STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225229	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	6 Morrill Place Amesbury, MA 01913

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to notify the physician of a refusal of a medication for one Resident (#55), out of a total sample of 24 residents. Specifically, the facility failed to notify the physician of Resident #55's refusals of his/her ordered furosemide (a medication that removes fluid). Findings include: Review of the facility policy titled, Administering Medications, dated as revised December 2012, indicated: Medications are administered in a safe and timely manner, and as prescribed. 18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record (MAR) space provided for that drug and dose. Review of the facility policy titled, Notification of Changes, dated August 2024, indicated notification to the resident's attending physician will be made with a need to alter treatment significantly or to commence a new form of treatment. Resident #55 was admitted to the facility in May 2025 with diagnoses including Chronic Obstructive Pulmonary Disease, Pulmonary Hypertension, and Congestive Heart Failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/9/25, indicated Resident #55 had a Brief Interview of Mental Status assessment score of 15 out of a total possible 15 indicating he/she was cognitively intact. Review of the physician's order, dated 5/24/25, indicated: - Furosemide Oral Tablet 40 MG (Furosemide). Give 1 tablet by mouth one time a day for pulmonary hypertension. Review of the Medication Administration Record (MAR), dated May 2025 and June 2025, indicated on 5/25/25, 5/26/25, 5/27/25, 5/29/25, 5/30/25, 6/1/25, and 6/2/25 at 6:00 A.M., Resident #55 refused his/her physician's ordered furosemide. Further review of the clinical record failed to indicate his/her physician was made aware of the medication refusal. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/25 at 9:46 A.M., Nurse #5 said that she was not aware that Resident #55 refused his/her furosemide. Nurse #5 said that Resident #55's physician should have been notified of the refusal. She said that Resident #55 should be educated about potential adverse effects of refusing furosemide including fluid overload and cardiac arrest. During an interview on 6/4/25 at 1:30 P.M., the Director of Nursing said that the physician should have been notified of Resident #55's refusal of furosemide, and he/she should be educated about potential adverse effects of refusing this medication that include fluid overload and hospitalization. During an interview on 6/5/25 at 11:42 A.M., the Nurse Practitioner said she was not made aware that Resident #55's refused his/her dose of furosemide for seven of the past ten days, but she should have been notified. She said that Resident's refusal of furosemide put him/her at risk for potential respiratory distress like he/she had been hospitalized for previously.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interviews, the facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) (a form issued by SNFs to notify Medicare beneficiaries of potential financial liability for certain services) for 2 out of a sample of 3 residents. Specifically, the facility failed to issue SNF ABN notices after skilled services ended. Findings include: A review of the facility policy titled 'Beneficiary Notice Policy and Procedure' indicated the following: -The facility shall inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services. A review of two Notices of Medicare Non-coverage issued for the two residents who remained in the facility after skilled services ended on 1/17/25 and 3/17/25, respectively failed to indicate that SNF ABN notices were issued. During an interview on 6/5/25 at 9:20 A.M., the Director of Nurses said the expectation for residents who remain in the facility after skilled services ending is to get a SNF ABN notice informing them of potential financial liability for certain services. During an interview on 6/5/25 at 10:35 A.M., the Administrator said the SNF ABN notices were not issued for the two residents after their skilled services ended. He said SNF ABN notices should have been issued outlining financial liability for specific services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. For Resident #60 the facility failed to ensure accuracy of the MDS related to documentation from the physician that a gradual dose reduction of administered antipsychotic medication was documented as clinically contraindicated. Resident #60 was admitted to the facility in November 2023 and has diagnoses that include but are not limited to unspecified dementia, encephalopathy, and bipolar disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a staff assessment of mental status indicated Resident #60 as having severe cognitive impairment, and he/she is dependent on staff for self-care including toileting, bathing and dressing. Review of the MDS dated [DATE] indicated under Section N, High-Risk Drug classes that Resident #60 is taking antipsychotic medication, the physician documented a GDR (gradual dose reduction) as clinically contraindicated. The physician documented the GDR as clinically contraindicated in a note dated 12/3/24. Review of the Nurse Practitioner note dated 12/3/24 failed to indicate that a GDR of the antipsychotic medication as clinically contraindicated. The MDS dated [DATE] under section N, High-Risk Drug classes indicated Resident #60 is taking antipsychotic medication, the physician documented a GDR (gradual dose reduction) as clinically contraindicated. The physician documented the GDR as clinically contraindicated in a note on 3/4/2025. Review of the Nurse Practitioner note dated 3/4/25 failed to indicate that a GDR of the antipsychotic medication as clinically contraindicated. During an interview on 6/3/25 at 3:03 P.M., the MDS Nurse said when she does the MDS, the date she uses to support documentation for a GDR to be clinically contraindicated is documented by the psychiatric nurse practitioner who reviews residents for psychotropic medications use. Review of the notes with the MDS nurse, written and dated 12/3/24 and 3/4/25 by the psychiatric nurse practitioner, failed to indicate a GDR was clinically contraindicated. The MDS nurse said those notes should not have been used to complete the MDS, and she would need to modify the MDS to be accurate. Based on record review and interview, the facility failed to ensure Minimum Data Set Assessments (MDS') to be coded accurately for three Residents (#68, #21, #60) out of a total of 24 sampled residents. Findings include: 1. Resident #68 was admitted to the facility in September 2024 with diagnoses including vascular dementia, hemiplegia, and anxiety disorder and depressive disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #68 is moderately cognitively impaired evidenced by a score of 10 out of a possible 15 on the Brief Interview for Mental Status Exam. Additional review of the MDS' dated 4/4/25, 1/2/25 and 10/3/24 failed to indicate Resident #68's diagnoses of anxiety and depression were coded on the MDS. During an interview on 6/4/25 at 11:42 A.M., the MDS Nurse said that MDS' should be coded accurately. The MDS nurse said that she was not aware of Resident #68's diagnoses. 2. Resident #21 was admitted to facility in October 2018 with diagnoses including stroke, and dementia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #21 is severely cognitively impaired and totally dependent on staff for all activities of daily living. Additional review of the MDS indicated Resident #21 has two pressure injuries that were present upon admission. Review of the clinical record indicated Resident #21 developed pressure injuries to his/her sacrum and hip while residing at the facility. During an interview on 6/4/25 at 11:42 A.M., the MDS Nurse said that MDS' should be coded accurately. The MDS Nurse said that Resident #21's MDS was coded inaccurately.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop a baseline care plan within 48 hours of the resident's admission for one Resident #224 out of a sample of 24 residents. Specifically, (i) the facility failed to develop a substance use history base-line care plan, (ii) a suicide attempt history base-line care plan within 48 hours of the resident's admission. Findings include: A review of the facility policy titled 'Care Plans-Baseline' with a revision date December 2016 indicated the following: -A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. -The interdisciplinary team will review the health care practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: Social Services. -The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. -The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: The initial goals of the resident. Resident #224 was admitted to the facility in May 2025 with diagnoses including psychoactive substance induced disorder, depression and anxiety. A review of the Minimum Data Set (MDS) dated [DATE] failed to indicate a Brief Interview for Mental Status (BIMS) Score. A review of the social services progress note dated 6/2/25 indicated the Resident is alert and oriented to time, place and person. A review of the hospital discharge paperwork dated 5/25/25 indicated the following psychiatry initial consult: -Resident has a history of opioid use disorder (suboxone maintenance). -Treatment history: history of inpatient psychiatric hospitalization in 02/25. -Suicidal history: Suicide attempts/aborted or interrupted suicide attempts, history of making suicidal statements. Further review of the hospital discharge paperwork dated 5/28/25 indicated the following social history: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Drug Use: Not currently. -Types-Heroin. -Comment-clean since 2004. A review of Resident #224's base line care plan failed to indicate a person centered suicide attempt history and a history of heroin use. During an interview and record review on 6/5/25 at 7:35 A.M., the Social Worker said she completes the social service section of base line care plans in the electronic health record within 48 hours of the Resident's admission. The Social Worker reviewed the hospital discharge paperwork with the surveyor and said she should have included the Resident's suicide attempt history and history of heroin use in the base line care plan. The Social Worker said the Resident is a risk for relapse and a baseline care plan should have been developed with personalized interventions. During an interview on 6/5/25 at 8:13 A.M., the Director of Nurses said social services is responsible for completing their department's baseline care plans. The DON said she expects a resident with a suicide attempt history and a history of using heroin to have personalized baseline care plans developed within 48 hours of admission. During an interview on 6/5/25 at 12:45 P.M., the MDS coordinator said 48-hour meetings should include all interdisciplinary staff. The MDS coordinator said the social worker schedules the meetings with the interdisciplinary team, runs the meetings and offers a copy of the base line care plan to the resident or representative. The MDS coordinator said all base line care plans are completed in the electronic health record. The MDS coordinator said she completes the Nurse's section of the base line care plans but all other departments including social services are responsible for completing their department's baseline care plans within 48 hours.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews, the facility failed to develop a comprehensive person-centered care plan for one Resident (#24) out of a total sample of 24 Residents. Specifically, the facility failed to develop a plan of care after Resident #24 developed pressure ulcers to his/her back. Findings include: Resident #24 was admitted to the facility in January 2023 with diagnoses that included fusion of spine, cervical region, protein calorie malnutrition and iron deficiency anemia. Review of the most recent Minimum Data Set (MDS) Assessment, dated 5/26/25, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident has one stage 1 pressure ulcer, and one unstageable pressure ulcer; neither of which were present on admission. Review of the medical record indicated the following: -A wound consultant note, dated 2/24/25, that initially indicated that Resident #24 had two stage 2 pressure ulcers, one to the proximal and one to the distal lower back. -Wound consultant notes, dated 3/20/25, 3/31/25, 4/28/25, 5/19/25 and 5/26/25, that indicated ongoing pressure injurie(s) to Resident #24's back. Review of Resident #24's plan of care failed to indicate a plan of care for actual skin breakdown and the development of two pressure ulcer injuries with indivulized interventions was developed. During an interview on 6/5/25 at 12:00 P.M., the Director of Nurses said that Resident #24 should have had a plan of care in place to address the ongoing pressure injuries that he/she had. The Director of Nurses said that a plan of care was developed for actual skin breakdown on 6/4/25; after the concern surrounding pressure injuries was brought to the facilities attention.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2b. For Resident #9 the facility failed to ensure skin assessments were implemented in accordance with the medical plan of care. Resident #9 was admitted to the facility in August 2012 and has diagnoses that include but are not limited to metabolic encephalopathy, bipolar disorder, moderate protein malnutrition, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 scored a 7 out of 15 on the Brief Interview for Mental Stats exam which indicated he/she as having severe cognitive impairment, requires partial/moderate assistance for self-care activities including bathing and dressing. Further review of the MDS indicated Resident #9 is at risk for developing pressure ulcers/injuries. Review of Resident #9's medical record indicated a Norton Scale for Predicting Risk of Pressure Ulcers, dated 10/22/24 as high risk. Review of the physician's order dated 3/14/23 indicated: -Weekly skin assessment on TUESDAY 3-11 shift. Document on PCC (electronic medical record) under assessment. Review of Resident #9's clinical record indicated weekly skin assessments were performed on the following dates: 12/3/24, 12/17/24, 3/25/25, 4/7/25, 4/8/25, 4/22/25, 5/13/25, 5/20/25. There were no additional weekly skin checks for Resident #9. Review of the clinical record indicated from 12/1/24 through 6/3/25, Resident #9 had only 8 weekly skin assessments performed, out of 27 weeks. During an interview on 6/5/25 at 12:45 P.M., Nurse #2 said each resident should have a weekly skin check completed on an assessment in the medical record. During an interview on 6/4/25 at 1:25 P.M., the Director of Nursing (DON) said that she was aware that the facility had been having issues with nursing obtaining skin checks weekly. Based on observation, record review and interview, the facility failed to provide care in accordance with professional standards of practice for six residents (#8, #68, #66, #55, #39, and #47) out of a total of 24 sampled residents. Specifically: 1. For Resident #8, the facility failed to ensure a physicians order was implemented for a newly developed skin injury. 2. For Resident #68, #66, #9, and #47 the facility failed to ensure weekly skin checks were completed as ordered. 3. For Resident #39 the facility failed to ensure pre and post skin checks were completed when donning and doffing a right wrist splint. Findings include: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of [NAME], Manual of Nursing Practice 11ed, dated 2019 indicated the following: - The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber 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. Resident #8 was admitted to the facility in October 2017 with diagnoses including dementia, cognitive communication deficit, and unsteadiness on feet. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #8 is severely cognitively impaired evidenced by a score of 5 out a possible 15 on the Brief Interview for Mental Status Exam. On 6/4/25 7:11 A.M., the surveyor observed Resident #8 in bed waiting for morning care. There was a dressing on Resident #8's lower right leg initialed by staff and dated 6/3. Review of Resident #8's progress notes and physician's orders failed to indicate any injury to Resident #8's leg or treatment orders. On 6/4/25 at 7:55 A.M. the surveyor observed Resident #8 seated in the dining room wearing shorts which exposed his/her lower right leg and dressing dated 6/3. The surveyor inquired with Nurse #4 who said she was not aware of any treatment or injury to Resident #8. During an interview on 6/4/25 at 9:58 A.M., Nurse #2 said that Resident #8 had a dressing on his/her right leg but was not sure what had happened. Nurse #2 said that Resident #8 often bumps his/her legs into things. Nurse #2 said that there should be a physicians order for Resident #8's leg. Nurse #2 reviewed Resident #8's physicians orders and said that there was no order for treatment. During an interview on 6/4/25 at 1:26 P.M., the Director of Nursing (DON) said that when a resident sustains a skin injury, the expectation is for an investigation and skin assessment to be completed, the physician to be alerted and for treatment orders to be obtained. The DON said she had been made aware today (6/4/25) that Resident #8 had a dressing placed on a skin injury without an order. 