicated but not limited to the following: a. Resident has a diagnosis of CHF/history of CHF, and hypertension. -Provide O2 at (Specify) liters per minute as ordered, date initiated 5/13/2021. b. Resident has respiratory disease related to CHF, COPD, and sleep apnea. On O2 at 2 liters nasal cannular. -O2 saturation and O2 as ordered: Oxygen at 2 liters per minute via nasal cannular continuously for diagnosis of COPD, initiated 5/20/21. During an interview on 7/23/2025 at 12:21 P.M., Resident #71 said someone stole his/her oxygen tank, so he/she walks and goes to activities without one. During an interview and observation on 7/23/2025 at 4:43 P.M., the surveyor observed Resident #71 walking down the hallway using a four wheeled walker and not on any supplemental oxygen. Resident #71 said he/she still did not have an O2 tank. During an interview and observation on 7/25/2025 at 1:04 P.M., the surveyor observed Resident #71 in his room on 2.5 liters of continuous O2, nasal cannula attached to the concentrator. Resident #71 said nobody has given him/her a portable O2 tank. During an interview on 7/29/25 at 9:18 A.M., Resident #71 said he/she still does not have a portable O2 tank. Resident #71 said his/her roommate has one, but it is empty. The surveyor observed the portable cannister on the ground to be empty. The roommate confirmed it was their O2 cannister. On 7/29/25 at 10:25 A.M., Resident #71 was observed walking in the hallway with his/her four wheeled walker down to the nursing station without any supplemental O2. There were nurses, certified nursing assistants, and activity staff present as Resident #71 walked the halls with no supplemental O2. On 7/29/25 at 10:31 A.M., Resident #71 was observed in the activity room watching television without supplemental O2. During an interview on 7/29/25 at 10:34 A.M., Activity Staff #2 said sometimes Resident #71 uses O2 and sometimes he/she doesn't. Activity Staff #2 said it depends if the nurse checks his/her O2 in the morning and it is O.K., he/she can come to activities without O2. During an interview on 7/29/25 at 10:58 A.M., Nurse #2 said resident #71 is supposed to wear O2 twenty-four hours a day, seven days a week. Nurse #2 said she was just informed Resident #71 does not have an O2 cannister in the room. Nurse #2 said he/she should always have a portable O2 cannister available for walking outside his/her room.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure two Residents (#148 and #135), out of a sample of 39 residents, received culturally competent, trauma-informed care accounting for resident experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. Specifically, the facility failed:1. For Resident #148, to develop a person-centered plan of care which included trauma informed approaches and identified triggers to avoid potential re-traumatization; and2. For Resident #135, to complete a trauma informed assessment with identified triggers and implement a care plan, specifically for side rails on his/her bed for security at nighttime. Findings include:Review of the facility's policy titled Trauma Informed Care, undated, indicated but was not limited to:-It is the policy of this facility to ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice.-Social Service will screen each resident for history of trauma upon admission.-If the screening indicates that the resident has history of trauma and/or trauma related symptoms, a physician's order will be obtained for the resident, with their consent, to be evaluated/assessed by the facility's behavioral health consultant professionals.-Social Service will be responsible for making the referral to behavioral health services.-Documentation regarding the resident's psychosocial well-being including their response to stressful life events/trauma and coping mechanisms will be reflected in the Initial Social Service Progress Notes.-Trauma informed care plan will be documented in the resident's medical record by social service in conjunction with the Interdisciplinary team (IDT). 1. Resident #148 was admitted to the facility in November 2024 with diagnoses including Post-Traumatic Stress Disorder (PTSD). Review of the Minimum Data Set (MDS) assessment, dated 5/23/25, indicated Resident #148 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 and had verbal behavioral symptoms directed towards others. Further review of the MDS indicated Resident #148 had a diagnosis of PTSD. During an interview on 7/23/25 at 12:35 P.M., Resident #148 said he/she had a lot of loss in the past 10 years including the death of a parent and sibling, as well as a traumatic death of a significant other. Resident #148 said he/she is often triggered by feeling rushed, being under pressure, loud sounds, and feeling as though they are being mistreated. Resident #148 said he/she was followed by psychiatry. Review of Resident #148's hospital Discharge summary, dated [DATE], indicated but was not limited to: -Passing of significant other is one of his/her