STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225232	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Holyoke	282 Cabot Street Holyoke, MA 01040

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on record review and interview, the facility failed to ensure that a quarterly review assessment was completed as required to ensure critical indicators of gradual status change were monitored for one Resident (#58) out of a total sample of 19 residents. Specifically, for Resident #58, the facility failed to ensure that the Resident was reviewed between comprehensive assessments with respect to the Minimum Data Set (MDS) items specified in the quarterly assessment. Findings include: Review of the RAI (Resident Assessment Instrument) Version 1.19.1 dated October 2024, indicated the following: -The Quarterly assessment is an OBRA (Federal law, known as the Omnibus Budget Reconciliation Act of 1987) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. -It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. -The ARD (Assessment Reference Date) must not be more than 92 days after the ARD of the most recent OBRA assessment of any type. Resident #58 was admitted to the facility in February 2023. Review of the clinical record indicated an MDS assessment was submitted for the Resident on 2/5/25. Further review of the clinical record failed to indicate that any other subsequent quarterly assessment was completed. During an interview on 6/20/25 at 12:20 P.M., the MDS Nurse said a quarterly MDS assessment should have been completed in May 2025 for Resident #58, but one was not completed. The MDS Nurse said she refers to the RAI Manual for timeliness of MDS assessments.

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

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed and transmitted within 14 days of completion for two Residents (#26, #45) reviewed, out of a total of three residents reviewed for MDS records over 120 days, and for one Resident (#25) reviewed, out of a total of three resident reviewed for closed records. Specifically, the facility failed: 1. For Resident #26, to complete a Discharge MDS Assessment. 2. For Residents #45 and #25, to complete Death in the Facility Tracking Records resulting in inaccurate resident tracking. Findings include: Review of the Resident Assessment Instrument (RAI) Version 1.19.1 dated [DATE] indicated the following: -Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. -Must be completed .within 14 days after the discharge date . -Must be submitted within 14 days after the MDS completion date . Review of the RAI Manual Version 1.19.1 dated [DATE] indicated the following: -A Death in Facility Tracking Record must be completed when the resident dies in the facility. -Must be completed within 7 days after the resident's death -Must be submitted within 14 days after the resident's death. 1. Resident #26 was admitted to the facility in February 2024 with a diagnosis of Sepsis. Review of the Nursing Progress Note, dated [DATE], indicated Resident #26 was discharged from the facility back to his/her home in the community. Review of Resident #26's MDS Assessments failed to indicate that a Discharge MDS Assessment had been completed at the time of Resident #26's discharge. During an interview on [DATE] at 8:43 A.M., the MDS Nurse said a Discharge MDS Assessment for Resident #26 should have been completed but was not. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	2A. Resident #45 was admitted to the facility in [DATE] with a diagnosis of Malignant Neoplasm of the skin (skin cancer). Review of Resident #45's Registered Nurse (RN)/Physician Assistant (PA)/Nurse Practitioner (NP) Pronouncement of Death, dated [DATE], indicated he/she expired in the facility on [DATE]. Review of Resident #45's MDS Assessments failed to indicate a Death in the Facility Tracking Record had been completed when Resident #45 expired on [DATE]. During an interview on [DATE] at 8:43 A.M., the MDS Nurse said a Death in the Facility Tracking Record for Resident #45 should have been completed but was not. B. Resident #25 was admitted to the facility in [DATE]. Review of Resident #25's nursing progress notes indicated the following: -the Resident expired in the facility on [DATE]. Review of the MDS Assessments failed to indicate a Death in the Facility Tracking Record had been completed when the Resident expired on [DATE]. During an interview on [DATE] at 1:03 P.M., the MDS Nurse said that a Death in the Facility Tracking Record should have been completed for Resident #25, but one was not. The MDS Nurse said that she refers to the RAI Manual for accuracy and timeliness of MDS Assessment completion.

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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** 4. Resident #44 was admitted to the facility in August 2023 with diagnoses including Peripheral Vascular Disease, Type 2 Diabetes, and Chronic Kidney Disease. Review of the MDS Assessment, dated 3/19/25, indicated Resident #44 utilized an anticoagulant (blood thinner) medication within the seven day look back period (3/13/25 through 3/19/25). Review of Resident #44's March 2025 Physician's orders failed to indicate any orders for an anticoagulant medication. Review of Resident #44's March 2025 Medication Administration Record (MAR) failed to indicate any documentation that Resident #44 was administered an anticoagulant medication during the month of March 2025. During an interview on 6/20/25 at 10:05 A.M., the MDS Nurse said Resident #44 was not on an anticoagulant medication during the look back period for the MDS assessment dated [DATE], and the use of anticoagulant medication was coded incorrectly. 