2a. Resident #68 was admitted to the facility in September 2024 with diagnoses including vascular dementia, hemiplegia, and anxiety disorder and depressive disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #68 is moderately cognitively impaired evidenced by a score of 10 out of a possible 15 on the Brief Interview for Mental Status Exam. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #68's physicians orders indicated two orders for weekly skin checks: Weekly skin assessment to be completed Thursday on the 7am-3pm shift. Document Findings under the assessment tab NSG: Skin Assessment, dated 4/24/25. Weekly skin check on Thursday 3-11 shift, dated 9/27/24. Review of Resident #68's clinical record indicated skin checks were performed on the following dates: 1/2/25, 3/15/25, 4/28/25, 5/1/25, 5/8/25 and 5/22/25. Review of Resident #68's care plans indicated: Resident has a potential for pressure ulcer development r/t (related to) immobility, left sided There were no additional skin checks completed for Resident #68. During an interview on 6/4/25 at 1:25 P.M., the Director of Nursing (DON) said that she was aware that the facility had been having issues with nursing obtaining skin checks weekly. 2b. Resident #66 was admitted to the facility in September 2024 with diagnoses including Alzheimer's disease. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #66 is severely cognitively impaired evidenced by a score of 00 out of a possible 15 on the Brief Interview for Mental Status exam. Review of Resident #66's physicians orders indicated two orders related to skin checks: Weekly skin check, dated 9/25/24. Weekly skin assessment to be completed Monday on the 3pm-11pm shift. Document Findings on under the assessment tab NSG: Skin Assessment, dated 4/28/25 Review of the clinical record indicated skin checks for Resident #66 were completed on; 12/25/24, 1/1/25, 25, 3/25/25, 4/23/35, 4/30/25 and 5/7/25. No other skin checks completed. During an interview on 6/4/25 at 1:25 P.M., the Director of Nursing (DON) said that she was aware that the facility had been having issues with nursing obtaining skin checks weekly. 2c. Resident #30 was admitted to the facility in October 2020 with diagnoses that included dementia, type 2 diabetes and muscle weakness. Review of Resident #30's most recent Quarterly Minimum Data Set (MDS) Assessment, dated, 3/21/25, indicated a Brief Interview for Mental Status score of 10 out of 15 indicating moderate cognitive impairment. The MDS further indicated that the Resident requires partial to moderate assistance for bed mobility and had not exhibited rejection of care. The MDS also indicated that the Resident is at risk for pressure ulcer development. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #30's active physician's orders indicated: -Weekly skin assessment to be completed Tuesday on the 7am-3pm shift. Document Findings on [Electronic Medical Record (EMR)] under the assessment tab NSG: Skin Assessment., dated 4/28/25. Review of Resident #30's discontinued physician's orders indicated: -Weekly skin assessment on TUESDAYS 7-3 shift. Document on [EMR] under assessment., in place from 3/21/23 through 4/28/25. Review of the most recent Norton Assessment (an assessment to determine risk for pressure ulcer development), dated 2/19/25, indicated a risk score of 7, which indicates high risk for skin breakdown. Review of Resident #30's active skin care plan, dated as revised 9/28/23, indicated Skin: [Resident] is at risk for skin breakdown as evidenced by: Shear/friction risks. Review of the Electronic Medical Record indicated that the NSG: Skin Assessment was completed on the following dates over the last six months: 12/3/24, 12/12/24, 12/20/24, 2/21/25, 4/29/25, 5/8/25, 5/16/25 and 6/3/25. Review of progress notes from 12/1/24 through 6/3/25 failed to indicate any skin checks were completed that were not documented in a Skin Assessment and failed to indicate that the Resident had refused a skin assessment or skin check. During an interview on 6/4/25 at 12:37 P.M., Nurse #5 said that until recently there has not been a regular Director of Nurses at the facility to oversee that skin checks are being completed. She said that the expectation is that physician's orders are followed to complete skin checks weekly. She said that completing the skin check includes opening the assessment and entering whether the resident has any skin concerns or not. Nurse #5 said that not assessing a resident's skin weekly could lead to new wounds forming that are not known about that could worsen or become infected. During an interview on 6/4/25 1:25 P.M., The Director of Nurses said that she would expect that skin checks are completed weekly based on physician's orders, including completing the Skin Assessment in the EMR. 2d. Resident #47 was admitted to the facility in August 2020 with diagnoses including diabetes, anxiety, and depression. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #47 is moderately cognitively impaired evidenced by a score of 12 out of a possible 15 on the Brief Interview for Mental Status Exam. Review of Resident #47's physicians orders, dated 5/4/25, indicated: Weekly skin assessment to be completed Sunday on 7am-3pm shift. Document findings in electronic medical record under skin assessment tab. Review of Resident #47's clinical record indicated skin checks were performed on the following dates: 1/19/25, 4/7/25, and 5/11/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no additional skin checks completed for Resident #47. During an interview on 6/4/25 at 1:25 P.M., the Director of Nursing (DON) said that she was aware that the facility had been having issues with nursing obtaining skin checks weekly. 3. Resident #39 was admitted to the facility in May 2020 with diagnoses including Diabetes and Congestive Heart Failure. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #39 was cognitively intact as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status Exam. Review of Resident #39's physicians orders, dated 4/28/25, indicated: [NAME] right wrist brace in morning, doff at night related to right hand osteoarthritis and gout per orthopedic recommendations. Complete as tolerated and complete skin check pre and post wear. Review of Resident #39's clinical record failed to indicate any documentation of skin checks pre and post wear of right wrist brace. Review of Resident #39's weekly skin checks, dated 5/8/25, 5/16/25, and 5/29/25 failed to indicate any reference to skin under right wrist brace. During an interview 6/4/25 at 7:31 A.M., Resident #39 said he can remove and replace the splint independently. He said that nursing does not check the skin under his/her splint. During an interview on 6/4/25 at 10:01 A.M., Nurse #5 said that nurses need to do skin check before and after use of splint, even if resident dons and doffs independently. During an interview on 6/4/25 at 1:25 P.M., the Director of Nursing (DON) said that she was aware that the facility had been having issues with nursing obtaining skin checks weekly.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to provide the necessary care and services related to showers for one resident (#37), in a total sample of 24 residents. Findings include: Resident #37 was admitted to the facility in May 2020 with diagnoses including diabetes and congestive Heart Failure. Review of the most recent Minimum Data Set assessment (MDS), dated [DATE], indicated cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. During an interview on 6/3/25 at 7:57 A.M., Resident #39 said that he/she had not received a shower in about 12 weeks. Resident #39 said that he/she would like to have a shower. He/she said that it's not that he/she refuses, but that they aren't offering a shower to him/her. He/she said that it depends on who's working or how much staff they have. During an interview, on 6/4/25 at 8:05 A.M., Resident #39 said that he/she still had not received a shower. Resident #39 said that he/she would like to have a shower. He/she said that it's not that he/she refuses, but that they aren't offering a shower to him/her. Resident #39 said his/her showers are scheduled for Wednesday and Saturday evenings. During an interview on 6/3/25 at 12:41 P.M., Certified Nuring Aide (CNA) #2 stated that scheduled shower days are on the shift assignment beside each residents' names, as well as a paper for CNA's to document that they gave the shower or if the resident refused and then taken to the nurse to sign so that she is aware. During an interview on 6/3/25 at 1:01 P.M., Nurse #5 said CNA's will let her know if a resident refused shower and she will also ask them if they would like at another time. She said that the nurses and CNA's document any refusals in the electronic medical record. During an interview on 6/4/25 at 9:56 A.M., Nurse #5 said residents are scheduled for showers two times per week. She said that sometimes the resident will refuse, and CNA would document if refused and pass along to nurse so she can document in the electronic medical record. Nurse #5 said showers should still be given even if they are short staffed. Review of shower check lists attached to CNA assignment sheets on 4/24/25, 4/28/25, and 4/30/25 indicated no showers- only 2 CNA's. Review of all CNA documentation and nurses' progress notes from 4/6/25- 6/3/25, failed to indicate that Resident #39 had a shower or that he/she refused a shower. Review of CNA assignment sheets and shower check list documentation from 4/6/25-6/3/25, failed to indicate that Resident #39 had received a shower. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 6/4/25 at 9:56 A.M., Nurse #5 said that she was unable to provide any documentation from nurses' progress notes or CNA flow sheets that Resident #39 refused showers. During an interview on 6/4/25 at 1:47 P.M., the Director of Nursing said the only thing she knows about showers is that the schedules are on assignment sheets. Refer to F867.

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. For Resident #69 the facility failed to a. ensure that treatment provided to a stage 4 left heel pressure ulcer was implemented in accordance with the wound consultant, and b. failed to ensure treatment to a deep tissue injury to Resident #69's left heel was provided in accordance with the physician's orders. Resident #69 was admitted to the facility in November 2024 with diagnoses that include but not limited to paralytic gait, acute respiratory failure with hypoxia, unspecified severe protein-calorie malnutrition, and Alzheimer's disease. Review of Resident #69's Minimum Data Set (MDS) assessment, dated 5/16/25 indicated Resident #69 scored a 4 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having severe cognitive impairment, requires partial/moderate assistance with self-care activities including bathing, toileting and dressing. Further, review of the MDS indicated Resident #69 was at risk for developing pressure ulcers and had 1 stage 4 pressure ulcer (Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle). Review of Resident #69's MDSs dated 11/17/24 indicated 1 unstageable suspected deep tissue injury in evolution, and the MDS dated [DATE] indicated Resident #69 had 1 unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar. On 6/3/25 at 12:17 P.M., Resident#69 was observed in the main dining room with a slipper sock on his/her left foot. On 6/4/25 at 8:34 A.M., Resident #69 was observed in the dining room in a wheelchair with his/her legs resting on the floor. He/she was wearing a red slipper sock on his/her left foot with a white dressing observed just above the top of the red slipper sock. Review of Resident #69's physician's orders indicated the following: -wound consult for left heel and right shin, dated 3/10/25. Review of the care plan with the focus Resident was admitted with a pressure (sic) to his/her left heel dated initiated 11/23/24, revision on 6/3/25. Interventions/Tasks included but not limited to, Administer treatments as ordered and monitor of effectiveness, date initiated 11/23/24. Follow the facility policies/protocols for the prevention/treatment of skin breakdown, date initiated 11/23/24. Review of Resident #69's clinical record indicated he/she was being seen by the wound consultant weekly beginning in 11/27/24. The 11/27/24 note indicated a pressure ulcer to the left heel, unstageable tissue type 100 % eschar (dead tissue). The wound consultant follow-up notes dated 12/2/24 indicated unstageable pressure ulcer left heel, Treatment recommendations: Wash with wound wash/cleanser. Pat dry. Apply skin prep to peri skin. Cover wound with Santyl/Ca (calcium) Alginate. Cover with ABD dressing and wrap with kerlix QD (once a day) and PRN (as needed). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of wound consultant notes dated 12/9/24, 12/16/24, 12/27/24, 12/30/24, 1/6/25, 1/13/25, 1/26/25, 1/31/25, 2/3/25, 2/10,25, 2/18/25, 2/24/25, 3/3/25, 3/20/25, 4/7/25 indicated the left heel pressure ulcer as unstageable and had the same treatment recommendation; Wash with wound wash/cleanser. Pat dry. Apply skin prep to peri skin. Cover wound with Santyl/Ca (calcium) Alginate. Cover with ABD dressing and wrap with kerlix QD (once a day) and PRN (as needed). Review of the wound consultant follow-up note dated 4/14/25 indicated: Debridement (a removal of dead, damaged or infected tissue) performed today which patient tolerated well. There is healthy exposed muscle in wound base, making this a stage 4 pressure injury. Discussed on going treatment with nurse. Wounds: Pressure ulcer heel left stage 4, Plan: Treatment Recommendations: instruction: wash with wound wash/cleanser, pat dry, skin prep to peri skin. Apply medihoney, cover with ABD with kerlix wrap. Review of the wound consultant follow-up progress notes dated 4/21/25, 4/28/25, 5/5/25 and 5/12/25 all indicated the left heel ulcer as a stage 4 and the treatment recommendation instruction: wash with wound wash/cleanser, pat dry, skin prep to peri skin. Apply medihoney, cover with ABD with kerlix wrap. Review of the Medication Administration Record dated 4/1/25-4/30/25 did not indicate any treatment orders. Review of the Treatment Administration Record (TAR) dated 4/1/25 through 4/30/25 indicated the following treatment as administered: Pressure ulcer heel Left: Wash with wound cleanser, pat dry, apply skin prep to peri wound, apply Santyl to necrotic skin calcium alginate to wound, cover with ABD pad wrap with Kerlix daily, every day shift for wound care, start date 3/26/25. The TAR failed to indicate the wound consultant recommendation dated 4/14/25, for the Stage 4 pressure ulcer to Resident #69's left heel was provided as indicated. The TAR indicated the order to treat the unstageable pressure ulcer to Resident #69's left heel continued. Review of the Treatment Administration Record dated 5/1/25 through 5/13/25 indicated Pressure Ulcer Heel Left: wash with wound cleanser, pat dry, apply skin prep to peri wound, apply Santyl to necrotic skin calcium alginate to the wound, cover with ABD pad wrap with Kerlix daily was signed off as administered 5/1/25-5/13/25 with the omission of 5/3/25. This treatment was for the unstageable pressure ulcer and not the treatment recommended by the wound consultant for the stage 4 pressure ulcer on Resident #69's left heel. Review of the MAR/TAR for April 2025 and May 2025 failed to indicate the treatment order for the stage 4 pressure ulcer to Resident #69's left heel was implemented until 5/14/25, resulting in 29 days without the recommended treatment by the wound consultant for Resident #69's stage 4 left heel pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 6/4/25 at 9:00 A.M., Nurse #2 said Resident #69 had a pressure ulcer on his/her left heel and is seen weekly by the wound consultant. Nurse #2 said the nurse caring for the resident will do the wound rounds with the wound consultant. Nurse #2 said recommendations for treatment is made by the wound consultant and the ADON (Assistant Director of Nursing) or DON (Director of Nursing) obtain the order from the doctor or nurse practitioner (NP) and the treatment is entered as an order. Nurse #2 said the doctor and NP always agree with the recommendations made by the wound consultant, especially for Resident #69. Nurse #2 said treatments are completed as ordered and signed off on either the MAR or TAR after the treatment is done. Nurse #2 said Resident #69 does not refuse treatments but sometimes will take off the dressing and that is why she coverers it with a slipper sock. Nurse #2 said in April (2025) the wound consultant changed the treatment to Resident's #69's left heel pressure ulcer after it was debrided. Nurse #2 reviewed the TAR and MAR and said the treatment order stayed the same and was not