major traumas. -Trauma History: Childhood abuse, multiple losses since 2011 (death of a parent, suicide of a sibling, loss of a leg, and death of a significant other). Review of the Social Service Trauma-Informed Care Screen Tool, dated 11/21/24, indicated but was not limited to: -Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? -No (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Have you ever experienced any of the following Serious Accident; Sexual or Physical Assault; Life-Threatening Illness; Natural Disaster; Violent Loss of a Family Member or Close Friend? -No -Have you ever had an experience that was so upsetting to you that it changed you emotionally, spiritually, physically, or behaviorally? -No Review of the Initial Social Service, dated 11/21/24, indicated but was not limited to: -Resident #148 had a family member commit suicide. -Resident #148 had a partial leg amputation. Review of the Psychosocial Evaluation Supportive Care, dated 12/17/24, indicated but was not limited to: -Resident shared psychosocial history and recent stressors including eviction and losing a pet which are main concerns. -History of trauma: -Yes -Have you ever had a life-threatening illness or serious accident? -Unable/unwilling to answer. -Have you ever been physically assaulted, physically threatened, sexually assaulted, or sexually assaulted? -Unable/unwilling to answer. -Have you ever been in a situation that was extremely frightening? -Unable/unwilling to answer. -Have you witnessed any extremely frightening situation? -Unable/unwilling to answer. -Have you recently felt any of the following due to any of the situations just asked about? -Decreased social interaction or withdrawn? -No -Angry? -No -Persistent negative mood state? -Yes -Trauma Screening Summary- Not Applicable Review of Resident #148's trauma informed care plan failed to indicate an individualized, person-centered approach to indicate his/her history of trauma and/or specific resident related interventions. During an interview on 7/30/25 at 1:47 P.M., the Psychiatric Nurse Practitioner said Resident #148 was being seen by the facility's Consultant Behavioral Health Services every two to three weeks. She said the Consultant Behavioral Health Services would identify trauma and triggers as well as work on coping strategies. She said she mostly would rely on nursing documentation, admission paperwork, talking to the residents to identify trauma and triggers. She said Resident #148 was working on sober counseling and controlling their emotions. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/25 at 11:27 A.M., the Director of Social Services said Resident #148 was followed by the facility's Consultant Behavioral Health Services. She said she completed the Initial Trauma Assessment for Resident #148, but he/she had not verbalized trauma. She said she would gather information about a resident by asking them questions and interviewing them. She said she was unaware of Resident #148's trauma history. She said she does not reevaluate residents after their initial Trauma Assessment because she's not a licensed practitioner and did not want to upset residents. She reviewed Resident #148's trauma informed care plan and said it was generic and not individualized to Resident #148's care needs. During an interview on 7/31/25 at 12:52 P.M., the Director of Nursing (DON) reviewed Resident #148's Trauma Assessment and care plan. She said Resident #148's trauma should have been reassessed quarterly and his/her trauma informed care plan was not specific or individualized to their care needs but should have been. 2. Resident #135 was admitted to the facility in June 2020 with diagnoses which included: psychotic disturbance, mood disturbance, and anxiety. Review of the MDS assessment, dated 7/16/25, indicated Resident #135 scored 14 out of 15 on the BIMS, indicating the Resident was cognitively intact. Further review of the MDS section I6100 indicated Resident #135 does not have PTSD. During an interview on 7/23/25 at 4:25 P.M., Resident #135 said he/she sleeps on the side of his/her bed due to his/her PTSD after witnessing a family member commit suicide. Resident #135 said he/she also had a bad fall last year and they put side rails on his/her bed. Resident #135 said they came around recently and took off the side rails for no reason. Resident #135 said he/she wants the side rails to put back on his/her bed for security due to his/her PTSD and falls. Review of PASRR level II, dated 4/28/20, indicated the PASRR criteria for serious mental illness has been met: -The onset of most of Resident #135's mental history diagnosis is unknown. However, per Discharge summary, dated [DATE], indicated patient developed symptoms of PTSD after witnessing family member commit suicide. -Listed a diagnosis of PTSD Review of PASRR level II, dated 11/29/23, has been determined as a result of your PASRR Level II evaluation, that you do not currently meet pass our criteria for significant mental