5. Resident #65 was admitted to the facility in March 2025 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, and Asthma. On 6/17/25 at 9:18 A.M., and 6/20/25 at 8:04 A.M., the surveyor observed Resident #65 with a nasal cannula in place and a portable oxygen tank delivering Oxygen via the nasal cannula at 2 liters per minute (LPM). Review of Resident #65's June 2025 Physician's orders indicated the following orders: -Oxygen at 0-4 LPM continuous to keep oxygen saturations above 90%, start date 3/28/25. Review of Resident #65's care plan titled Resident #65 had altered respiratory status/difficulty breathing . initiated 3/6/25, indicated the following interventions: -Oxygen Settings: Oxygen 1-4 via nasal cannula .initiated 4/17/25 Review of the MDS Assessment, dated 6/3/25, indicated Resident #65 had not utilized oxygen while a Resident at the facility. During an interview on 6/20/25 at 2:50 P.M., the MDS Nurse said Resident #65 had been utilizing Oxygen since his/her admission to the facility and the MDS Assessment, dated 6/3/25, was coded inaccurately and should have indicated Resident #65 had utilized Oxygen while a Resident at the facility. Based on observation, interview, and record review, the facility failed to accurately code Minimum Data Set (MDS) Assessments for six Residents (#83, #55, #91, #44, #65, and #93), out of a total sample of 19 residents. Specifically, the facility failed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. For Resident #83, to accurately code medications administered when the Resident received Insulin daily. 2. For Resident #55, to accurately code a pressure injury that was present upon admission to the facility. 3. For Resident #91, to accurately code a pressure injury that was present during the MDS observation look back time period. 4. For Resident #44, to accurately code medications administered while in the facility when the Resident was coded as utilized an anticoagulant (blood thinner) medication but was not ordered for an anticoagulant. 5. For Resident #65, to accurately code the use of oxygen therapy while in the facility when the Resident was coded as had not utilized oxygen, and was ordered for continuous oxygen and using oxygen. 6. For Resident #93, to accurately complete a Discharge MDS Assessment, when the Resident was coded as discharged to an acute hospital and the Resident was discharged to home. Findings include: 1. Resident #83 was admitted to the facility in October 2024 with diagnoses including Type 2 Diabetes Mellitus (DM) without complications. Review of the Resident's MDS Assessment, dated 5/28/25, indicated that the Resident had not been administered any Insulin or had any injections during the MDS observation period. Review of Resident #83's June 2025 Physician's orders included: -Insulin Glargine Subcutaneous Solution 100 UNIT/ML (milliliter), Inject 18 units subcutaneously (under the skin) at bedtime for diabetes. (Start date 12/18/24) Review of the Resident's May 2025 Medication Administration Record (MAR) indicated that the Insulin Glargine injection was administered to the Resident each evening as ordered by the Physician. During an interview on 6/24/25 at 11:20 A.M., the MDS Nurse said that the Resident did receive Insulin injections each evening during the MDS lookback observation period and the correct response on the MDS dated [DATE] should have been 7 days of injections and 7 days of Insulin administration. The MDS Nurse said the MDS dated [DATE] was coded inaccurately for injections and Insulin. 2. Resident #55 was admitted to the facility in September 2024 with diagnoses including corns and callosities, muscle weakness, and Dementia. Review of the Physician's Progress Note, dated 10/21/24, included . left foot has a large callous to the base of foot which has been there for years per pt (patient). He/she has a new open area towards the base of the mid foot/ankle that is open and bleeding. Pt states his/her callous was taken off and it is attached to his/her sock. Foot was placed in a soapy bath of warm water and will have a dressing placed daily. Wound Consult to see in the near future. (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 Initial Progress Note by the Wound Care Physician, dated 10/23/24, indicated that the pressure ulcer to the left plantar heel began as a callous which was present when the Resident was admitted to the facility and was considered community acquired. The Wound Care Physician continued to evaluate and treat the Resident's left plantar heel. The follow-up progress note, dated 4/22/25, noted that the open area on the left plantar heel was the result of a callous falling off that was present upon admission to the facility. Review of the facility Weekly Wound Rounds Report, dated 4/22/25, indicated that the Left heel plantar Stage 3 pressure ulcer was present upon admission to the facility. Review of the MDS Assessment, dated 4/23/25, indicated that the Stage 3 pressure area was not present upon admission to the facility. During an interview on 6/25/25 at 12:22 P.M., the Assistant Director of Nursing (ADON) said the open area on the Resident's left plantar heel was a result of a callous falling off. The ADON said that the callous was present upon the Resident's admission to the facility. During an interview on 6/25/25 at 2:20 P.M., the MDS Regional Nurse said that the MDS Assessment, dated 4/23/25, was coded incorrectly and the Stage 3 pressure area noted in Section M of the MDS Assessment should have also indicated that the pressure area was present upon admission to the facility. 3. Resident #91 was admitted to the facility in May 2025 with diagnoses of Type 2 Diabetes, Essential Hypertension, and Unspecified Fall. Review of the Resident's clinical record included a Nursing Progress Note, dated 5/22/25, which noted .one cm (centimeter) open area observed on coccyx, uneven borders, red, 0 (no) s/sx (signs and symptoms) infection, triad (a cream that creates a moist wound healing environment) applied, nsg (nursing) and cna (Certified Nursing Assistant) to inform colleagues to monitor. Note left in dr (Doctor) book for evaluation and tx (treatment) . Review of Resident #91's May 2025 Physician's orders and Treatment Administration Record (TAR) included: -apply zinc paste to coccyx 2x day, two times a day for skin integrity, Start Date 5/23/25, D/C (discontinue) 5/27/25. The zinc paste treatment was noted as done daily 5/23/25 through 5/27/25. -coccyx, cleanse with N/S (normal saline) pat dry gently, apply Silver Alginate (a dressing that is absorbent with antimicrobial silver) to wound bed f/b (followed by) dcd (dry clean dressing) daily and prn (as needed). Start Date 5/28/25. The treatment was noted on the TAR as done daily 5/28/25 through 5/31/25. Review of the Resident's June 2025 TAR indicated that the treatment to the coccyx started on 5/28/25 was still in place and noted as done daily on the TAR from 6/1/25 through 6/23/25, except for four days when the Resident was in the hospital (from 6/5/25 through 6/8/25). Review of the MDS Assessment, dated 6/5/25, failed to indicate the Resident had any pressure areas present. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/23/25 at 9:34 A.M., the MDS Nurse said that the MDS Assessment, dated 6/5/25, was coded inaccurately. The MDS Nurse said that the Resident had a Stage 3 pressure area present during the MDS observation period and it should have been coded on the MDS Assessment but it had not been. 6. Review of the RAI (Resident Assessment Instrument) Manual, dated October 2024, indicated the following for MDS item A2105: -This item documents the location to which the resident is being discharged at the time of discharge. -Knowing the setting to which the individual was discharged helps to inform discharge planning. -Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. Resident #93 was admitted to the facility in May 2025. Review of Resident #93's MDS Assessment, dated 5/23/25, indicated the following: -the Resident was discharged to a Short-term General Hospital (acute hospital .) Review of Resident #93's Clinical Nurse Progress Note, dated 5/23/25, indicated the Resident was discharged home. During an interview on 6/20/25 at 1:02 P.M., the MDS Nurse said she had incorrectly coded the Resident's Discharge MDS Assessment regarding the Resident's discharge location. The MDS Nurse said that she refers to the RAI Manual for accuracy of Assessments completed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR - preadmission screening to identify residents with mental health disorders or intellectual disabilities) was accurately completed prior to admission for one Resident (#46), out of a total sample of 19 residents. Findings include: Review of the facility's policy titled admission Criteria, revised 4/22, indicated the following: -All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. [sic] Resident #46 was admitted to the facility in March 2025 with a diagnoses including Schizoaffective Disorder and a history of alcohol use. Review of the Hospital Discharge/Transfer Note, dated 3/13/25, indicated Resident #46 had a diagnosis of Schizoaffective Disorder and had medication changes in the hospital relative to his/her antipsychotic medication. Review of the Medical Doctor's (MD) History and Physical, completed on 3/18/25, indicated Resident #46 had a diagnosis of Schizoaffective Disorder. Review of Resident #46's PASRR, dated 3/19/25 (completed post admission to the facility), indicated the following: -Resident #46 had no diagnosis of serious mental illness (SMI). During an interview on 6/17/25 at 2:45 P.M., the Social Worker (SW) said prior to being admitted to the facility all residents needed to have a PASRR completed. The SW said for Resident #46, his/her PASRR was not completed until after he/she had been admitted to the facility. The SW said Resident #46's PASRR was also completed inaccurately and did not indicate he/she had a diagnosis of Schizoaffective Disorder and a new PASRR needed to be submitted with the accurate diagnosis. The SW further said she was aware there were issues with PASRR completion and PASRR accuracy, but no audit had been completed to see which residents in the facility did not have PASRRs completed at admission and/or if their PASRRs had been completed accurately. During an interview on 6/18/25 at 7:33 A.M., the Ombudsman said the facility was not ensuring PASRRs were being completed accurately and when the Nurses from the local Elder Services Agency were reviewing resident PASRRs during Medicaid Screenings, the PASRRs were often missing mental health diagnoses and other information.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interview, the facility failed to provide services that meet professional standards of quality for one Resident (#34), out of a total sample of 19 residents. Specifically, for Resident #34, the facility failed to administer the medication Ingrezza (Valbenazine Tosylate - medication used to treat tardive dyskinesia (TD) and help reduce uncontrolled body movements) as prescribed: -for increased involuntary movement symptoms when the medication was ordered to be administered daily. -when the medication was discontinued by facility staff, and was being administered without current Physician orders. Findings include: Review of [NAME], Manual of Nursing Practice 11th ed, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Change of Condition in a Resident Status, dated 3/17, indicated the following: -the facility shall notify the resident, his or her attending physician, and representative (sponsor of changes in the resident's medical mental condition). -The nurse will notify the resident's Attending Physician or On-call Physician when there has been a need to alter the resident's medical treatment significantly. Resident #34 was admitted to the facility in June 2024 with diagnoses including malignant neoplasm of the brain (brain tumor), adult failure to thrive, Parkinson's Disease, epilepsy, drug induced subacute dyskinesia, and a history of falling. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #34's May 2025 Medication Administration Record (MAR) indicated the following: -Valbenazine Tosylate Oral Capsule 40 milligrams (mg). Give one capsule via G-tube (gastrostomy tube - a feeding tube inserted into the stomach through the abdomen) in the morning for TD (tardive dyskinesia) - start date 5/9/25, discontinue date 5/15/25. >5/9/25 - initialed by the Nurse as a 9 (other/see progress notes) indicating the medication was not administered. -Valbenazine Tosylate Oral Capsule 40 mg. Give two capsules via G-tube at bedtime for TD - start date 5/15/25, discontinue date 6/13/25. >5/21/25, 5/22/25 and 5/30/25 were left blank and not initialed by the Nurse as being administered. >5/25/25-initialed by the Nurse as a 9. >Valbenazine Tosylate Oral Capsule was not administered on 5/9/25, 5/21/25, 5/22/25, 5/25/25, and 5/30/25. Review of Resident #34's June 2025 MAR indicated the following: -Valbenazine Tosylate Oral Capsule 40 mg. Give two capsules via G-tube at bedtime for TD -start date 5/15/25, discontinue date 6/13/25. >6/2/25 - initialed by the Nurse as a 9. Review of Resident #34's Provider's Progress Note, dated 6/4/25, indicated the following: -Resident had been off the Ingrezza per nursing for several days, now receiving 80 mg and movements improving. He/she remains with notable involuntary movements but able to stay in bed. It seems he/she is getting his/her Ingrezza per