changed in April as recommended. Nurse #2 said she knew the treatment was changed to medihoney. During an interview on 6/4/25 at 1:38 P.M., the DON said Resident #69 is followed by the wound consultant. The DON said any recommendation made by the wound consultant should be placed in the physician's orders and completed as ordered. The DON said the nurses who round with the wound consultant do not realize they are able to get an order from the doctor or NP and place the order in the medical record. The DON said the wound consultant is the person who assesses and knows how to treat a pressure ulcer and if orders are not followed or implemented there could be a potential for the wound to worsen. During an interview on 6/4/25 at 2:59 P.M. the wound consultant said she is a nurse practitioner and wound care specialist. The wound consultant said she rounds weekly on wounds and the nurse on the floor caring for the resident rounds with her most times. The wound consultant said when recommendations are made, she tells the nurse verbally, then I provide a note with who I have seen, and recommendations made and give it to the Director Nursing at the end of my rounding and the next day my full note would be uploaded in the electronic medical record. The wound consultant said she would expect the recommendations to be entered as physician's orders. The wound consultant said there are many factors on how a wound can heal and the dressing is the cherry on top. The wound consultant said off-loading, chronic conditions are factors for a wound to heal or worsen. The wound consultant said when she first met Resident #69 around the end of March 2025 or April 2025 the wound was unstageable and covered with necrotic tissue. The wound consultant said she then debrided the wound and determined the appropriate staging after the debridement of the left heel as a stage 4 pressure ulcer. The wound consultant said she changed the treatment at that time to treat the stage 4 open area on Resident #69's left heel. The wound consultant said the treatment for the unstageable pressure ulcer was Santyl which is an enzymatic to breakdown necrotic tissue and the calcium to manage any drainage from the wound. The wound consultant said once the wound was opened and clean the wound no longer needed Santyl, but the Santyl would not breakdown healthy skin. The wound consultant said she changed the treatment to medihoney as treatment for the left heel stage 4 pressure ulcer and was not aware that the treatment to the stage 4 left heel pressure ulcer was not implemented for nearly a month. During an interview on 6/4/25 at 4:22 P.M., Resident #69's nurse practitioner said the wound consultant has the expertise, not me to make recommendations for pressure ulcer treatments. The NP said she would follow the recommendations and expect the treatment to be entered as an order and provided by the nurse caring for Resident #69. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 6/5/25 at 10:57 A.M., the Medical Director, who is Resident #69's physician said orders are to be implemented after the wound provider rounds and makes recommendations. The MD said this has been identified as a problem at the facility with staff not following through. The MD said he would 100% follow the wound consultant recommendations for Resident #69's pressure ulcer on his/he left heel, as this is their area of knowledge. The MD said the risk of not implementing the wound consultant recommendations could lead to infection, worsening or neglect. The MD said the wound consultant notes are sent to him for review and that he was not aware the treatment recommendation was not implemented as an order for Resident #69's left heel stage 4 pressure ulcer. 4b. Review of Resident #69's Treatment Administration Record (TAR) dated 2/1/25 through 2/28/25 indicated the following order: Pressure Ulcer Heel left, wash with wound cleanser, pat dry, apply skin prep to peri skin, calcium alginate to wound, cover with ABD pad wrap with Kerlix daily and PRN (as needed). Further, review of the TAR indicated the treatment was not signed off as competed on 2/3/25, 2/4/25, 2/6/25, 2/17/25, 2/19/25, 2/20/25, 2/24/25, and 2/27/25. Eight pressure ulcer treatments were not documented as provided out of 28. Review of the clinical record indicated progress notes dated 2/15/25 and 2/22/25 that Resident #69 refused the treatment. These dates did not correspond with the days that were left blank on the TAR. There were no progress notes dated for the eight blank days on the TAR. During an interview on 6/4/25 at 9:00 A.M., Nurse #2 said nurses provide wound treatments, date and sign the dressing, them sign off in the TAR as completed. Nurse #2 said if for any reason the treatment is not provided then a progress note should be written. Nurse #2 said the TAR should not be left blank. Nurse #2 reviewed the February TAR and said 8 treatments were blank and not signed off as completed. During an interview on 6/4/25 at 1:38 P.M., the Director of Nursing said if the TAR is blank then there is no documentation to support the treatment was completed. 5. Resident #21 was admitted to facility in October 2018 with diagnoses including stroke, and dementia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #21 is severely cognitively impaired and totally dependent on staff for all activities of daily living. On 6/3/25 at 7:38 A.M., the surveyor observed Resident #21 resting in bed on an air mattress (a specialty mattress utilized to reduce pressure to the body.) Resident #21 appeared thin, frail and was unable to engage in the interview process. Review of the clinical record indicated Resident #21 had pressure injuries on his/her left hip and sacrum and was being followed by the Wound Consultant. Review of the Wound Consultant note dated 5/26/25 indicated: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Patient laying in bed. Seen with nurse today. Patient has new DTI (deep tissue injury) to gluteal cleft (the groove between the buttocks that runs from just below the sacrum to the perineum,) and left hip pressure injury has re-occurred. Patient unable to provide history. Nurse does not recall seeing these wounds a few days ago when last caring for patient. Treatment Recommendations: Instruction: Wash with wound cleanser, cover with bordered foam dressing. Change daily and PRN. Review of Resident #21's physician orders failed to indicate any treatment order related to his/her newly developed DTI on his/her gluteal cleft. During an interview on 6/3/25 at 11:50 A.M., Nurse #3 said that Resident #21 has pressure injuries on his/her sacrum and hip. Nurse #3 did not say Resident #21 had a wound to his/her gluteal cleft. During an interview on 6/4/25 at approximately 8:15 A.M., Nurse #1 said that Resident #21 has wounds on his/her hip, sacrum and possibly on his/her heel but it may have healed at this point. During an interview on 6/4/25 at 9:54 A.M., Certified Nursing Assistant (CNA) #1 said that she is assigned to care for Resident #21 and he/she needs two staff for assistance with turning and positioning. CNA #1 said that Resident #21 has two pressure areas and pointed to the left and right hip. On 6/4/25 at 10:01 A.M., the surveyor observed Nurse #1 (with the assistance of Nurse #2) complete Resident #21's wound treatments. Nurse #1 said that Resident #21 has two areas; one on the right hip which requires skin prep and an unstageable area to his/her sacrum which required cleansing with calcium alginate with silver and to cover with a border foam dressing. At 10:04 A.M. Nurse #1 checked the orders and returned with supplies to perform the dressing changes. During the treatment, Resident #21's gluteal cleft was observed to be red, fragile, and did not have a dressing on it. Nurse #1 said that there was no treatment in place for that area and Nurse #2 said that the area had been open in the past for Resident #21, although it was not currently an open area. During an interview on 6/4/25 at 10:21 A.M., Nurse #1 said that the recommended treatment made by the Wound Consultant for Resident #21's gluteal cleft should have been implemented. Nurse #1 said she was not sure who is responsible for reviewing the wound treatment recommendations and entering them into the computer as the unit does not currently have a Unit Manager. Nurse #1 said that when treatment recommendations are not implemented, there is a risk of a wound worsening and infection. During an interview on 6/4/25 at 1:18 P.M., the Director of Nursing (DON) said that the Wound Consultant rounds weekly with the floor nurses who are then responsible for inputting the treatment recommendations into the electronic health record as orders. The DON said that the Wound Consultant notes are automatically uploaded to the resident record and she will also review them and input the treatment orders if they are missing. The DON was not aware a treatment and dressing was not in place for Resident #21 newly acquired DTI at the time of the surveyor's observation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 6/5/25 at 10:52 A.M., the Medical Director said that he was not aware that recommendations from the wound consultant were not being implemented by the facility. He said that his expectation is that recommendations are reviewed with the attending providers and implemented as recommended. He said that he would not go against the recommendations of the wound consultant because they are the experts in wounds, and he is not. He said that not implementing treatment recommendations as ordered could result in infection, sepsis, and worsening wounds. He said wounds are a big risk factor for residents and that nurses and medical staff need to stay on top of them and ensure proper treatment. Refer to F726, F867 Based on observation, record review and interview, the facility failed to ensure five Residents (#24, #61, #30, #69 and #21) with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, out of a total sample of 24 Residents. Specifically, 1. For Resident #24 the facility failed to implement recommendations from the Wound Consultant over a three-month period resulting in the deterioration of a pressure wound from a stage 2 pressure wound to an unstageable pressure wound. 2. For Resident #61 the facility failed to implement recommendations from the Wound Consultant for the treatment of a pressure ulcer. 3. For Resident #30 the facility failed to implement recommendations from the Wound Consultant for the treatment of a pressure ulcer. 4. For Resident #69 the facility failed to a. ensure that treatment provided to a stage 4 left heel pressure ulcer was implemented in accordance with the wound consultant recommendation, and b. failed to ensure treatment to a deep tissue injury to Resident #69's left heel was provided in accordance with the physician's orders. 5. For Resident #21 the facility failed to implement recommendations from the Wound Consultant for the treatment of a pressure ulcer. Findings include: Review of the facility policy titled Pressure Ulcers/ Skin Breakdown- Clinical Protocol, Revised October 2010, indicated the following: -The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss and a history of pressure ulcer(s). -The physician will authorize pertinent treatment orders related to wound treatments, including pressure reduction surfaces, wound cleaning and debridement approaches, dressings (occlusive, absorption, etc.) and application of topical agents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	6 Morrill Place Amesbury, MA 01913

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F 0686 Level of Harm - Actual harm Residents Affected - Some	1. Resident #24 was admitted to the facility in January 2023 with diagnoses that included fusion of spine, cervical region, protein calorie malnutrition and iron deficiency anemia. Review of the most recent Minimum Data Set (MDS) Assessment, dated 5/26/25, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident has one stage 1 pressure ulcer, and one unstageable pressure ulcer, neither of which were present on admission. The MDS dated [DATE] did not assess for behaviors, however, review of an MDS assessment dated [DATE] indicated that the behavior of rejection of care was not present. Review of the most recent Norton Assessment (an assessment to determine risk for skin breakdown), dated 5/28/25, indicated a risk score of 18, indicating low risk for skin breakdown. Review of Resident #24's active risk for skin breakdown care plan indicated the following, dated as revised 5/11/23: Skin: [Resident] has OCC. (occasional) incontinence r/t (related to) Confusion, Impaired Mobility, Physical limitations, with a goal that indicated, [Resident] will remain free from skin breakdown due to incontinence and brief use through the review date. Review of the wound consultant note, dated 2/24/25, indicated the following: -With facility-acquired pressure ulcers. PU2 (pressure ulcer) to proximal lower back and distal lower back over the vertebrae. No other areas of concern. The patient denies pain. No signs or symptoms of infection were noted. Tx (treatment) plan is added. -Treatment recommendations for both areas: #3 Pressure ulcer Lower Back proximal and #4 Pressure ulcer Lower Back distal -Measurements for Pressure ulcer to the lower back proximal were 0.8 centimeters (cm) x 0.6 cm x 0.1 cm in depth, and for the pressure ulcer to the lower back distal were indicated as 1 cm x 2.2 cm x 0.1 cm in depth. Instruction: Wash with wound cleanser. Pat dry. Skin prep to peri skin. Cover with Xeroform, Silicone bordered dressing QD (daily) and PRN (as needed). Frequent repositioning. Off Load pressure Q2hrs (every two hours). *Recommend Vitamin C 500mg, Zinc 50mg and protein supplement. Review of active and discontinued physician's orders failed to indicate that recommendations were implemented as indicated in the wound consultant note, and indicated the following orders: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-Santyl (a prescription medication that removes dead tissue from wounds) Ointment 250 unit/gm (gram) (Collagenase) Apply to Proximal lower back topically every day shift related to pressure ulcer of unspecified site, stage 2, Cleanse wound with wound cleanser. Rinse wound with normal saline. Pat dry. Apply skin barrier to peri wound skin. Apply Santyl then normal saline to the wound base. Cover with Xeroform then silicone bordered dressing daily & PRN AND Apply to proximal lower back topically every 24 hours as needed for dislodgement or soiled dressing, cleanse wound with wound cleanser. Rinse wound with normal saline. Pat dry. Apply skin barrier to peri wound skin. Apply Santyl then normal saline to the wound base. Cover with Xeroform then silicone bordered dressing, dated as active from 2/26/25 through 3/21/25. [sic] -Santyl Ointment 250 unit/gm (Collagenase) Apply to distal lower back topically every day shift related to pressure ulcer of unspecified site, stage 2, cleanse wound with wound cleanser. Rinse wound with normal saline. Pat dry. Apply skin barrier to peri wound skin. Apply Santyl then normal saline to the wound base. Cover with Xeroform then then silicone bordered dressing. Change daily and PRN AND Apply to distal lower back topically every 24 hours as needed for dislodgement or soiled dressing Cleanse wound with wound cleanser. Rinse wound with normal saline. Pat dry. Apply skin barrier to peri wound skin. Apply Santyl then normal saline to the wound base. Cover with Xeroform then silicone bordered dressing, dated as active from 2/26/25 through 3/21/25. [sic] Review of the medical record failed to indicate that the recommendations for offloading the wounds, Vitamin C or Zinc were implemented. The medical record further indicated that the Resident was already receiving protein supplementation, prior to the recommendation. Review of the medical record failed to indicate that the care plan was updated to indicate actual skin breakdown and that new interventions for repositioning or offloading were implemented in the plan of care for Resident #24. Review of the wound consultant note, dated 3/20/25, indicated the following: -#4 Pressure ulcer Lower Back distal- stage 2 (stage 2 pressure ulcer) -Measurement: 2 cm x 1 cm x 0.1 cm in depth. Instruction: Wash with wound cleanser. Pat dry. Skin prep to periskin. Cover with Xeroform, Silicone bordered dressing QD and PRN. Frequent repositioning. Off Load pressure Q2hrs. *Recommend Vitamin C 500mg, Zinc 50mg and protein supplement. [sic] Review of the medical record failed to indicate that any recommendations were implemented following the Wound Consultant visit. Review of discontinued physician's orders indicated the following: -Cleanse unstageable wound lower spine with NS. Pat dry. Apply skin prep every shift May apply ABD over lower spine wound for comfort, dated 3/21/25, and active until 4/17/25, (which did not match the recommendations from the Wound Consultant). Review of the wound consultant note, dated 3/31/25, indicated the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-PU2 to lower distal back is improving to this week. PU2 to lower proximal back has resolved. -Treatment