illness, but previously have been termed to have an SMI through a previous Level 2 evaluation. -Trauma History: Per previous level 2 (4/28/20), witnessed a family suicide. -The onset of Resident #135's symptoms of mental health was precipitated by witnessing a family member commit suicide. Review of Resident #135's Social Service Trauma-Informed Care Screening Tool, signed by facility staff on 6/19/20, indicated but was not limited to the following: 1. Have you ever experienced, witnessed or had to deal with an extremely traumatic event that (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included actual or threatened death or serious injury to you or someone else? Answer: Yes 2. Have you ever experienced any of the following: Serious Accident; Sexual or Physical Assault; Life-Threatening Illness; Natural Disaster; Violent Loss of a Family Member or Close Friend? Answer: Yes 3. Have you ever served in a war or a non-combat job in which were exposed to casualties? Answer: No 4. Have you ever had an experience that was so upsetting to you that it changed you emotionally, spiritually, physically, or behaviorally? Emotionally was circled Answer: Yes 5. If yes to any of the above, does this experience bother you now? Answer: Yes- Sometimes I cry and drink. a. If yes, what are the triggers that cause the experience to bother you? Blank b. If yes, how do you cope with these feelings? Talk about it! 6. Do you wish to discuss these feelings with a professional? Blank 7. Referral to be made to behavioral health Provider? Blank. Signed by the Facility's licensed social worker. Review of Resident #135's care plan indicated there was no care plan developed for Resident #135's history of PTSD. During an interview on 7/30/25 at 11:56 A.M., Social Worker (SW) #1 said Resident #135 does not have PTSD and showed the surveyor a Trauma Informed Care assessment completed on 12/13/21. SW #1 said this was Resident #135's initial assessment and it was negative. The surveyor reviewed with SW #1 statements made to the surveyor in which Resident #135 stated he/she had PTSD, the Trauma Informed Care assessment dated [DATE], and reviewed the two Level II PASRRs dated 4/28/20 and 11/29/23 both indicating Recent #135 has a history of PTSD. SW #1 said she was not aware of the Trauma Informed Care assessment dated [DATE]. SW #1 said she met with Resident #135 and completed a Trauma Informed Care assessment today, and a referral was made to the Psychiatric Nurse Practitioner (NP). During an interview on 7/30/25 at 12:06 P.M., the DON said she was aware Resident #135 has PTSD from witnessing a family member commit suicide. The DON said she was not aware Resident #135 wanted bed rails related to his/her PTSD. During an interview on 7/30/25 at 1:35 P.M., Psychiatric NP #2 said she met with Resident #135 today and confirmed Resident #135 has PTSD from witnessing a family member commit suicide and has a family history of abuse. Psychiatric NP #2 said Resident #135 also expressed nighttime fear of falling out of bed and requested bed rails.		

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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 observation, record review, and interview, the facility failed to ensure it was free from a medication error rate of greater than 5% when one of two nurses observed during the medication pass made four errors out of 29 opportunities, resulting in a medication error rate of 13.79%. Those errors impacted two Residents (#104 and #43). Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice dated as revised April 11, 2018, indicated but was not limited to the following: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers. On 7/24/25 at 9:20 A.M., the surveyor observed Nurse #8 administer medications to Resident #104 as follows: -Nurse #8 poured the following medications into the medication cup for Resident #104: Omeprazole 20 milligrams (mg), Plavix 75mg, Enteric Coated (EC) Aspirin 81mg, and Clonazepam 0.5mg. -Nurse #8 proceeded to crush the Plavix and Clonazepam and put the powder into pudding, The Omeprazole capsule was opened and sprinkles poured into the pudding, the EC Aspirin was put into the pudding whole. -Nurse #8 scrolled through the Medication Administration Record (MAR) and signed off an order for Amlodipine Besylate 10mg prior to locking the computer screen. (This medication was not poured)-The pudding mixture was administered to Resident #104. Review of the Physician's Orders indicated but were not limited to the following: -Diet: Puree Consistency with Nectar thick liquids. -May crush all appropriate medications according to guidelines. -Amlodipine Besylate Tablet 10mg by mouth one time a day for hypertension. -Aspirin EC Oral Tablet Delayed Release 81mg by mouth in the morning for analgesics. -Clonazepam Tablet 0.5mg by mouth two times a day for anxiety. -Omeprazole Delayed Release 20mg by mouth one time a day for GERD (acid reflux). -Plavix Tablet 75mg by mouth one time a day for blood