Medication Administration Record (MAR) but missed a dose the other day. -Tardive Dyskinesia - continue Ingrezza 80 mg via G-tube (gastrostomy tube - a feeding tube inserted into the stomach through the abdomen) qhs (every night at bedtime) for significant TD. Involuntary movements likely contributing to falls. Review of Resident #34's Provider's Progress Note, dated 6/12/25, indicated the following: -Resident remains with notable involuntary [sic], but able to stay in bed -Tardive Dyskinesia, continue Ingrezza 80 mg via G-tube qhs for significant TD. Involuntary movements likely contribute to falls, Ingrezza seems to be helping. Review of Resident #34's Provider's Progress Note, dated 6/16/25, indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident had a notable increase in movements so significant he/she had fallen out of the bed and the chair. -Tardive Dyskinesia, continue Ingrezza 80 mg via G-tube qhs for significant TD. Involuntary movements likely contribute to falls, Ingrezza seems to be helping. Review of Resident #34's June 2025 MAR indicated the following: -Valbenazine Tosylate Oral Capsule 40 mg. Give two capsules via G-tube at bedtime for TD - start date 5/15/25, discontinue date 6/13/25. >6/2/25 - initialed by the Nurse as a 9. -Valbenazine Tosylate was discontinued on 6/13/25 and not administered on 6/13/25, 6/14/25, 6/15/25 or 6/17/25. -A one-time order for Ingrezza 80 mg capsule to be given on 6/16/25 was administered and initialed by the nurse. Further review of Resident #34's medical record failed to indicate any evidence or correlating progress notes relative to why the Valbenazine Tosylate medication was not administered or Provider communication that the medication had not been administered on 5/9/25, 5/21/25, 5/22/25, 5/25/25, 5/30/25, 6/2/25, 6/13/15, 6/14/25, 6/15/25 or 6/17/25 (10 occasions). During an interview on 6/18/25 at 5:22 P.M., Nurse #2 said Resident #34 was prescribed Ingrezza and currently received it in the evening. The surveyor and Nurse #2 reviewed the current Physician's orders and Nurse #2 said there was no current order for the Valbenazine Tosylate/Ingrezza. Nurse #2 said it appeared the medication was discontinued and she was not sure why. Nurse #2 said there had been adjustments made to the medication to be administered in the evening at bedtime instead of in the morning, but the medication had not been discontinued to the best of her knowledge. On 6/18/25 at 5:25 P.M., the surveyor and Nurse #2 observed multiple blister packs that held the Valbenazine Tosylate/Ingrezza, located in the nurses' medication cart. Nurse #2 was unable to determine the last time Resident #34 received the Ingrezza medication based on what medication was left in the blister packs. During an interview on 6/23/25 at 11:06 A.M., the Nurse Practitioner (NP) said Resident # 34 was prescribed Ingrezza because the NP felt he/she was benefiting from it and had noted less (involuntary) movement. The NP said she had not discontinued the Ingrezza medication since re-starting it in May 2025. The surveyor and the NP reviewed the dates that indicated the Resident did not receive the Ingrezza. The NP said she was not made aware Resident #34 had not received the medication that many times. The NP said that the staff had notified her about some missed doses, but not that many. The NP further said that she would not expect the staff to call her for one missed dose but to notify her when she came in the following morning. The NP said she did not recall the facility staff notifying her that the Resident had not received the Ingrezza medication on the ten missed occasions noted and should have. Please Refer to F760

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Holyoke	282 Cabot Street Holyoke, MA 01040

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record reviews, and interviews, the facility failed to ensure the environment remained free of accidental hazards and was safe for one Resident (#27), out of a total sample of 19 residents. Specifically, for Resident #27, the facility failed to ensure that the call bell was placed within reach for the Resident's use and that fall mats were appropriately implemented after the Resident sustained an unwitnessed fall. Findings include: Review of the facility's policy titled Fall and Fall Risk Managing, revised on 3/2022, indicated the following: -Based on previous evaluations and current data, the staff will identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. -The staff, with the input of the attending physician, will implement a resident centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Resident #27 was admitted to the facility in March 2025 with diagnoses including paraplegia, spinal stenosis, contracture of muscles, blindness in the left eye, and indwelling urinary catheter. On 6/18/25 at 5:06 P.M., the surveyor heard a muffled, groaning sound from Resident #27's room. The surveyor did not observe a Resident from the room doorway but heard a muffled, groaning sound and observed a urinary catheter attached to the right side of the bed which stretched across the bed. The surveyor further observed Resident #27 lying on the floor on the left side of his/her bed. The surveyor immediately notified staff that Resident #27 was heard by the surveyor from the hallway groaning and making muffled sounds and was found lying on the floor, on the left side of his/her bed. The surveyor observed that Resident #27's call bell had not been activated as it was not lit up in the hallway. During an interview on 6/18/25 at 5:11 P.M., the Unit Manager (UM) said the Resident had experienced an unwitnessed fall out of bed but was thankfully okay. During an interview on 6/18/25 at 5:14 P.M., Certified Nurses Aide (CNA) #1 said Resident #27 was alert and orientated to him/herself and able to use a call bell. CNA #1 said he was not sure why the Resident did not use his/her call bell to ask for help as he/she usually does. CNA #1 said sometimes Resident #27 will roll side-to-side putting him/her at risk of rolling out of the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/25 at 5:34 P.M., Nurse #6 said she and two CNAs had assessed Resident #27 after his/her fall and then placed him/her back into the bed using a Hoyer Lift (a mechanical lift used to move residents who are dependent on staff to be transferred from one space to another). Nurse #6 further