plan is updated. Nursing aware of wound assessment and treatment plan. No new skin concerns were noted. The patient denies pain. No signs or symptoms of infection were noted. -#4 Pressure ulcer Lower Back distal- Stage 2 -Measurement: 1.7 cm x 0.5 cm x .01 cm in depth. Instruction: Wash with wound cleanser. Pat dry. Skin prep to periskin. Cover with Xeroform, Silicone bordered dressing QD and PRN. Frequent repositioning. Recommend: Vitamin C 500mg, Zinc 50mg and protein supplement. [sic] Review of discontinued physician's orders indicated the following: -Cleanse unstageable wound lower spine with NS. Pat dry. Apply skin prep every shift May apply ABD over lower spine wound for comfort, dated 3/21/25, and active until 4/17/25, (which did not match the recommendations from the Wound Consultant). Review of the wound consultant note, dated 4/28/25, indicated the following: -Patient is being seen for evaluation and treatment recommendation regarding lower back pressure injuries. -Patient was seen with nurse today. He/She denies concerns. The proximal pressure injury to his/her lower back has reopened since the last visit. He/She denies pain to the site and tells me that the wound comes and goes because the curvature of his/her spine. He/She reports that offloading helps. There are no signs or symptoms of infection. The distal pressure injury to the low back is improved. No other concerns noted. Discussed ongoing treatment plan with nurse. #3 Pressure ulcer Lower Back proximal (re opened)- stage 2 -Measurements: 1 cm x 0.5 cm x 0.2 cm in depth. Instruction: Wash with wound cleanser. Pat dry. Skin prep to intact skin. Cover with silicone foam dressing. Change QD and PRN. Frequent repositioning to offload bony prominence. Recommend: Vitamin C 500mg, Zinc 50mg and protein supplement. -#4 Pressure ulcer Lower Back distal- stage 2 measurement: 1.2 cm x 0.6 cm x 0.1 cm in depth- moderate serous drainage. Instruction: Wash with wound cleanser. Pat dry. Skin prep to intact skin. Cover with silicone foam dressing. Change QD and PRN. Frequent repositioning. Recommend: Vitamin C 500mg, Zinc 50mg and protein supplement. [sic] (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the medical record failed to indicate that any recommendations were implemented from the Wound Consultant visit. Further review of the medical record failed to indicate that any dressing changes or wound care were provided, beginning on 4/17/25. Review of the wound consultant note, dated 5/19/25, indicated the following: -Patient is being seen for evaluation and treatment recommendation regarding lower back pressure injuries. -Patient seen sitting in WC. He/She denies pain or concerns related to wound care. Wounds are improving. No new areas of concern. Treatment plan updated and discussed with nurse. -#3 Pressure ulcer Lower Back proximal- stage 2 -Measurement: 0.5 cm x 0.5 cm x 0.1 cm in depth. Instruction: Wash with wound cleanser. Pat dry. Skin prep to intact skin. Apply single layer xeroform to wound. Cover with bordered gauze dressing. Change QD and PRN. Frequent repositioning to offload bony prominence. Recommend: Vitamin C 500mg, Zinc 50mg and protein supplement. [sic] -#4 Pressure ulcer Lower Back distal- stage 2 measurement: 1 cm x 0.5 cm x 0.1 cm in depth. Instruction: Wash with wound cleanser. Pat dry. Skin prep to intact skin. Apply single layer xeroform to wound. Cover with bordered gauze dressing. Change QD and PRN. Frequent repositioning. Recommend: Vitamin C 500mg, Zinc 50mg and protein supplement. Review of the medical record failed to indicate that any recommendations were implemented from the Wound Consultant visit. Further review of the medical record failed to indicate that any dressing changes or wound care were provided, beginning on 4/17/25. Review of the wound consultant progress note, dated, 5/26/25 indicated the following: -Pressure ulcer to distal lower back is deteriorating while pressure ulcer to proximal lower back continues to improve. Stage 2 PU to distal lower back has changed into unstageable PU. Patient denies pain. No new areas of concern or s/s (signs and symptoms) of infection. Treatment plan updated and discussed with nurse. -#3 Pressure ulcer Lower Back proximal- stage 2 -Measurement: 0.5 cm x 0.5 cm x 0.1 cm in depth. Instruction: Wash with wound cleanser. Pat dry. Skin prep to intact skin. Apply single layer xeroform to wound. Cover with bordered gauze dressing. Change QD and PRN. Frequent repositioning. Recommend: Vitamin C 500mg, Zinc 50mg and protein supplement. -#4 Pressure ulcer Lower Back distal- unstageable pressure ulcer (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	measurement: 2 cm x 1.5 cm x 0.2 cm in depth- moderate serous drainage. 90% Slough (in wound bed). Instruction: Wash with wound cleanser. Pat dry. Skin prep to intact skin. Apply santyl to wound followed by cut-to-fit piece of moist gauze. Cover with bordered foam dressing. Change QD and PRN. Frequent repositioning to offload bony prominence with pillow behind back on wheelchair. Recommend: Vitamin C 500mg, Zinc 50mg and protein supplement. Review of the May 2025 Medication Administration Record and Treatment Administration Record failed to indicate that the treatments for either pressure ulcer were initiated and implemented as per the recommendations from the wound consultant. Further review of the medical record indicated that the Zinc 50 mg recommendation was not implemented until 5/31/25, 96 days after it was initially recommended to aid in wound healing. Review of active physician's orders as of 6/3/25 indicated the following: -Zinc 220 mg daily, dated 5/31/25, initially recommended in wound recs on 2/24/25, 96 days after it was recommended to aid in wound healing. -Cleanse wound on back with NS (Normal saline) and apply skin prep and optifoam dressing daily, dated 3/31/25. (This order was entered as ancillary and was not scheduled on any Medication or Treatment Administration Record, therefore there is no sign off to indicate that the order was completed or implemented. Review of nursing progress notes also failed to indicate that the treatment was provided). Review of active and discontinued physician's orders failed to indicate that Vitamin C, offloading of the pressure areas and frequent repositioning were ever initiated or monitored per the Wound Consultant recommendations beginning 2/24/25. Review of the medical record failed to indicate that from 4/17/25 to 6/3/25 a wound treatment order was completed or implemented as recommended by the wound consultant. Review of the medical record from 5/19/25 through 5/26/25, when the pressure ulcer to the distal lower back was documented as deteriorated and now assessed as an unstageable wound by the Wound Consultant, failed to indicate that any treatments were in place or implemented, and failed to indicate refusal of any skin wound treatments. Review of the medical record also failed to indicate that the recommendations from 5/26/25 were implemented until 6/4/25 when the surveyor brought it to the attention of the facility. During an interview and observation on 6/3/25 at 12:35 P.M., Resident #24 said he/she has a wound on his/her back, but they are no longer providing treatments to it. The surveyor requested to observe the wound, and the Resident declined for today. The surveyor asked if they could return tomorrow and re-address and the Resident said that would be fine but that at this time, he/she wants to lay down. During this observation, the resident was lying in bed, on his/her back, without any offloading measures in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 6/4/25 at 7:34 A.M., Nurse #5 said that she often takes care of Resident #24. She said Resident #24 has no wounds and no orders for any dressings or offloading/ repositioning measures. She said she has not completed any wound treatment or dressing changes on Resident #24 recently. She reviewed the medical record and confirmed, there are no ordered treatments on the Treatment Administration Record. During an interview on 6/4/25 at 7:45 A.M., Certified Nurse Aide #2[TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#55) out of sample of 24 residents. Specifically, the facility failed to include a physician's order for the use of oxygen in the medical record. Findings include: Review of the facility policy titled Oxygen Administration dated as revised October 2010, indicated to verify there is a physician's order for the administration of oxygen before applying. Further review indicated to review the resident's care plan to assess for any special needs of the resident. Resident #55 was admitted to the facility in May 2025 with diagnoses including Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #55's cognition is cognitively intact as evidenced by a scored 14 out of 15 on the Brief Interview for Mental Status assessment. Further review indicated that Resident #55 used oxygen. On 6/3/25 at 7:37 A.M. and 6/4/25 at 7:45 A.M., the surveyor observed Resident #55 laying in bed receiving oxygen (O2) via nasal cannula at 4 L/min (liters per minute). Review of the physician's orders dated June 2025 failed to indicate an order for the administration of oxygen. Review of the care plan failed to indicate a care plan was developed for the use of oxygen. During an interview on 6/4/25 at 9:46 A.M., Nurse #5 said Resident #55 should have had a physician's order and a care plan developed for the use of oxygen. During an interview on 6/4/25 at 1:30 P.M., the Director of Nursing said that there should be a physician's order, and a care plan developed for the use of oxygen.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physician visits were completed as required upon admission for two residents (#50 and #66) out of a total of 24 sampled residents. Findings include: Review of the facility policy titled, Physician Services, dated April 2013, indicated: 1. The Resident's attending physician participates in the resident's assessments and care planning, monitoring changes in resident's medical status, providing consultation or treatment when called by the facility and overseeing a relevant plan of care for the resident. 1. Resident #50 was admitted to the facility in October 2024 with diagnoses including schizophrenia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #14 was cognitively intact evidenced by a score of 14 out of a possible 15 on the Brief Interview for Mental Status Exam. Review of Resident #50's physician and nurse practitioner visits since October 2024 indicated Resident #50 was seen by the nurse practitioner on 10/4/24, 4/10/25, and was seen by the attending physician once on 11/30/24. (Resident #50 had behavioral health nurse practitioner visits related to medication reviews and mental health follow up on 12/6/24, 3/18/25, 3/25/25, and 4/21/25). During an interview on 6/4/25 at 1:16 P.M., the Director of Nursing said that residents should be seen by the nurse practitioner or physician every 60 days and was unsure about the alternating frequency but would follow up on that. The DON was not aware of the requirement to be seen every 30 days for the first 90 days upon admission During an interview on 6/5/25 at 11:20 A.M., Physician #1 said that residents should be seen every 60 days. Physician #1 said that after a resident is admitted , the Nurse Practitioner sees the resident the next day and he will come in within 2-3 business day after that. 2. Resident #66 was admitted to the facility in September 2024 with diagnoses including Alzheimer's disease. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #66 is severely cognitively impaired evidenced by a score of 00 out of a possible 15 on the Brief Interview for Mental Status exam. Review of Resident #66's nurse practitioner and physician notes indicated he/she had been seen by the nurse practitioner on 9/19/24, 10/21/24, and 5/30/25 and then seen by the physician on 11/30/24, 3/5/25, and 4/30/25, (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident #66 had behavioral health nurse practitioner visits related to medication reviews and mental health follow up on 12/3/24, 1/2/25, and 2/4/25.) During an interview on 6/4/25 at 1:16 P.M., the Director of Nursing said that residents should be seen by the nurse practitioner or physician every 60 days and was unsure about the alternating frequency but would follow up on that. The DON was not aware of the requirement to be seen every 30 days for the first 90 days upon admission During an interview on 6/5/25 at 11:20 A.M., Physician #1 said that residents should be seen every 60 days. Physician #1 said that after a resident is admitted , the Nurse Practitioner sees the resident the next day and he will come in within 2-3 business day after that.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and records reviewed, the facility failed to have sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Specifically, the facility failed to maintain sufficient staffing according to the facility assessment and facility staffing requirements. Findings include: Review of the Facility Assessment Tool, dated and reviewed by the facility in May 2024, indicated the following staffing ratios for Nurses and Certified Nursing Aides (CNA's): -4 Licensed Practical Nurses (LPN) / Registered Nurses (RN) Full time days - weekdays and weekends. -4 LPN / RN Full time evening - weekdays and weekends. -2 LPN / RN Full time nights - weekdays and weekends. -8 CNA's Full time days - weekdays and weekends. -8 CNA's Full time evenings - weekdays and weekends. -4 CNA's Full time nights - weekdays and weekends. During the recertification survey the surveyors' observed concerns with showers not being provided and low staffing reports from staff and residents. During the initial tour of the facility on 6/3/25, there were multiple concerns reported to the surveyors by residents who expressed concerns about needing more staff in the building. Some of these interviews included: - One resident said, They don't have enough staff and I haven't had a shower in weeks. - One resident further said There is not enough staff, especially on the weekends. There is no help. During an interview on 6/3/25 at 7:57 A.M., Resident #39 said that he/she had not received a shower in about 12 weeks. Resident #39 stated that it's not that he/she refuses, but that they aren't offering a shower to him/her. He/she said that it depends on who's working or how much staff they have. During the Resident Group meeting held on 6/4/25 at 3:30 P.M., residents said they do not always have enough staff. Residents said they know this because it takes longer to get someone to help with answering call lights. The residents reported concerns with all shifts and they need to wait to be assisted to the bathroom or other needs including showers. Ten out of 17 residents in attendance said they often wait over 25 minutes to get the assistance they need. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Payroll-Based Journal (PBJ) Staffing Data Report submitted by the facility for fiscal year (FY) Quarter 1, 2025 (October 1, 2024 - December 31, 2024) was reviewed. The facility's report triggered the following: Review of the PBJ Staffing Data Report, submitted by the facility for fiscal year (FY) Quarter 1: Dated 2025 (October 1 - December 31), indicated the following: -One Star Staffing Rating Triggered = Star Staffing Rating Equals 1. -Excessively Low Weekend Staffing Triggered = Submitted Weekend Staffing data is excessively low. -No RN Hours Triggered = Four or More Days Within the Quarter with no RN Hours. Review of the weekend staff schedule, dated October 1, 2024, to December 31, 2024, indicated that the facility was staffed below their determined minimum necessary for Licensed Nurses and CNA's for seven weekends. The weekend staff schedules indicated the following staffing during this quarter: Review of the actual daily schedule report for Saturday 10/19/24 indicated the following: -4 LPN / RN Day shift: Only 3 Nurses scheduled. -4 LPN / RN Evening shift: Only 2 Nurses scheduled. -8 CNA's Day shift: Only 6 CNA's scheduled. -8 CNA's Evening shift: Only 5 CNA's scheduled. Review of the actual daily schedule report for Saturday 11/2/24 indicated the following: -4 LPN / RN Day shift: Only 3 Nurses scheduled. -4 LPN / RN Evening shift: Only 2 Nurses scheduled. -8 CNA's Day shift: Only 7 CNA's scheduled. -8 CNA's Evening shift: Only 6 CNA's scheduled. Review of the actual daily schedule report for Sunday 11/3/24 indicated the following: -4 LPN / RN Day shift: Only 3 Nurses scheduled. -8 CNA's Evening shift: Only 6 CNA's scheduled. Review of the actual daily schedule report for Saturday 11/9/24 indicated the following: -8 CNA's Evening shift: Only 5 CNA's scheduled. Review of the actual daily schedule report for Sunday 11/10/24 indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-8 CNA's Day shift: Only 7 CNA's scheduled. -8 CNA's Evening shift: Only 6 CNA's scheduled. -4 CNA's Nights shift: Only 3 CNA's scheduled. Review of the actual daily schedule report for Sunday 12/1/24 indicated the following: -4 LPN / RN Evening shift: Only 3 Nurses scheduled. -8 CNA's Evening shift: Only 5 CNA's scheduled. Review of the actual daily schedule report for Sunday 12/15/24 indicated the following: -8 CNA's Evening shift: Only 5 CNA's scheduled. Further review of the weekend staff schedules continued to indicate the facility was staffed below their determined minimum necessary of Licensed Nurses and CNA's on four weekends. The weekend staff schedules indicated the following staffing: Review of the actual daily schedule report for Saturday 5/24/25 indicated the following: -4 LPN / RN Day shift: Only 1 Nurse scheduled. -4 LPN / RN Evening shift: Only 1 Nurse scheduled. -2 LPN / RN Night shift: Only 1 Nurse scheduled. -8 CNA's Day shift: Only 5 CNA's scheduled. -8 CNA's Evening shift: Only 5 CNA's scheduled. Review of the actual daily schedule report for Saturday 5/25/25 indicated the following: -4 LPN / RN Day shift: Only 2 Nurses scheduled. -4 LPN / RN Evening shift: Only 1 Nurse scheduled. -2 LPN / RN Night shift: Only 1 Nurse scheduled. -8 CNA's Day shift: Only 5 CNA's scheduled. -8 CNA's Evening shift: Only 4 CNA's scheduled. Review of the actual daily schedule report for Saturday 5/31/25 indicated the following: -4 LPN / RN Day shift: Only 2 Nurses scheduled. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	6 Morrill Place Amesbury, MA 01913