thinner. Review of the medication card from the pharmacy for Clonazepam indicated: Swallow Whole with a drink of Water. Caution Hazardous Drug. Observe Special handling, administration, and disposal requirements. Review of the medication card from the pharmacy for Plavix indicated the medication could be taken with or without food. The pills were a light pink and had a coating on them. Review of the Federal Drug Administration (FDA) data sheet for Clonazepam indicated but was not limited to the following: Clonazepam is available as a tablet. The tablets should be administered with water by swallowing the tablet whole. Review of the FDA data sheet for Plavix indicated but was not limited to the following: Plavix is a pink film coated tablet. Review of the National Library of Medicine website pcm.ncbi.nlm.gov section titled: Crushing Tablet Administration for Patients with dysphagia (difficulty swallowing): Challenges and Considerations dated 9/14/23 indicated but was not limited to the following: -Administering crushed medications mixed with a soft food or liquid vehicle is a common strategy in patients with dysphagia. However inappropriate medication use, and improper crushing technique can reduce medication dose a patient receives, alter medication pharmacokinetics and pharmacodynamics, and compromise the treatment efficacy and patient safety. -A coordinated effort from the care team is necessary to develop and implement an individualized plan for administering medications. -Medications may be inappropriate to crush if they have enteric or slow-release coatings. -Combining multiple crushed medications may create unpredictable changes and potentially lead to adverse reactions. Further review of the medical record failed to indicate he/she had an order to specifically crush either medication. During an interview on 7/24/25 at 1:28 P.M., Nurse #8 said both Clonazepam and Plavix should be given whole and not crushed, but Resident #104 has trouble swallowing pills, so she must crush them. She said that is why she opened the Omeprazole and poured the contents into the cup of pudding. She said the EC Aspirin is small so they can swallow that one in the pudding. She said she thinks the provider knows he/she can't swallow the pills but was not sure and said she did not call him/her about the medications. Additionally, she said did not realize she did not administer the Amlodipine. On 7/24/25 at 9:30 A.M., the surveyor observed Nurse #8 administer medications to Resident #43 as follows: -Nurse #8 poured the following medications into the medication cup for Resident #43: Acetaminophen (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1000mg, Aspirin 81mg, Colace 100mg, Baclofen 5mg, Benztropine Mesylate 0.5mg, Depakote Solution 500mg, Toprol XL 25mg, Lexapro 20mg, Protonix, Risperidone 1mg, Lidoderm Patch, Salonpas Patch, and Iron 325mg.-Eliquis 5mg was not poured and marked not available with a note indicating the medication was on order.-The Medications were administered to Resident #43, but he/she refused the Salonpas Patch. Review of the progress notes failed to indicate the provider was notified the Eliquis (blood thinner) was not available and was not administered. During an interview on 7/24/25 at 1:28 P.M., Nurse #8 said if a medication is not available, they should call the provider to get an order to hold it, to give it later, or obtain an order for something else. She said she did not call the provider that morning about the Eliquis; she just wrote a note that it was not available. During an interview on 7/24/25 at 5:00 P.M., the Director of Nurses (DON) said if a medication is not available the nurse should call the provider to get an order to hold it, give it later, or for something else, whatever the provider tells them to do should be written in a physician's order. A progress note should also be written. The DON said medications that are coated should not be crushed. She said neither the Clonazepam nor the Plavix should have been crushed. The DON said if medications cannot be administered per orders/guidelines the provider should be called to get new orders. Additionally, she said all medications should be administered per physician's orders and double checked when signing off the MAR.