said the Resident was able to use the call bell to ask for help. The surveyor and Nurse #6 entered the room and observed Resident #27 lying in bed. The surveyor observed the Resident's call bell was located on the floor on the left side of the Resident's bed, partially under the bed, and out of reach for the Resident. Nurse #6 said the call bell should be within reach and was not. The surveyor observed that three staff members (Nurse #6 and 2 - CNA's) had exited the Resident's room after assisting with getting him/her into bed after the unwitnessed fall, and failed to place the call bell within reach to ensure the Resident could call for assistance as needed before exiting the room. Review of the At Risk for Falls Care Plan, initiated on 6/3/25 and updated on 6/19/25, indicated the following: -Place mats on both sides of the bed, initiated on 6/19/25. On 6/23/25 at 4:27 P.M., the surveyor and Nurse #2 observed the following: -Resident #27 was lying in bed with the bed in the low position. -the Resident was alert and leaning slightly to the left. -the call bell was within reach. -there were no bilateral mats on the floor next to the Resident's bed. During an interview immediately following the observation, Nurse #2 looked throughout the Resident's room and said she did not see any fall mats available in the room that could be placed on the floor. The surveyor and Nurse #2 reviewed Resident #27's Care Plan and observed the following intervention was updated on 6/19/25: -place mats on both sides of the bed. Nurse #2 said the intervention had not been implemented and should have been. During an interview on 6/23/25 at 4:46 P.M., the Assistant Director of Nursing (ADON) said Resident #27 had been provided the fall mats as a new intervention for safety relative to falls, however the housekeeping staff removed the mats to clean the floors and had placed them in the shower room while the Resident was out at an appointment. The ADON said the housekeeping staff had not replaced the fall mats on each side of the Resident's bed prior to the Resident returning to the facility.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#22), of one applicable resident receiving dialysis (process that filters wastes, salts and fluid from your blood when the kidneys are unable to work adequately) services, out of a total sample of 19 residents. Specifically, for Resident #22, the facility failed to ensure: -timely medication administration on the Resident's dialysis scheduled days, when scheduled morning medications were delayed in being administered until after the Resident's return to the facility in the early afternoon on Mondays, Wednesdays, and Fridays. -that Sevelamer (medication to lower phosphorus levels in the blood) medication was administered as ordered by the Physician with meals, when the Resident's blood phosphorus level was elevated, and the Resident was missing the breakfast Sevelamer medication dosage on Mondays, Wednesdays, and Fridays. Findings include: Review of the facility's policy titled Care of a Resident with End-Stage Renal Disease, revised 4/2022, indicated the following: -Residents with End-Stage Renal Disease (ESRD) will be cared for according to currently recognized standards of care -staff caring for residents with ESRD, including residents receiving dialysis care outside of the facility, shall be trained in the care and special needs of these residents -education and training of staff include, specifically: >timing and administration of medications, particularly those before and after dialysis . Review of the facility's policy titled Administering Medications, revised 1/2025, indicated: -medications are administered in a safe and timely manner, and as prescribed. -medications are administered in accordance with prescriber orders, including any required time frame -medication administration times are determined by resident need and benefit, not staff convenience. Factors that are covered include: >enhancing optimal therapeutic effect of the medication >preventing potential medication or food interactions; and (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>honoring resident choices and preferences, consistent with his or her care plan -medications are administered within one (1) hour of their prescribed time, . Resident #22 was admitted to the facility in April 2025 with diagnoses including Chronic Kidney Disease. Review of the Minimum Data Set (MDS) Assessment, dated 5/17/25, indicated Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and received dialysis while in the facility. Review of the Renal/Dialysis Care Plan, initiated 5/21/25, indicated Resident #22 had a potential for complications related to hemodialysis (use of a machine to conduct dialysis) and included the following interventions also initiated 5/21/25: -administer and monitor effectiveness of medications as ordered (see Physician's orders/Medication Administration Record [MAR]) -communicate with dialysis center regarding medication, diet, and lab results -dialysis days: Mondays, Wednesdays, Fridays Review of Resident #22's lab work, dated 4/21/25, indicated a Phosphorus level of 5.4 mg/dL (High) (hyperphosphatemia = level greater than 4.5 milligrams (mg) per deciliter (dL); Normal phosphorus level = 2. 5 to 4.5 mg/dL). Review of Resident #22's Nutrition Evaluation, dated 5/14/25, indicated: -phosphorus level obtained on 4/21/25 was 5.4 mg/dL . communicated to Nurse Practitioner (NP) Review of the Resident #22's lab work, dated 6/4/25, indicated the Phosphorus level remained at 5.4 mg/dL (High). During an interview on 6/17/25 at 9:01 A.M., Resident #22 said he/she received dialysis on Mondays, Wednesdays, and Fridays at an outside clinic. Resident #22 said he/she was picked up by transportation services at 6:15 A.M. and returned around 1:30 P.M. Resident #22 said he/she received a bagged breakfast prior to leaving the facility and did not have medications from the facility sent with him/her. Resident #22 further said a dialysis communication book was sent with him/her from the facility to dialysis. Review of Resident #22's June 2025 Physician's orders indicated the following: -Folic Acid 1 milligram (mg) daily, initiated 4/9/25 -Oxybutynin Chloride ER 24 hour (medication for overactive bladder), 10 mg daily, initiated 4/9/25 -Pantoprazole Sodium Delayed Release (medication to reduce stomach acid), 40 mg daily initiated 4/10/25 