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-4 LPN / RN Evening shift: Only 1 Nurse scheduled. -2 LPN / RN Night shift: Only 1 Nurse scheduled. -8 CNA's Day shift: Only 4 CNA's scheduled. -8 CNA's Evening shift: Only 5 CNA's scheduled. Review of the actual daily schedule report for Sunday 6/1/25 indicated the following: -4 LPN / RN Day shift: Only 3 Nurses scheduled. -4 LPN / RN Evening shift: Only 1 Nurse scheduled. -2 LPN / RN Night shift: Only 1 Nurse scheduled. -8 CNA's Day shift: Only 7 CNA's scheduled. -8 CNA's Evening shift: Only 5 CNA's scheduled. During an interview on 6/04/25 at 8:17 A.M., a staff member on the second floor unit said, there is not enough staff, and they only have three CNA's scheduled. If one CNA goes on break and the other two are assisting a resident with transfers, then there is no one. The staff member said sometimes care/showers don't get completed because there is not enough staff. The staff member said the schedule will look good and staffed appropriately but it's not accurate of the number of staff in the building. During a telephone interview on 6/4/25 at 9:43 A.M., Certified Nurse Assistant (CNA) #2 said the facility has been short staffed often during the days and on the evening shift for a long time. CNA #2 said it is hard to find help to get residents up and showered because residents might need two or three staff to assist them. During an interview on 6/4/25 at 9:46 A.M., Nurse #7 said they are very short staffed and not enough CNA's are scheduled to care for the Residents that need help with showers, and care and said there is not enough staff to help with transfers. Nurse #7 said weekend shifts often run with 2-3 CNA's and said she had to stay late after a double shift because staff did not come in and no one came in to relieve her. Nurse #7 said she is always late with her medications because she needs to stop and help with care needs to keep the Residents safe. Nurse #7 said when staff go on break the Residents are left with 1-2 CNA's. During an interview on 6/5/25 at 8:24 A.M., the Human Resources Director who is also the Scheduler said she manages the schedule for the two units in the facility, and each unit requires 2 Nurses and 4 CNA's during the day shift, 2 Nurses and 4 CNA's during the evening shift, and 1 Nurse and 2 CNA's during the night shift. The Staff Scheduler said there have been staffing issues and said they have been running low and asking staff to pick up extra shifts to cover the staffing needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/5/25 at 8:50 A.M., the Director of Nurses (DON) said she expects the facility to be staffed appropriately and said a lot of staff will work double shifts or pick up shifts if we are low. The DON said they have been working on recruiting and having to use agency staff because they are running low. The DON said she has discussed the concerns with Administration. During an interview on 6/5/25 at 9:54 A.M., a staff member on the second-floor unit said there is not enough staff and only three CNA's are scheduled on the unit; (been like that for a couple months). When we only have three, we can't everything done, can't give showers if they're scheduled or requested. The residents aren't getting the care they need. Couldn't give any showers yesterday because there was not enough staff. During an interview on 6/5/25 at 12:04 P.M., a staff member on the second-floor unit said, there is not enough staff and things aren't getting done, management does not listen and thinks we are okay but we need more CNA's. During an interview on 6/5/25 at 11:26 A.M., the Administrator said it is his expectation that the building is staff appropriately as indicated in the facility assessment and said they have been facing staffing issues for quite some time. During an interview on 6/5/24 at 11:19 A.M., the Medical Director said the facility is understaffed and overworked and said he would like to see more seasoned nurses here and that they are doing the best they can. The Medical Director said there have been multiple Director of Nurses that have come and gone and its been a top priority for him to fix but change in leadership it keeps falling through. Refer to F726, F727, F730, F732, F867.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interviews and record review, the facility failed to ensure the nursing staff were trained and demonstrated the competencies and skill sets necessary to provide the level and types of care and services needed as outlined in the Facility Assessment. Specifically, the facility failed to: 1. Ensure licensed nursing staff were trained and demonstrated competency to identify, assess, evaluate, intervene, and respond to change in condition of a wound and implement treatment recommendations, for 5 Residents (#24, #61, #30, #69, and #21), out of a total sample of 24 Residents. As a result of these failures, for Resident #24 the facility failed to implement recommendations from the Wound Consultant over a three-month period resulting in the deterioration of a pressure wound from a stage 2 pressure wound to an unstageable pressure wound. 2. Ensure that seven out of seven staff education records reviewed, had education and competencies and were completed and documented annually, per the Facility Assessment. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. -Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. -Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies and training in areas as indicated in the facility assessment: - Activities of Daily Living (ADL's): Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment, supporting resident independence in doing as much of these activities by himself/herself. - Mobility and fall/fall with injury prevention: Transfers, ambulation, restorative nursing, contracture prevention/care, supporting resident independence in doing as much of these activities by him or herself. - Skin Integrity: Pressure injury prevention and care, skin care, wound care, surgical and other skin wounds. - Infection Prevention and Control: Identification and containment of infections, prevention of infections. - Management of Medical Conditions: Assessment, early in identification of problem/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), gastroenteritis, infections such as UTI and gastroenteritis, pneumonia, hypothyroidism. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility Assessment, dated as reviewed with the QAA/QAPI committee, in May 2025, indicated the following: Staff training/education and competencies -Considerations: Training's will be conducted based on regulation, facility need and acuity or admissions. -Infection Control: Conducted on hire, annually and retraining as needed based on CDC (Center for Disease Control) and DPH (Department of Public Health) updates for COVD-19 [SIC] and other infections. Staff Competencies: Staff Type and Timing (on hire, annually, PRN (as needed), on demand) -Person Centered Care: All staff on hire, annually and as needed. -Activities of Daily Living All staff on hire, annually and as needed. -Infection Control: Hand Hygiene, Universal Precautions, Protective Equipment. -As needed with updates from DPH, CMS (Centers for Medicaid and Medicare Services) and CDC regarding COVID-19 following all CDC guidelines. -Medication Administration: All staff on hire, annually and as needed. -Measurements - Vitals and intake and output: All staff on hire, annually and as needed. -Resident Assessment: All staff on hire, annually and as needed. -Caring for Residents with dementia, Alzheimer's, and Cognitive Impairments. 8 hours of training upon hire and 4 hours upon annual recertification. -Caring for Residents with Mental and Psychosocial Disorders: All appropriate staff upon hire, annually and as needed. -Non-Pharmacological Management of Responsive Behaviors: All staff on hire, annually and as needed. -Caring for Residents with Trauma/PTSD (Post Traumatic Stress Disorder): All staff on hire, annually and as needed. -Clinical Competencies: All staff on hire, annually and as needed/As COVID-19 protocols change. -Evaluation of Infection Prevention and Control Program: Individuals are tracked and monitored on the line listings. Line listing review identifies trends. All staff is educated on infection control standards. The facility partners with vendors who educate and uphold infection control standards. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of seven personnel files of actively working clinical nursing staff in the facility on 6/5/25 indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Further review of the education files indicated licensed clinical staff did not have the necessary skills and competency to evaluate, document, or recognize a change in condition related to skin integrity and proper wound management. Competencies reviewed included Skin and Wound Care. There was no documented evidence that licensed clinical staff had the required clinical training or that competencies were completed as indicated in the facility assessment. Seven out of seven employee records did not have the necessary training and clinical competencies on file upon hire or annually related to ADL', Falls, Change in Condition, Skin Integrity, Infection Control, Required Dementia Training and Medication Administration. During an interview on 6/5/25 at 8:52 A.M., the Director of Nurses (DON) said training and clinical competencies must be completed upon hire, annually and said she expects staff to have been checked off as passing a wound care competency and training before coming off orientation. The DON said she has not completed any training or competencies with clinical staff and said clinical staff should have the required clinical competences on file and annually including those listed in the facility assessment. During an interview on 6/5/25 at 9:38 A.M., the Administrator said it is his expectation that the clinical staff are trained appropriately and have the required completed clinical competencies and training on file according to the facility assessment. The Administrator said they have been without an Assistant Director of Nursing or Staff Educator since last fall and said they had a staff member helping out but she went on leave and he is not sure what training system is in place. During an interview on 6/5/24 at 11:19 A.M., the Medical Director said he would expect the facility is maintaining and keeping up with required trainings upon hire and annually as required and completing clinical competencies for all clinical staff. During an interview on 6/05/25 at 12:36 P.M., the [NAME] President of Clinical Operations said staff must have mandatory education and demonstrated clinical competencies completed upon hire and annually and said they know they need to improve and have not been able to complete the required training. REF F 867

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and records reviewed, the facility failed to utilize the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week, as required placing all residents at risk for not having their clinical needs met either directly by the RN or indirectly by the Licensed Practical Nurse (LPN) or Certified Nurses Aides (CNA) that the RN was responsible for overseeing with provision of resident care. Specifically, the facility failed to provide the services of a RN for at least eight consecutive hours a day, seven days a week when no staffing waivers were in place for seven days for the period of 10/1/24 to 12/31/24. Findings include: 1. Review of the PBJ Staffing Data Report, dated Quarter 1: 2025 (October 1 - December 31), indicated the following: -One Star Staffing Rating Triggered = Star Staffing Rating Equals 1. -Excessively Low Weekend Staffing Triggered = Submitted Weekend Staffing data is excessively low. -No RN Hours Triggered = Four or More Days Within the Quarter with no RN Hours. Review of the as worked nursing schedule provided by the facility failed to indicate that a Registered Nurse worked for eight hours in the facility on the following days: -10/19/24 -11/2/24 -11/3/24 -11/9/24 -11/10/24 -12/1/24 -12/15/24 The facility failed to provide evidence through timecards or payroll information that an RN was onsite for 8 consecutive hours on the dates noted on the PBJ Staffing Data Report. Further review of the staff schedules continued to indicate the facility failed to provide evidence through timecards or payroll information that an RN was onsite for 8 consecutive hours on the following days: -5/24/25 (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-5/25/25 -5/31/25 -6/1/25 During an interview on 6/5/25 at 8:35 A.M., the Director of Nurses (DON) said she was not employed at the facility at the time of the PBJ Staffing report and said she would expect RN coverage to be provided as indicated per the regulation. The DON said on occasion she will come in if they need help on the weekends but said the facility does not have a staff RN always scheduled and said the facility continues to have staffing issues. During an interview on 6/5/25 at 9:37 A.M., the Administrator said the facility does not have any staffing waivers and said there should be an RN working at least 8 hours every day.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and records reviewed, the facility failed to complete annual Certified Nurse Aide (CNA) performance reviews for 3 out of 3 eligible sampled CNA's. Findings include: During review of 3 CNA employee records, the Surveyor was unable to locate annual performance reviews for 3 out of 3 eligible CNA's. During an interview on 6/5/25 at 8:27 A.M., the Human Resource Director said the annual reviews were not completed and said she does not manage that process as the former Director of Nursing handled the reviews. During an interview on 6/5/25 at 1:49 P.M., the Director of Nursing (DON) said annual reviews must be completed yearly and documented in the employee record. The DON said she has not conducted any performance reviews since starting in the facility in April 2025.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and interviews, the facility failed to post nursing staff data daily, at the start of each shift, as required. Specifically, the facility failed to ensure they consistently posted the staffing as required. Findings include: During the survey the surveyor was unable to locate the staffing posting that is required to be available for residents and visitors to view. On 6/4/25 at 8:20 A.M., the surveyor observed a blank single sheet of white paper in the clear plastic document holder, located on the wall near the receptionist desk. During an observation and interview on 6/4/25 at 8:21 A.M., the Receptionist said staffing information and schedules are posted down the hall near the employee time clock and not located at the receptionist desk. The Receptionist said Residents and families do not have access to this employee area. The Receptionist said staffing schedules and data is not kept at the entrance or front receptionist area and said the employee time clock is where the information is posted. On 6/5/25 at 7:24 A.M., and 10:22 A.M., the surveyor observed a blank single sheet of white paper in the clear plastic document holder, located on the wall near the receptionist desk. During an observation and interview on 6/5/25 at 12:32 P.M., [NAME] President of Clinical Operations said the staffing schedule/data must be posted and visible to families and residents and said it should be located near the receptionist desk. During an observation of the clear plastic document holder on the wall, a staffing data sheet dated 6/4/25 was located behind a blank white piece of paper and was not visible. The [NAME] President of Clinical Operations said the staffing information must be posted, visible and updated daily and in a location accessible and visible to residents and visitors. During an interview on 6/5/25 at 12:44 P.M., the Administrator said the staffing data must be visible and updated daily.