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain completed medical records for two Residents (#14 and #97), out of a sample of 39 residents. Specifically, for Residents #14 and #97, the facility failed to ensure evaluations were completed in a timely manner. Findings include: Review of Resident #14's medical record indicated, but was not limited to, the following evaluations with a status of In Progress:-6/2/25, Self Administration of Medication, incomplete for 59 days;-6/2/25, Elopement & Wandering, incomplete for 59 days. Review of Resident #97's medical record indicated, but was not limited to, the following evaluations with a status of In Progress:-5/19/25, Substance and/or Alcohol Abuse Evaluation, incomplete for 73 days;-5/19/25 Side Rail Evaluation, incomplete for 73 days;-5/19/25 Self Administration of Medication, incomplete for 73 days;-5/19/25 Pain Evaluation, incomplete for 73 days;-5/19/25 Norton Plus, incomplete for 73 days;-5/19/25 Fall Risk Evaluation, incomplete for 73 days;-5/19/25 Elopement & Wandering Evaluation, incomplete for 73 days. During an interview on 7/30/25 at 2:30 P.M., Staff #11 said she assisted the Minimum Data Set (MDS) nurse and was responsible for initiating resident evaluations that were due for completion in the electronic health record as a prompt for nursing to complete them. Once opened, evaluations would remain in In Progress status and would change to Complete status once nursing completed the evaluation documentation in the electronic health record. During an interview on 7/31/25 at 12:14 P.M., the Director of Nursing (DON) said nurses are responsible for completing all necessary resident evaluations that are due, and the evaluations should be completed in a timely manner. The DON said Resident #14's evaluations from 6/2/25 and Resident #97's evaluations from 5/19/25 were incomplete and should not have remained incomplete for 59 and 73 days, respectively.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure for one Resident (#80), out of 39 sampled residents, that the call bell system (a communication system for residents to contact staff for assistance) in the Resident's bathroom was functional. Findings include: Review of the facility's policy titled Call Light, dated April 2015, indicated but was not limited to: Residents/patients will have a call light or alternative communication device within his/her reach when unattended. Report any defective call lights in the maintenance log. Resident #80 was admitted to the facility in May 2025 with diagnoses including cerebral infarct (stroke) and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 5/8/25, indicated Resident #80 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review of Resident #80's MDS indicated he/she was dependent for toilet transfers. During an interview on 7/23/25 at 10:36 A.M., Resident #80 said the call light in his/her bathroom has not been working for two to three weeks. Resident #80 said when he/she would use the bathroom and pulled the call light cord nothing would happen, and he/she would have to wait for someone to come in and help them in the bathroom. During an interview on 7/23/25 at 10:49 A.M., Certified Nursing Assistant (CNA) #1 said each resident bathroom had a call light with a pull cord and if a resident needed assistance in the bathroom, then they would pull the cord to the call light, and it would light up and make a sound in the hallway. CNA #1 said if a call light had not been working it would need to be reported to maintenance. The surveyor observed CNA #1 pull the call light cord in Resident #80's bathroom. CNA #1 said the call light was not working and she walked out of the room and went into the unit dining room without notifying maintenance of the broken call light. During an interview on 7/23/25 at 11:05 A.M., Unit Manager #1 said all the call lights on the [NAME] Unit were in working order a month ago when audited by maintenance. Unit Manager #1 said if a call light was not in working order, then it needed to be documented in the maintenance logbook and reported to maintenance right away. The surveyor observed Unit Manager #1 pull the call light in Resident #80's bathroom. Unit Manager #1 said the call light was not working. Unit Manager #1 reviewed the maintenance logbook and said the broken call light was not documented in the logbook. Unit Manager #1 said all residents must have a working call light or alternate way to call for assistance. During an interview on 7/31/25 at 5:25 P.M., the Director of Maintenance said call lights systems are audited monthly and if a call light was not in working order, then it should have been reported to the maintenance department right away. During an interview on 7/31/25 at 12:52 P.M., the Director of Nursing (DON) said all residents must have a working call light or an alternative way to call for assistance. The DON said maintenance must be notified of all broken call lights right away.		

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. Based on record review and interview, the facility failed to report the change in Director of Nurses (DON) in June 2025 to the state agency (SA) in the Health Care Facility Reporting System (HCFRS) as required. Findings include: Upon entry to the facility on 7/23/25 at 7:30 A.M., the name of the current DON was provided to the surveyors. Review of the HCFRS report failed to indicate the current DON had been reported to the SA. During an interview on 7/31/25 at 10:23 A.M., the Administrator said he thought he had 90 days to report the change in DON. During an interview on 7/31/25 at 10:45 A.M., the DON said she does not have access to HCFRS and does not do the reporting, but the change in DON should have been reported.		