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fluticasone Propionate Nasal Spray (allergy medication), 50 micrograms (mcg) per actuation (ACT), 2 spray in each nostril daily, initiated 4/10/25 -Potassium 20 milliequivalents (mEq) daily, initiated 4/10/25 -Cholecalciferol (Vitamin D supplement) 50000 international units (IU) every Monday, initiated 4/14/25 -Dialysis on Mondays, Wednesdays, and Fridays initiated 4/18/25 -Torsemide (diuretic medication), 20 mg twice daily, initiated 4/20/25 -Selevamer HCL (phosphate binder) 800 mg, one tablet with meals (TID: three times daily), initiated 5/14/25 -Apixaban (anticoagulant) 5 mg every 12 hours (twice daily), initiated 5/15/25 -Carvedilol (blood pressure medication) 25 mg twice daily, initiated 5/15/25 -Losartan Potassium (blood pressure medication), 25 mg daily, may hold on dialysis days, initiated 5/22/25 -Fluticasone Furoate-Vilanterol 50-25 mcg/ACT, 1 puff inhale orally in the morning . initiated 6/6/25 Review of Resident #22's June 2025 Medication Administration Record (MAR), indicated the following medications were documented as administered at the prescribed morning times from 6/1/25 through 6/19/25 (exception of Wednesday 6/4/25 when the Resident was documented to be out of the facility): -Folic Acid 1 mg, scheduled to be administered daily at 8:00 A.M., -Oxybutynin Chloride ER 10 mg, scheduled to be administered daily at 8:00 A.M., -Pantoprazole 40 mg, scheduled to be administered daily at 9:00 A.M., -Fluticasone Propionate 50 mcg/ACT, scheduled to be administered daily at 9:00 A.M., -Potassium 20 mEq, scheduled to be administered daily at 9:00 A.M., -Cholecalciferol 50000 IU, scheduled to be administered on Mondays at 9:00 A.M., was documented as administered on 6/2/25, 6/9/25 and 6/16/25 -Torsemide 20 mg, scheduled to be administered at 8:00 A.M., -Sevelamer HCL 800 mg, scheduled to be administered at 8:30 A.M., -Apixaban 5 mg, scheduled to be administered at 8:00 A.M., (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Carvedilol 25 mg, scheduled to be administered at 8:00 A.M., -Losartan Potassium 25 mg, scheduled to be administered daily at 8:00 A.M., -Fluticasone Furoate-Vilanterol 50-25 mcg/ACT, scheduled to be administered daily at 8:00 A.M., During an interview on 6/18/25 at 2:13 P.M., Nurse #2 said Resident #22 left the facility for dialysis on Mondays, Wednesdays and Fridays around 6:00 A.M. and returned to the facility around 1:00 - 1:30 P.M. Nurse #2 said no medications from the facility were sent to dialysis with Resident #22, and the medications scheduled to be administered in the morning (8:00 A.M., 8:30 A.M., and 9:00 A.M.) when the Resident was out at dialysis, would be administered when he/she returned from dialysis treatment at 1:00 P.M. - 1:30 P.M. Nurse #2 further said the Resident's MAR should reflect the times that the Resident's medications were administered and currently the MAR was not accurate relative to the medication administration times. During an interview on 6/18/25 at 2:30 P.M., Unit Manager (UM) #2 said no medications were sent from the facility with Resident #22 to dialysis, and that he/she received a bagged breakfast prior to leaving the facility and that he/she would receive the lunch meal when he/she returned from dialysis. The surveyor and UM #2 reviewed Resident #22's June 2025 MAR which indicated the Resident was receiving morning medications (scheduled for 8:00, 8:30 and 9:00 A.M.) on Mondays, Wednesdays and Fridays,when he/she was not in the facility and UM #2 said she would have to look into this. UM #2 further said she would also look into the Sevelamer medication which was scheduled to be given with the Resident's meals. Review of the Nutritional Evaluation Note, dated 6/18/25, indicated: -Resident was evaluated for monthly high nutrition risk related to hemodialysis and ESRD. -Phosphorus level obtained on 6/4/25 was 5.4 mg/dL . -Phosphorus binder initiated on 5/14/25 . During an interview on 6/18/25 at 4:45 P.M., the Director of Nursing (DON) said Resident #22 started dialysis treatments after admission to the facility, and that his/her medication administration times should have been adjusted based on his/her dialysis schedule. The DON further said she would have to look into the Sevelamer medication administration. During a follow-up interview on 6/25/25 at 8:23 A.M., the DON said Resident #22's orders were adjusted after the surveyor brought the concerns about the medication administration times. The DON further said she was unsure if the Provider was made aware that morning medications scheduled for 8:00 A.M. and 9:00 A.M. on dialysis days were given after the Resident's return from dialysis prior to this adjustment or that the Sevelamer medication (scheduled for 8:30 A.M. with breakfast) was not being administered as ordered for the breakfast meal on the days (Mondays, Wednesdays, and Fridays) Resident #22 was at dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/25 at 9:37 A.M., the Registered Dietitian (RD) said Resident #22 was considered high nutritional risk due to hemodialysis treatments and was followed monthly and as needed (PRN). The RD said when he completed his assessments, he contacted the Resident's dialysis clinic to coordinate the Resident's plan of care, which included a review of the Resident's weights, intake and lab work. The RD said he noted the Resident's elevated phosphorus level on 5/14/25 and relayed this information to the NP, who added a phosphorus binder medication (Sevelamer). The RD said the Sevelamer medication would need to be administered with the Resident's meals so that it could bind to the phosphorus in the food, and that the medication would not be effective if administered after the meal as the medication would not serve its purpose. The RD further said he was unaware that the Sevelemar was not being administered with the Resident's breakfast meal on dialysis days. During an interview on 6/25/25 at 10:41 A.M., the NP said she was made aware of the issue with Resident #22's medications administration times the previous week (week of 6/17/25) by UM #2, and the medication times have been adjusted based on his/her dialysis schedule. The NP said prior to last week, she was unaware that the Resident's morning medications were administered after (he/she returned from) dialysis, and she was not made aware that the Sevelemar medication was not being administered