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide behavioral health services for one Resident, (#68) out of a total of 24 sampled Residents. Specifically, the facility failed to ensure ongoing psychotherapy/talk therapy was provided for Resident #68 and failed to develop and implement a care plan related to Resident #68's diagnosis of depression and anxiety. Findings include: Resident #68 was admitted to the facility in September 2024 with diagnoses including vascular dementia, hemiplegia, and anxiety disorder and depressive disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #68 is moderately cognitively impaired evidenced by a score of 10 out of a possible 15 on the Brief Interview for Mental Status Exam. During an interview on 6/4/25 at 8:07 A.M., Resident #68 said that he/she had not been offered any counseling or therapy services while residing in the facility and that he/she was very interested in talking to someone. Review of Resident #68's care plans indicated a care plan addressing Resident #68's depression/anxiety was initiated on 6/3/25, (approximately nine months after his/her admission to the facility): Focus: Resident my have distressed mood related to his/her diagnosis of MDD (major depressive disorder), anxiety, sadness/depression. Goals: Resident will demonstrate improved mood state, a happier demeanor and less anxious feelings through next review. Resident will demonstrate the ability to seek out staff support when feeling frustrated or provoked by next review. Resident will express his/her feelings of such fears by next review. Interventions: Allow time for expression of feelings with empathy and reassurance. Allow time for vervalization (sic) of feelings/needs and attempt to resolve area of being upset. Encourage resident to seek staff support when fearful. Encourage activities of choice. Evaluate the need for psych/behavioral health consult. Monitor for worsening signs/symptoms or worsening sadness/depression. Review of Resident #68's Behavioral Health services note dated 10/1/24 indicated: Target Symptoms: Anger, Anxiety, Depression Clinical Assessment: Initial exam, pt (patient) a&ox3 (alert and oriented to person, place and time).Pt with anger, shouting, demanding, intense, paranoia. Recommending to continue with the same plan of care and treatment as writer is new to the patient and needing extra assessment with the patient. Starting therapy due to patient past trauma. Plan/Recommendations: Psychotherapy 1-2 times per month. Continue to monitor. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to indicate Resident #68 had received psychotherapy services after the initial visit on 10/1/24. During an interview on 6/5/25 at 7:50 A.M., the Social Worker said she believed Resident #68 had been receiving counseling services in the fall of 2024. The Social Worker was not sure if a care plan addressing Resident #68's depression and anxiety was implemented prior to 6/3/25. During interviews on 6/4/25 8:28 A.M., and 6/5/25 at 11:56 A.M., the Director of Nursing (DON) said that she had spoken with Behavioral Health Services and was informed that Resident #68 had not received psychotherapy services and the agency could not say why. The DON reviewed Resident #68's careplans and did not see one specific to depression and anxiety prior to 6/3/25.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure for one Resident (#13), out of 5 applicable residents, out of a total sample of 24 residents, that monthly pharmacy medication regimen review recommendations were implemented in accordance with the physician/nurse practitioner response to the recommendations. Findings include: Resident #13 was admitted to the facility in September of 2020 and has diagnoses that include but are not limited to neurocognitive disorder with Lewy Bodies, unspecified dementia, moderate protein-calorie malnutrition. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #13 scored a 9 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately impaired cognition and requires partial/moderate assistance for self-care activities. Review of Resident #13's medical record indicated the consulting pharmacist provided recommendations during the Monthly Medication Regimen Review on 2/24/25 and 4/10/25. The medical record failed to indicate the consulting pharmacist finding/referrals for 2/24/25 and 4/10/25. Review of the documents provided by the Director of Nursing (DON) indicated the following: -A Consultant Pharmacist Recommendation dated 2/24/25. Resident is currently receiving Gabapentin in dose exceeding 300 mg a daily with estimated CrCl (a creatinine clearance laboratory test to see how well your kidneys are working) below 15ml/min. To decrease the risk of central nervous system adverse effects including ataxia, dizziness, and drowsiness consider taper Gabapentin to 100 mg 3 times daily, if appropriate Physician Prescriber Response: Agree; Will do, signed and dated 5/9/25 (74 days after the recommendation was made). -A Consultant Pharmacist Recommendation dated 4/10/25. Resident #13 is currently receiving Gabapentin in dose exceeding 300mg daily with and estimated CrCl below 15 ml/min. Of note, resident with recent falls documented in PCC (electronic medical record) To decrease the risk of central nervous system adverse effects including ataxia, dizziness, and drowsiness consider taper Gabapentin to 100 mg 3 times daily, if appropriate. Physician/Prescriber response indicated Agree; Will do 'Duplicate', dated 4/10/25. Review of Resident #13's Medication Administration Record (MAR) indicated Gabapentin 300 mg three times a day was administered to Resident #13 each of the following months: 2/1/25-2/28/25, 3/1/25-3/31/25, 4/1/25-4/30/25, 5/1/25-5/31/25 and 6/1/25-6/4/25. Therefore, the pharmacy recommendation was not implemented per the NPs response to the consultant pharmacist recommendation dated 2/24/25 and 4/10/25. During an interview on 6/4/25 at 1:51 P.M., the DON said she identified that pharmacy recommendations were behind in being addressed. The DON said that after the recommendations are reviewed and signed by the physician or nurse practitioner they should have been implemented. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/25 at 4:12 P.M., the Nurse Practitioner said she reviews the consultant pharmacist recommendations and if in agreement with the recommendation she would expect the recommendations to be implemented. The Nurse Practitioner said they were catching up on some of the pharmacy recommendations from a few months ago. The Nurse Practitioner reviewed orders and said Resident #13 continues on gabapentin 300 mg 3 times a day and the order should have been changed per the recommendation from the consulting pharmacist. During an interview on 6/5/25 at 11:08 A.M., the facility Medical Director (Resident #13's attending physician), said when they get pharmacy recommendations, and they agree with the recommendation the order should be placed in the medical record by the facility nurse.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, and interviews, the facility failed to ensure medications were stored in locked compartments on one nursing unit. Findings include: Review of the facility policy titled, Storage of Medications, dated as revised April 2007, indicated: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. -Only persons authorized to prepare and administer medications shall have access to the medication room, including keys. On 6/4/25 at 9:14 A.M., the surveyor observed the medication storage room was unlocked and unattended on the first floor Unit 1. The surveyor was able to open the door and gain access into the medication storage room. There were no staff present in or around the medication storage room. Residents were observed walking around the unit. On 6/4/25 at 10:08 A.M., the surveyor observed the medication storage room was unlocked and unattended on the first floor Unit 1. The surveyor was able to open the door and gain access into the medication storage room. There were no staff present in or around the medication storage room. Residents were observed walking around the unit. During an interview on 6/4/25 at 10:58 A.M., Nurse #7 said the medication storage room must be locked at all times and said she is not sure how it got unlocked. During an interview on 6/5/25 at 8:48 A.M., the Director of Nursing said medication storage rooms must always remain locked and said no one should have access to the medication rooms except the nursing staff who have the keys to unlock the doors to gain access.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on records reviewed and interviews, the facility failed to ensure it provided appropriate administrative oversight in a manner that enabled the facility to use its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility administration failed to ensure orientation, education and training was provided to all staff to provide competent, safe, and effective resident care as well as ensuring the governance and leadership members sustain a sufficient Quality Assurance Performance Improvement (QAPI) program during transitions in leadership and staffing. Specifically, the facility administration failed to: 1. Ensure effective systems were in place for education, and training for licensed staff to ensure competent, safe, and effective resident care related to wound management, and communication with consulting providers; 2. Establish and maintain an IPCP (Infection Prevention Control Program) designed to provide a safe, sanitary, and comfortable environment and to help prevent development and transmission of disease and infection. 3. Implement a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement, based on the facility assessment. 4. Develop an Antibiotic Stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. 5. Ensure that the IPCP was overseen by a qualified individual and has the appropriate knowledge and skills to care for the IPCP needs of the facility's resident population and to be responsible for the IPCP. 6. Ensure sufficient staffing according to the facility assessment and facility staffing requirements. Findings include: During the survey process it was identified that the Administration's failure to orient and educate staff on policies and procedures specifically related to residents' care and services that resulted in residents who required wound management and oversight and did not have the clinical competencies on file to provide wound assessment and wound dressing changes, resulting in the deterioration of a wound for one Resident. In addition, the facility failed to implement or maintain Enhanced Barrier Precautions and hand hygiene during a wound dressing treatment. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the survey process it was identified that the Administration's failure to implement an infection control program for identifying, tracking, monitoring and/or reporting of infections, communicable diseases and outbreaks among residents and staff resulted in the facility's failure to document information related to tracking and reporting of infections in the facility. The facility failed to document, monitor and report infections and document information for the months of August 2024, September 2024, October 2024, November 2024, December 2024, January 2025, February 2025, March 2025, April 2025, May 2025, June 2025. This included the failure to develop and implement an Antibiotic Stewardship Program, The facility failed to ensure an Infection Control Program was overseen by a qualified individual the has the appropriate knowledge and skills to care for the Infection Control Program needs of the facility's resident population and to be responsible for the Infection Control Program. The facility did not have a qualified Infection Preventionist working in the facility. Review of the facility staffing requirements indicated the facility was staffed below their determined minimum necessary for Licensed Nurses and CNA's and failed to provide the services of a RN for at least eight consecutive hours a day, seven days a week when no staffing waivers were in place. During an interview on 6/5/25 at 8:57 A.M., the Director of Nurses (DON) said training and clinical competencies must be completed upon hire and annually and said she expects staff to have been checked off as passing clinical competencies before coming off orientation. The DON said she has not completed any training or competencies with clinical staff and said she has voiced her concerns to Administration as well as the [NAME] President of Clinical Operations regarding the oversight and help needed. The DON said the facility does not have an Assistant Director of Nursing, Unit Managers or a full-time Infection Preventionist or Staff Development Coordinator at this time and said they have staff issues that need to be addressed. During an interview on 6/5/25 at 9:39 A.M., the Administrator said it is his expectation that the clinical staff are trained appropriately and have the required completed clinical competencies on file according to the facility assessment. The Administrator said he could not speak of what education had been done at the facility and did not know if any new hires had been oriented, educated, assessed for competency, or had dementia training. The Administrator said they have been without key management roles since he started in August 2024, including an Assistant Director of Nursing or a Staff Educator since last fall and said they had a staff member helping out but she is no longer here. The Administrator said the facility does not have an Infection Preventionist at this time and said he is unaware of who is managing the Infection Control Program. The Administrator said the Director of Nursing position had changed multiple times since his arrival to the building in August 2024 and said that he could provide no documentation of clinical concerns brought to the QAPI meetings including infection control measures, clinical competent staffing and training/education, and quality of care or quality of life that was comprehensive and measurable with goals. The Administrator said they have been facing staffing challenges and working on hiring more staff. During an interview on 6/5/24 at 11:19 A.M., the Medical Director said he would expect that the facility implements the required training and competencies for all staff to care for the needs of the residents in the facility. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/05/25 at 12:36 P.M., the [NAME] President of Clinical Operations said the facility must provide the care and services that are outlined and offered per the facility assessment and said staffing has been a challenge for the facility. Despite the Nursing Home Administrator voicing knowledge that there had not been an Assistant Director of Nursing, Staff Educator, or a dedicated qualified Infection Preventionist in the building since August 2024, and that new staff hires in that time frame were not provided with orientation, or assessed for competency, the facility's administrative team failed to develop a plan to ensure the facility could safely provide the services to meet the needs of the residents. Further review indicated, the facility Administration failed to make efforts to identify areas of concern, such as sufficient staffing, Infection Control Program including implementing an Antibiotic Stewardship and make attempts to improve the quality-of-care delivery.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on Facility Assessment review and staff interview, the facility failed to identify resources based on the resident population to determine the necessary care, support services, and educational resources (in-servicing) needed to care for residents. Specifically, the facility failed to address sufficient staffing, education resources and include a competency-based approach, including competencies necessary upon orientation and/or annually, to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. In addition, The facility failed to implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting of infections, communicable diseases and outbreaks among residents and staff and failed to have a qualified Infection Preventionist with completed specialized training in infection prevention and control. Findings include: Review of the Facility Assessment, dated as reviewed with the QAA/QAPI committee, in May 2025, indicated the following: Staff training/education and competencies -Considerations: Training's will be conducted based on regulation, facility need and acuity or admissions. -Infection Control: Conducted on hire, annually and retraining as needed based on CDC (Center for Disease Control) and DPH (Department of Public Health) updates for COVD-19 [SIC] and other infections. Staff Competencies: Staff Type and Timing (on hire, annually, PRN (as needed), on demand) -Person Centered Care: All staff on hire, annually and as needed. -Activities of Daily Living All staff on hire, annually and as needed. -Infection Control: Hand Hygiene, Universal Precautions, Protective Equipment. -As needed with updates from DPH, CMS (Centers for Medicaid and Medicare Services) and CDC regarding COVID-19 following all CDC guidelines. -Medication Administration: All staff on hire, annually and as needed. -Measurements - Vitals and intake and output: All staff on hire, annually and as needed. -Resident Assessment: All staff on hire, annually and as needed. -Caring for Residents with dementia, Alzheimer's, and Cognitive Impairments. 