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on resident and staff interview, the facility failed to ensure that staff delivered packages mailed to the residents on Saturdays and Sundays. Findings include: On 7/23/25 at 5:05 P.M., the surveyor observed a sign posted in the facility lobby which read:Attention to activity [sic], no more package delivery on weekends per Administrator's request. Thank you for your understanding. (signed by the Administrator) The surveyor observed the sign posted in the lobby throughout survey. During the Resident Group Meeting on 7/25/25 at 1:00 P.M., 17 out of 17 residents said activities staff deliver the mail Monday through Friday but if a package is delivered on the weekend, administration has to review it prior to it being delivered to the resident. The residents said there was a sign posted in the lobby from the administrator indicating that activities could not deliver packages on the weekends. During the Resident Group meeting half of the residents expressed frustration and disappointment with not receiving their packages timely. During an interview on 7/24/25 at 2:34 P.M., the Activities Director said the activities department is responsible for delivering mail seven days a week. She said she was aware of an incident where a resident ordered a package that contained items the resident was not allowed to have. She said she knows it is a resident right to have mail delivered but was aware of the sign from administration. She said the activities department does deliver paper mail every day. During an interview on 7/24/25 at 2:54 P.M., the Administrator said he wasn't aware the sign was posted but did acknowledge he created and signed the posting. He said there were residents ordering contraband and to keep everyone safe the packages need to be reviewed by management to see which resident ordered the package. He said some residents have to open their packages in front of him to ensure resident safety. He said he cannot allow residents to order items that are unsafe for themselves or other residents, so this was his solution. He said certain residents can come and ask for their packages on the weekend. During an interview on 7/24/25 at 2:54 P.M., the Director of Nurses said it is a resident right to have mail delivered on the weekends and she was unaware that the sign was posted. She said mail should be delivered everyday including packages and the sign should not be posted.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0712 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on record review and interviews, the facility failed to ensure timely physician visits for one Resident (#97), out of a sample of 39 residents. Specifically, the facility failed to ensure alternating and timely physician's visits for Resident #97. Findings include: Resident #97 was admitted to the facility in January 2021 with diagnoses which included atherosclerosis, peripheral vascular disease, seizures, traumatic brain injury, and major depressive disorder. Review of Resident #97's Minimum Data Set (MDS) assessment, dated 6/6/25, indicated Resident #97 was cognitively intact based on a Brief Interview of Mental Status (BIMS) score of 15 out of 15. During an interview on 7/29/25 at 11:00 A.M., Resident #97 said he/she was unsure of when their last doctor's visit was and said it had been many months since he/she had visited with the doctor. Review of Resident #97's medical record indicated he/she was not visited and assessed by a physician in 164 days as follows: Practitioner Visits:- 6/24/25 Nurse Practitioner (NP) visit-5/27/25, NP visit-5/19/25, NP visit-2/17/25, Physician's Assistant (PA) visit During an interview on 7/20/25 at 9:00 A.M., Nurse #2 said she was unsure of when the doctor last assessed Resident #97. She said physician encounters are in the electronic health record. Nurse #2 reviewed the Resident's medical record and could not find any physician's assessments. During an interview on 7/30/25 at 9:18 A.M., the Assistant Director of Nursing (ADON) said physician notes are generated into the electronic health record when the physician writes their notes, and an absence of physician notes may mean the physician did not write notes for the Resident. During an interview on 7/31/25 at 12:14 P.M., the Director of Nursing (DON) said frequency of physician visits should be performed according to Medicare guidelines. The DON said physician notes should be in the Resident's record, and she was unsure why the NP notes were in the record but not the physician's notes. During an interview on 7/31/25 at 6:00 P.M., the DON said she could not locate physician's visit notes for Resident #97.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to ensure three of four Certified Nursing Assistants (CNA) employee records reviewed had an annual performance review at least every 12 months. Findings include: Review of the facility's policy titled Employee Performance Appraisals, dated as revised 6/2023, indicated but was not limited to: -It is the policy of this facility to evaluate the job performance of each employee on a period basis-Department Heads and Supervisors will complete performance appraisals upon the following occasions:(a) By the end of the first three months of employment(b) Prior to the anniversary date of employment(c) Six months after the employee is transferred or promoted to a new job Review of CNA #12's employee file indicated a hire date of 10/1/15. The file failed to include a performance review dated within the past 12 months. Review of CNA #13's employee file indicated a hire date of 9/20/21. The file failed to include a performance review dated within the past 12 months. Review of CNA #14's employee file indicated a hire date of 9/24/14. The file failed to include a performance review dated within the past 12 months. During an interview on 7/31/25 at 9:55 A.M., the Human Resource Director said it was the responsibility of the appropriate department managers to complete all performance review appraisals every 12 months. The Human Resource Director said she was unable to provide the surveyor with the three CNA performance review appraisals as she had not received the documents from the appropriate department manager to place in the files of the CNAs. During an interview on 7/31/25 at 10:05 A.M., the Director of Nurses (DON) said either the DON or the Assistant Director of Nurses (ADON) would be responsible for completion of the performance review appraisals for CNAs. The DON said she had only been in the facility for one month while a new DON was being hired. She said she would check with the ADON to inquire if the required performance reviews had been completed. During an interview on 7/31/25 at 1:49 P.M., the DON said she was unable to provide the surveyor with the three requested CNAs' performance reviews. The DON said it was the expectation all staff have yearly performance reviews as required and the documentation was unable to be located.		