on dialysis days for the breakfast meal. The NP said she would have expected the facility staff to review the Resident's medication times and coordinate theses times based on his/her dialysis schedule to ensure the medications were administered as ordered. The NP said Resident #22's medications would have needed to be adjusted once the dialysis schedule was determined since dialysis treatments started after his/her admission. The NP said relative to the Sevelamer medication, some dialysis clinics administer this medication to the resident while at dialysis. The NP further said she was made aware by UM #2 that the Sevelemar medication was not administered to Resident #22 at dialysis and that it would now be sent with him/her on dialysis days from the facility. During an interview on 6/25/25 at 11:49 A.M., the Regional Nurse said the facility policy should have been followed relative to dialysis and medication timing for Resident #22. The Regional Nurse said the facility should have coordinated with the Resident's dialysis clinic relative to his/her medications and should have made adjustments to the medication administration times on dialysis days. Please refer to F842

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure that one Resident (#34), out of a total sample of 19 residents, was free from significant medication errors. Specifically, for Resident #34, the facility failed to ensure that the medication Ingrezza (Valbenazine Tosylate- a medication to treat Tardive Dyskinesia (TD) used to help reduce uncontrolled body movements) was transcribed accurately as prescribed by the Provider, resulting in missed medication administration for a total of ten occasions out of 47 opportunities, for May 2025 and June 2025, putting the Resident at risk for involuntary movements not being managed appropriately. Findings include: Resident #34 was admitted to the facility in June 2024 with diagnoses including malignant neoplasm of the brain (brain tumor), adult failure to thrive, Parkinson's Disease, Epilepsy, drug induced subacute dyskinesia, and a history of falling. Review of Resident #34's June 2025 Physician orders on 6/17/25 at 5:22 P.M., indicated no current order for Valbenazine Tosylate/Ingrezza medication. Review of Resident #34's Provider's Progress Note, dated 6/4/25, indicated the following: -Resident had been off the Ingrezza per nursing for several days, now receiving 80 mg and movements improving. He/she remains with notable involuntary movements but able to stay in bed. It seems he/she is getting his/her Ingrezza per Medication Administration Record (MAR) but missed a dose the other day. -Assessment and Plan: >Tardive Dyskinesia- continue Ingrezza 80 mg via G-tube (gastrostomy tube - a feeding tube inserted into the stomach through the abdomen) qhs (every night at bedtime) for significant TD. Involuntary movements likely contributing to falls. Review of Resident #34's Provider's Progress Note, dated 6/12/25, indicated the following: -Resident remains with notable involuntary[sic], but able to stay in bed -Assessment and Plan: >Tardive Dyskinesia, continue Ingrezza 80 mg via G-tube qhs for significant TD. Involuntary movements likely contribute to falls, Ingrezza seems to be helping. Review of Resident #34's Provider's Progress Note, dated 6/16/25, indicated the following: -Resident had a notable increase in movements so significant he/she had fallen out of the bed and the chair. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Per nursing today Ingrezza is in stock in the nursing cart but unclear if the Resident received the medication over the weekend as it was not indicated on the MAR and it was not charted as given consistently. Ingrezza has helped with TD symptoms and involuntary movements are likely contributing to falls. -Assessment and Plan: >Tardive Dyskinesia, continue Ingrezza 80 mg via G-tube qhs for significant TD. Involuntary movements likely contribute to falls, Ingrezza seems to be helping. Review of Resident #34's Provider's Progress Note, dated 6/17/25, indicated the following: -Assessment and Plan: >Tardive Dyskinesia, continue Ingrezza 80 mg via G-tube qhs for significant TD. Involuntary movements likely contribute to falls, Ingrezza seems to be helping. Review of Resident #34's May 2025 MAR indicated the following: -Valbenazine Tosylate Oral Capsule 40 milligrams (mg). Give one capsule via G-tube in the morning for TD -start date 5/9/25, discontinue date 5/15/25. >5/9/25 -initialed by the nurse as a 9 (other/see progress notes) indicating the medication was not administered. -Valbenazine Tosylate Oral Capsule 40 mg. Give two capsules (total dose of 80 mg) via G-tube at bedtime for TD -start date 5/15/25, discontinue date 6/13/25. >5/21/25, 5/22/25 and 5/30/25 were left blank and not initialed by the nurse as being administered. >5/25/25-initialed by the nurse as a 9. Review of Resident #34's June 2025 MAR indicated the following: -Valbenazine Tosylate Oral Capsule 40 mg. Give two capsules (total dose 80 mg) via G-tube at bedtime for TD -start date 5/15/25, discontinue date 6/13/25. >6/2/25 -initialed by the nurse as a 9. -Valbenazine Tosylate was discontinued on 6/13/25 and not administered on 6/13/25 6/14/25, 6/15/25 or 6/17/25. -A one-time order for Ingrezza 80 mg capsule to be given on 6/16/25 was administered and initialed by the Nurse. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the medical record indicated no documented evidence, or correlating progress notes relative to why the Valbenazine Tosylate was not administered or that the provider had been notified that the medication had not been administered on 5/9/25, 5/21/25, 5/22/25, 5/25/25, 5/30/25, 6/2/25, 6/13/15, 6/14/25, 6/15/25 and 6/17/25 (10 occasions). During an interview on 6/18/25 at 5:22 P.M. Nurse #2 said Resident #34 was prescribed Ingrezza and currently received it in the evening. The surveyor and Nurse #2 reviewed the current order Physician orders and Nurse #2 said there was no current order for the Valbenazine Tosylate/Ingrezza. Nurse #2 said it appeared the medication was discontinued and was not sure why. Nurse #2 said there had been adjustments made to the medication to be administered in the evening at bedtime instead of in the morning, but the medication had not been discontinued to the best of her knowledge. During an interview on 6/23/25 at 11:06 A.M., the Nurse Practitioner (NP) said Resident #34 was prescribed Ingrezza because the NP felt the Resident was benefiting from it and had noted less (involuntary) movement. The NP further said she had not discontinued the Ingrezza medication since re-starting it in May 2025. During an interview on 6/23/25 at 12:01 P.M., with the Regional Nurse Consultant and the Director of Nursing (DON), the DON said there were dates that the medication was not available but would have to go back and research that information. The DON and Regional Nurse Consultant reviewed the May 2025 and June 2025 MARs and said it appeared the Resident did not receive the medication five times in May and once in June. The DON was unsure why the medication had been discontinued on 6/13/25, administered once on 6/16/25 and not administered again on 6/17/25. The DON said that the Resident missed an additional four doses of Ingrezza due to the medication being accidentally discontinued.