8 hours of training upon hire and 4 hours upon annual recertification. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Caring for Residents with Mental and Psychosocial Disorders: All appropriate staff upon hire, annually and as needed. -Non-Pharmacological Management of Responsive Behaviors: All staff on hire, annually and as needed. -Caring for Residents with Trauma/ PTSD (Post Traumatic Stress Disorder): All staff on hire, annually and as needed. -Clinical Competencies: All staff on hire, annually and as needed/ As COVID-19 protocols change. -Evaluation of Infection Prevention and Control Program: The facility looks at infection control through its morning clinical review. Individuals are tracked and monitored on the line listings. Line listing review identifies trends. Information is sent to the lab. This information is reviewed by the lab and processed on an infection control report which is returned to the facility. Infection control is reviewed monthly and quarterly at QAPI meetings and as needed through ad-hoc meetings if trends are identified. The infection control review includes nursing, administration, medical director and lab/X-ray provider. All staff is educated on infection control standards. The facility partners with vendors who educate and uphold infection control standards. -Staffing ratios for Nurses and Certified Nursing Aides (CNA's): -4 Licensed Practical Nurses (LPN) / Registered Nurses (RN) Full time days - weekdays and weekends. -4 LPN / RN Full time evening - weekdays and weekends. -2 LPN / RN Full time nights - weekdays and weekends. -8 CNA's Full time days - weekdays and weekends. -8 CNA's Full time evenings - weekdays and weekends. -4 CNA's Full time nights - weekdays and weekends. -Staff type/Plan: Infection Control and Prevention. 1 Full time Infection Control/ADON -weekdays and weekends if needed. During an interview on 6/5/25 at 8:52 A.M., the Director of Nurses (DON) said training and clinical competencies must be completed upon hire and annually according to the facility assessment and said she has not completed any training or competencies with clinical staff and is covering the role of infection preventionist and educator since she started. The DON said she does not have training or clinical competencies on file as required by all staff and was unable to locate any during survey. The DON said the facility needs to have a designated Infection Preventionist to monitor and implement the program and said staffing has been an issue. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/5/25 at 9:38 A.M., the Administrator said it is his expectation that the clinical staff are trained appropriately and have the required completed clinical competencies on file according to the facility assessment. The Administrator said he is not aware of what competencies are required and said the Staff Educator or Assistant Director manages that process and continued to say the facility does not have an Assistant Director or Staff Educator employed at this time. The Administrator said a qualified Infection Preventionist is not assigned to the building at this time and said it is the expectation that residents receive the care and services outlined in the facility assessment and that sufficient staffing needs are met.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interviews, the facility failed to ensure that the Quality Assurance Committee developed and implemented an effective Performance Improvement Plan (PIP), including a corrective action plan with effective monitoring for Pressure ulcers, infection control surveillance plan, adequate Nursing staffing, and annual wound competencies. Specifically, (i) the facility failed to develop and implement an action plan after Nursing staff failed to implement recommendations for treatment received from the wound consultant, resulting in the deterioration of a wound for one Resident, #24 (ii) develop and implement an action plan for infection control surveillance planning for identifying, tracking, monitoring, reporting infections, and communicable diseases (iii) failed to develop and implement and action plan ensuring there was sufficient and qualified staff at all times to provide Nursing and related services to meet the resident's needs safely in a manner that promotes each resident's rights, physical, mental and psychosocial well-being (iv) failed to develop and implement an action plan ensuring nursing staff were trained and demonstrated the competencies and skills necessary to identify, assess, evaluate, intervene and respond to pressure ulcers. Findings include: A review of the facility policy titled 'Quality Assurance Performance Improvement (QAPI) Plan' with a revision date of 11/2019 indicated the following: -To maintain an effective, interdisciplinary, comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of this care, improvements in quality of care, evaluations of changes made to resident care, and optimal resident quality of life. -The QAPI program consists of data collection, benchmarking, root cause analysis, data analysis, trending, and evaluation for selected performance indicators. The performance indicators to be examined are categorized into the following areas: -Clinical Indicators-Pressure Ulcers. -Resident Experience-Resident Care and Grooming. -Special performance improvement projects-These are performance indicators to be selected based on the identified needs of the facility. A review of the QAPI binder indicated the following quarterly meetings were conducted and dated 10/15/24, 1/21/25, and 4/15/25. The monthly QAPI meeting summaries attached to each meeting failed to indicate the specific action plans for implementing recommendations from the wound consultant, implementing the infection control surveillance plan which include the Antibiotics stewardship program and line listing, having sufficient and qualified staff to provide nursing and related services to meet the resident's needs, and ensuring nursing staff were trained and had annual competencies and skills necessary to identify, assess, evaluate, intervene and respond to pressure ulcers. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the QAPI Sign-In Sheet dated 1/21/25, reviewed for the months of October 2024 - December 2024, failed to indicate an Assistant Director of Nurses/Staff Development Coordinator, and Infection Preventionist, (ADON/ SDC/ IP, attended the meeting and the signatures section was left blank. Further review of the QAPI Sign-In Sheet dated 10/15/24, Reviewed for the months of July 2024 - September 2024, failed to indicate an Assistant Director of Nurses (ADON) / Staff Development Coordinator (SDC)/ Infection Preventionist (IP), attended the meeting and the signatures section was left blank. During a telephone interview on 6/6/25 at 4:04 P.M., the Director of Nurses said she started working at the facility in April 2025, she said she was aware of the wound concerns in the facility, she said she identified the root cause as a culture in the facility where the nurses believe they should not be adding the new wound recommendations made by the wound consultant to the physicians orders. The DON provided a copy of a PIP she started dated 5/1/25 that addressed wound recommendations not being added to the physician's orders and education to nursing staff regarding this PIP dated 5/9/25. The DON said this PIP will be introduced in the next QAPI meeting on 6/10/25. The DON said there were no PIPs for wound recommendations, implementing infection control surveillance plan for identifying, tracking, monitoring or reporting infections, sufficient staffing and annual wound competencies that had been initiated prior to her start date. The DON said the expectation is for systemic issues to be identified by the interdisciplinary team and brought to QAPI so action plans can be initiated to identify the root causes and fix the issues. During a telephone interview on 6/9/25 at 10:05 A.M., the Administrator said he started working in the facility in August 2024. The Administrator said he has been present in the facility for three quarters and has managed three quarterly meetings, dated 10/15/24, 1/21/25, and 4/15/25. The Administrator said that during his first 90 days, he was aware of wound care issues, staffing issues that included a lack of an Infection Preventionist (IP), whose other role would include Staff Development Coordinator (SDC) and Assistant Director of Nurses (ADON). The Administrator said he did work on getting a new wound care provider, a new Medical Director (MD), and started an aggressive new hiring process. The Administrator said he did not initiate PIPs for the specific wound care concerns where nursing staff were not adding wound recommendations made by the wound consultant to the physicians orders, sufficient staffing to provide nursing services on the units, implement an infection control surveillance plan to track, monitor and report infections, and making sure nursing staff received annual wound care competencies because he was not aware of these specific concerns. The Administrator said he did have a permanent DON in October 2024, November 2024, December 2024, January 2025, February 2025, and March 2025, with an interim DON who filled in until April 2025 when the current DON started. The Administrator said the DON did not inform him of these specific issues. The Administrator said the expectation is that these issues are identified by the interdisciplinary team, then brought to QAPI so an action plan can be initiated. The Administrator said he had an IP employee who would also have had the title of SDC and ADON for a short while and not the majority of the time in his first 90 days. The Administrator said he was not aware of the lack of an infection control surveillance plan for identifying and tracking infections as expected by the regulations, and staff annual wound competencies not being completed. The Administrator said if he was aware, he would have initiated an action plan in QAPI to fix these systemic issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident # 63 was admitted to the facility in [DATE] with diagnoses including hypertension. A review of the most recent Minimum Data Set (MDS) assessment, dated [DATE] failed to indicate a Brief Interview for Mental Status (BIMS) score. A review of Resident #63's care plan initiated [DATE] indicated that Resident #63 makes his/her own health decisions. A review of Resident #63's [DATE] physician's orders indicated the following: -Incision right hip. Start date [DATE]. -Wound vacuum settings 125 mmhhg (milliliters of mercury), change Monday-Wednesday-Friday. Start date [DATE]. -Cefazolin Sodium injection solution, use 2 grams intravenously every 8 hours for surgical incision until [DATE]. Start date [DATE]. On [DATE] at 8:46 A.M., the surveyor observed Resident #63 in bed. There was no Enhanced Barrier Precautions (EBP) signage and a Personal Protective Equipment (PPE) cart prior to room entry. On [DATE] at 8:04 A.M., 9:25 A.M., and 2:15 P.M., the surveyor observed Resident #63 in bed. There was no Enhanced Barrier Precautions (EBP) signage and a Personal Protective Equipment (PPE) cart prior to room entry. On [DATE] at 4:58 P.M., the surveyor observed Nurse #6 hanging the intravenous (IV) line. Nurse #6 was wearing gloves only, no other PPE. During an interview on [DATE] at 4:58 P.M., Nurse #6 said the Resident has a (Peripherally Inserted Central Catheter) PICC line and does not require any precautions. During an interview on [DATE] at 8:22 A.M., the Director of Nurses said EBP signage and a PPE cart should be available prior to entering the Resident's room because he/she has a PICC line and a right hip surgical incision with a wound vacuum. She said EBPs should be in place to prevent infections.3. Review of the facility policy titled Infection Control Policy and Procedure, undated, indicated the following: -To help prevent the development and transmission of communicable disease and infection in the Facility and to ensure that the Facility: I. Develops and implements an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible and reviews and updates the IPCP annually and as necessary. This would include revision of the IPCP as national standards change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	II. Designates one or more individual(s) as the Infection Preventionist (IP) who are responsible for the facilities IPCP. Establishes Facility wide systems for the prevention, identification, investigation, and control of infections of residents, staff (which includes employees, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, and students in the facilities nurse aid training programs or from affiliated academic institutions) and visitors. This includes an ongoing system of surveillance designated to identify possible communicable diseases or infections before they can spread to other persons in the Facility and procedures for reporting possible incidents of communicable diseases or infections. -An antibiotic Stewardship Program that includes antibiotic use protocols and a system to monitor antibiotic use. -A system for recording incidents identified under the Facility's IPCP and the corrective actions taken by the Facility. III. Infection Preventionist -IPCP should develop and implement IPCP with leadership support and accountability via the participation of the medical director consulting pharmacist nursing and administrative leadership utilizing and working collaboratively with these team members. The IP should review and approve infection prevention and control training topics and content as well as ensure facility staff are trained on the IPCP. Review of the Facility assessment dated [DATE], indicated the following: Diseases /conditions, physical and cognitive disabilities. -Infectious Diseases: COVID-19, Skin and Soft Tissue Infections, Respiratory Infections, Tuberculosis, Urinary Tract Infections, Infections with Multi-Drug Resistant Organisms (MDRO), Septicemia, Viral Hepatitis, Clostridium difficile, Influenza, Scabies, Legionella's. -Resident Support/Care Needs: Infection prevention and control. Identification and containment of infections, prevention of infections. COVID-19 CDC/DPH (Center of Disease Control / Department of Public Health) protocols. Management and preventions of MDRO's. Consult with LBOH (Local Board of Health) and MA (Massachusetts) Epidemiology when required and as needed. -Management of Medical Conditions: Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failures, diabetes, chronic obstructive pulmonary disease (COPD), gastroenteritis, infectious such as UTI (Urinary Tract Infection) and gastroenteritis, pneumonia and hypothyroidism. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Evaluation of Infection Prevention and Control Program: The facility looks at infection control through its morning clinical review. Individuals are tracked and monitored on the line listings. Line listing review identifies trends. Information is sent to the lab. This information is reviewed by the lab and processed on an infection control report which is returned to the facility. Infection control is revived monthly and quarterly, at QAPI (Quality Assurance Performance Improvement Plan) meetings and as needed through ad-hoc meetings if trends are identified. The infection control review includes nursing, administration, medical director, and lab/x-ray provider. All staff is educated on infection control standards. The facility partners with vendors who educate and uphold infection control standards. During the survey period the surveyor requested infection control program information for tracking infections, including line listings and reporting data. The facility failed to have any documented information related to tracking and reporting of infections in the facility. Further review indicated the facility failed to have any documented information for the months of [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], February 2025, [DATE], [DATE], [DATE], [DATE]. During the course of the survey the facility was unable to provide surveillance data and documentation of follow-up activity in response to the active antibiotic use in the facility. Review of the electronic Antibiotic Order Listing report dated [DATE], indicated the following prescribed antibiotics for the following infections: [DATE] Antibiotics for skin infections. [DATE] Antibiotics for leg wound infections, Eye infections, Urinary Tract Infections, Pneumonia, Skin infections. [DATE] Antibiotics for Clostridium difficile (C.diff.)- (severe diarrhea that is highly contagious), Right Hip wound infection, Head Lice infection, Urinary Tract Infections, Pneumonia, Hand infection, Bullous Pemphigoid (blisters and itching on skin). [DATE] Antibiotics for Wound infections, Eye infection, Urinary Tract Infections, Skin abscess. February 2025 Antibiotics for Pneumonia, Abscess, Bacterial Infections. [DATE] Antibiotics for Pneumonia, Bacterial Infections, Cellulitis, COVID-19, Urinary Tract Infections. [DATE] Antibiotics for skin rashes, Pneumonia. [DATE] Antibiotics for wound infections. [DATE] Antibiotics for Urinary Tract Infections, Skin Infections. [DATE] COVID +, C.diff +, Right Toe infection, Urinary Tract Infections, Pneumonia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:15 A.M. the Director of Nurses (DON) said infections and surveillance of infections should be tracked, monitored, documented and reported and said the facility does not have an active Infection Preventionist in place and said she does not have any line listings in place. The DON said she does not know the rate of infections and said she has no data available and relies on what is reported to her by nursing staff. The DON said she is new to the facility and started in [DATE] and said she is unaware of the infections and has no information available regarding tracking, surveillance or outbreak information available. The DON said she does not have any training or certification completed and was unable to provide the surveyors with proof of certification of anyone overseeing the program. During an interview on [DATE] at 9:56 A.M., the Administrator said the Infection Control program should be implemented and followed and said he is not aware of the infections in the building and said he hires staff specialized in clinical areas to manage those issues and expects the requirements to be followed. During an interview on [DATE] at 12:50 P.M., the [NAME] President of Clinical Operations said the facility has been without an Infection Preventionist and said she did not conduct any infection control tracking, reporting, surveillance or follow-up activity within the facility and said it is her expectation that the Infection Prevention and Control program is managed daily. The [NAME] President of Clinical Operations said they do not have an infection preventionist in the building. 4. Review of the facility policy titled, Legionella Water Management Program to Reduce Growth and Spread dated [DATE], indicated the following: -The Facility will identify and manage hazardous conditions that support growth and spread of Legionella. -Water Management Program Team will include the facility Infection Prevention, Director of Maintenance, Administrator and other members of the safety committee. The Facility must conduct a risk assessment to identify where the Legionella and other opportunities for waterborne pathogens could grow and spread in facility water system and assess how much risk the hazardous condition in those water system pose. -Review the elements of the water management program at least once a year to make sure the program is running as designed and is effective. -Refer to flow diagram: Areas where Legionella could grow and spread. Review of the Water Management documents submitted during survey, failed to include an assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread and did not contain measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them. During an interview on [DATE] at 1:59 P.M., the Maintenance Director said he has no involvement with the Legionella program and said it is managed by the Regional Maintenance Director. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 12:49 P.M., the Administrator said the facility is required to have a program in place to monitor for Legionella and said he expects it to be implemented and followed. The Administrator said he does not have any information regarding the program and said it is managed by the Regional Maintenance Director. During an interview on [DATE] at 1:13 P.M., the Regional Maintenance Director said they follow the facility policy and test if needed and said he is not aware of any flow diagram and said the Facility has not had any issues. Based on observations, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two Residents (#21 and #63) out of a total sample of 24 Residents. Specifically, 1. For Resident #21 the facility failed to implement or maintain Enhanced Barrier Precautions and hand hygiene during a wound dressing treatment. 2. For Resident #63 the facility failed to implement Enhanced Barrier Precautions. 3. The facility failed to implement an infection control surveillance plan for identifying, tracking, monitoring and/or reporting of infections, communicable diseases and outbreaks among residents and staff. 4. The facility failed to have a documented water management program. Findings include: Review of the Centers for Disease Control (CDC) website indicated the following, dated [DATE]: -Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 1. Resident #21 was admitted to the facility in [DATE] with diagnoses that included cerebral infarction and need for assistance with personal care. Review of Resident #21's most recent Minimum Data Set (MDS) Assessment, dated [DATE], indicated that the Resident was unable to participate in the Brief Interview for Mental Status exam and was assessed by staff to have severe cognitive impairment. Further review of the MDS indicated that the Resident has one or more unhealed pressure ulcer. The Resident is coded as having one stage 3 and one stage 4 pressure ulcer that were both present on admission. Review of Resident #21's active physician's orders indicated the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Unstageable pressure ulcer sacrum: Cleanse wound and peri-wound area with wound cleanser, pat and dry. Apply Calcium alginate with silver. Cover with bordered Form dressing. Daily And PRN (as needed), dated [DATE]. -left hip dry scab: apply Skin prep Topically every day and evening shift, dated [DATE]. Review of Resident #21's most recent wound consultant note, dated [DATE], indicated the following: -A stage 4 pressure ulcer to the sacrum, measuring 3 centimeters (cm) x 3.9 cm x 0.2 cm in depth. -A stage 3 pressure ulcer to the gluteal cleft, measuring 6 cm x 4 cm x 0.1 cm in depth. During a wound dressing observation on [DATE] at 10:01 A.M., Nurse #1 entered Resident #21's room. There were no signs on the doorway or door to the Resident's room indicating a need for any EBP. Nurse #1 and the assisting nurse both washed their hands and applied gloves upon entering the room. Neither nurse donned a gown. Nurse #1 removed a dressing from Resident #21's left hip. Nurse #1 then removed her gloves and without performing hand hygiene donned a new pair of gloves. She applied skin prep to the area of the wound, removed her gloves, and again, without performing hand hygiene, applied another pair of gloves to apply the covering over the wound. Nurse #1 then changed her gloves without performing hand hygiene and performed the treatment to Resident #21's sacrum. Nurse #1 removed the old dressing, changed her gloves without performing hand hygiene and then completed the wound dressing. During an interview on [DATE] at 10:21 A.M., Nurse #1 said that residents who have wounds should be on EBP. She said she should have worn a gown to change the dressing on Resident #21, but she did not. She said that the Infection Preventionist is responsible for managing who is on EBP, and residents on EBP would have a sign on the door or doorway of their room and a physician's order to utilize them. She also said that she should have sanitized her hands in between all her glove changes, but she did not. She said that not implementing EBP places the resident at risk for infection. During an interview on [DATE] at 1:37 P.M., the Director of Nurses (who is also covering as the Infection Preventionist at this time) said that she would expect that a resident who has wounds is on EBP. She said she would expect that when nurses are providing wound care, they are wearing a gown and gloves. She said that not implementing EBP would pose a risk for infection. During an interview on [DATE] at 11:15 A.M., the Medical Director said that he was not aware that EBP were not being implemented and would expect that to prevent the spread of infections, staff would implement EBP and other infection control procedures.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interview the facility failed to implement an Antibiotic Stewardship Program to promote and monitor the appropriate use of antibiotics. Findings include: Review of the facility policy titled Antibiotic Stewardship, dated as revised December 2016 indicated the following: -Antibiotics will be prescribed and administered to residents under the guidance of the facilities antibiotic stewardship program. -The purpose of our Antibiotics Stewardship Program is to monitor the use of antibiotics in our residents. -Orientation, training and education of staff will emphasize the importance of Antibiotic Stewardship and will include how appropriate use of antibiotics affects individual residents and the overall community. -Training and education will include emphasis on the relationship between antibiotic use and: a. Gastrointestinal disorders; b. Opportunistic infections (e.g., C.difficile, candida albicans, etc.). c. Medication interactions; and d. The evolution of drug resistant pathogens. During the survey period the surveyor requested infection control line listings and antibiotic stewardship information. The facility failed to have any documented information related to tracking, follow up or review with the physician or nurse practitioner following the initiation of the antibiotics for 7 out of 7 active physician antibiotic orders prescribed. Further review indicated the facility failed to have any documented information for the months of August 2024, September 2024, October 2024, November 2024, December 2024, January 2025, February 2025, March 2025, April 2025, May 2025, June 2025. During an interview on 6/5/25 at 9:12 A.M. the Director of Nurses (DON) said antibiotics should be tracked, documented and reported and said the facility does not have an active Infection Preventionist in place and said she is told in morning meeting if someone is on an antibiotic but has not been tracking or monitoring specific data regarding the antibiotic stewardship program. The DON said she does not have any line listings in place. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/5/25 at 9:52 A.M., the Administrator said the Infection Control and Antibiotic Stewardship program should be tracked and followed and said the facility has been without an Infection Preventionist and said he had a staff member helping but not full time and said she is no longer here.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of the Facility Assessment, the facility failed to designate one or more individuals as the infection preventionist who are responsible for the facility's infection prevention and control plan. Specifically, the facility failed to have a qualified infection preventionist with completed specialized training in infection prevention and control. Findings include: Review of the facility policy titled Infection Control Policy and Procedure, undated, indicated the following: -To help prevent the development and transmission of communicable disease and infection in the Facility and to ensure that the Facility: -Designates one or more individual(s) as the Infection Preventionist (IP) who are responsible for the facilities IPCP. Establishes Facility wide systems for the prevention, identification, investigation, and control of infections of residents, staff (which includes employees, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, and students in the facilities nurse aid training programs or from affiliated academic institutions) and visitors. This includes an ongoing system of surveillance designated to identify possible communicable diseases or infections before they can spread to other persons in the Facility and procedures for reporting possible incidents of communicable diseases or infections. -Infection Preventionist a. IPCP should develop and implement IPCP with leadership support and accountability via the participation of the medical director consulting pharmacist nursing and administrative leadership utilizing and working collaboratively with these team members. The IP should review and approve infection prevention and control training topics and content as well as ensure facility staff are trained on the IPCP. Review of the Facility assessment dated [DATE], indicated the following: Staff type/Plan: Infection Control and Prevention. 1 Full time Infection Control/ADON -weekdays and weekends if needed. Review of the facility document titled Designation of Infection Preventioninst undated, failed to include any information and was left blank. During an interview on 6/5/25 at 9:10 A.M., the Director of Nursing (DON) said she started in this role at the end of April 2025. The DON said she does not have the required infection control certification, and the facility does not have an approved Infection Preventionist working in the facility. The DON said she discussed this with the Administrator and [NAME] President of Clinical Operations and said she is trying her best to monitor the infections. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/5/25 at 9:56 A.M., the Administrator said he was aware that the facility did not have an infection preventionist in the building. During an interview on 6/5/25 at 12:54 P.M., the [NAME] President of Clinical Operations said the facility has been without an Infection Preventionist and said they had a staff member helping with the role but is no longer here.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to offer the COVID-19 (Coronavirus disease) vaccine to three out of a sample of five employees. Specifically, the facility failed to offer COVID-19 vaccinations during the new hire orientation. Findings include: Review of the Facility assessment dated [DATE], indicated the following: -Infection prevention and control. COVID-19 Response - Follow all CDC and DPH Guidelines. A review of five employee health records indicated three out of the five employees had not been vaccinated for COVID-19. During an interview and record review on 6/5/25 at 8:32 A.M., the Human Resources Director said she will request copies of COVID-19 vaccination cards and notify the Director of Nurses if a staff member does not have one and said she does not keep track of vaccinations and does not know if staff have been offered the COVID-19 vaccination during their new hire orientation. During an interview on 6/25/25 at 8:55 A.M., the Director of Nurses (DON) said all immunizations are received by Human Resources and said she does not track immunizations in the building and expects the information to be tracked. The DON said she does not know who is tracking vaccinations in the facility. During an interview on 6/5/25 at 9:58 A.M., the Administrator said he expects the vaccinations to be tracked, monitored upon hire and documentation kept on file and said vaccines should be offered to all staff members. The Administrator said he was not sure who was tracking the vaccination status and said they do not have an Infection Preventionist at this time. During an interview on 6/5/25 at 12:54 P.M., the [NAME] President of Clinical Operations said the facility has been without an Infection Preventionist and said they had a staff member helping with the role but is no longer here.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on document review and interview, the facility failed to maintain records of Certified Nurse Aide (CNA) trainings for continuing competency that included no less than 12 hours of mandatory trainings per year for each CNA employed by the facility for two out of five CNAs reviewed. Findings include: During an interview on 6/5/25 at 1:48 P.M., the Director of Nurses (DON) said all staff education is tracked by the Human Resource Director (HR) to ensure the education is completed. On 6/4/25 at 10:14 A.M., the survey team requested proof of 12 hours of CNA training time for five employees. Review of the education records, for CNA #2 failed to indicate education had been completed and documented as required. Review of the education records, for CNA #3 failed to indicate education had been completed and documented as required. During an interview on 6/5/25 at 8:39 A.M., the DON said she was unable to provide the surveyor with additional education records for CNA #2 or CNA #3. The DON said she would expect any education and training to be kept in the employee folders. During an interview on 6/5/25 at 8:24 A.M., the Human Resource Director (HR) said she manages the onboarding and policy training for staff during orientation and the DON completes the clinical training for staff and makes the determination as to what she educates them on. The HR Director said she does not know what is required and could provide no additional education records for CNA #2 or CNA #3.