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Holyoke	282 Cabot Street Holyoke, MA 01040

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to ensure complete and accurate medical records were maintained for two Residents (#22, and #91), out of a total sample of 19 residents. Specifically, 1. For Resident #22, the facility failed to ensure accurate documentation of medications scheduled at 8:00 A. M., 8:30 A.M. and 9:00 A.M., were administered, when the Resident was out of the facility receiving dialysis services on Mondays, Wednesdays, and Fridays, and the medications were documented as being administered during the time the Resident was away at dialysis. 2. For Resident #91, the facility failed to ensure accurate documentation on the Skin Observation/ Assessment Tools and Nursing Evaluations when the Resident had a Stage 3 pressure area present on his/her coccyx. Findings include: 1. Resident #22 was admitted to the facility in April 2025 with diagnoses including Chronic Kidney Disease. Review of the facility policy titled Administering Medications, revised 1/2025, indicated: -medications are administered in a safe and timely manner, and as prescribed. -medications are administered in accordance with prescriber orders, including any required time frame -medication administration times are determined by resident need and benefit, not staff convenience. Factors that are covered include: >honoring resident choices and preferences, consistent with his or her care plan -medications are administered within one (1) hour of their prescribed time, Review of the Minimum Data Set (MDS) Assessment, dated 5/17/25, indicated Resident #22: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 possible points -received dialysis while in the facility. Review of the Renal/Dialysis Care Plan, initiated 5/21/25, indicated Resident #22 had a potential for complications related to hemodialysis (use of a machine to conduct dialysis) and included the following interventions: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-administer and monitor effectiveness of medications as ordered (see Physician's orders/Medication Administration Record [MAR]) -communicate with dialysis center regarding medication, diet, and lab results -dialysis days: Mondays, Wednesday, Fridays During an interview on 6/17/25 at 9:01 A.M., Resident #22 said he/she received dialysis on Mondays, Wednesdays, and Fridays at an outside clinic. Resident #22 said he/she was picked up by transportation services at 6:15 A.M. and returned to the facility around 1:30 P.M. Resident #22 said he/she received a bagged breakfast prior to leaving the facility and did not have medications from the facility sent with him/her to dialysis. Review of the June 2025 Physician's orders indicated the following: -Folic Acid 1 milligram (mg) daily, initiated 4/9/25 -Oxybutynin Chloride ER 24 hour (medication for overactive bladder), 10 mg daily, initiated 4/9/25 -Pantoprazole Sodium Delayed Release (medication to reduce stomach acid), 40 mg daily initiated 4/10/25 -Fluticasone Propionate Nasal Spray (medication for allergies), 50 micrograms (mcg) per actuation (ACT), 2 spray in each nostril daily, initiated 4/10/25 -Potassium 20 milliequivalents (mEq) daily, initiated 4/10/25 -Cholecalciferol (Vitamin D supplement) 50000 international units (IU) every Monday, initiated 4/14/25 -Dialysis on Mondays, Wednesdays, and Fridays initiated 4/18/25 -Resident may receive, as per Medical Doctor (MD) order, while at dialysis, initiated 4/18/25 -Torsemide (diuretic medication), 20 mg twice daily, intimated 4/20/25 -Selevamer HCL (phosphate binder), 800 mg, one tablet with meals, initiated 5/14/25 -Apixaban (anticoagulant) 5 mg every 12 hours (twice daily), initiated 5/15/25 -Carvedilol (blood pressure medication) 25 mg twice daily, initiated 5/15/25 -Losartan Potassium (blood pressure medication), 25 mg daily, may hold on dialysis days, initiated 5/22/25 -Fluticasone Furoate-Vilanterol 50-25 mcg/ACT, 1 puff inhale orally in the morning . initiated 6/6/25 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's June 2025 Medication Administration Record (MAR), indicated the following medications were documented as administered at the prescribed morning times from 6/1/25 through 6/19/25 (except Wednesday 6/4/25 when the Resident was documented to be out of the facility): -Folic Acid 1 mg, scheduled to be administered daily at 8:00 A.M., -Oxybutynin Chloride ER 10 mg, scheduled to be administered daily at 8:00 A.M., -Pantoprazole 40 mg, scheduled to be administered daily at 9:00 A.M., -Fluticasone Propionate 50 mcg/ACT, scheduled to be administered daily at 9:00 A.M., -Potassium 20 mEq, scheduled to be administered daily at 9:00 A.M., -Cholecalciferol 50000 IU, scheduled to be administered on Mondays at 9:00 A.M., was documented as administered on 6/2/25, 6/9/25 and 6/16/25 -Torsemide 20 mg, scheduled to be administered at 8:00 A.M., -Sevelamer HCL 800 mg, scheduled to be administered at 8:30 A.M., -Apixaban 5 mg, scheduled to be administered at 8:00 A.M., -Carvedilol 25 mg, scheduled to be administered at 8:00 A.M., -Losartan Potassium 25 mg, scheduled to be administered daily at 8:00 A.M., -Fluticasone Furoate-Vilanterol 50-25 mcg/ACT, scheduled to be administered daily at 8:00 A.M., During an interview on 6/18/25 at 2:13 P.M., Nurse #2 said Resident #22 left the facility for dialysis on Mondays, Wednesdays and Fridays around 6:00 A.M. and returned to the facility around 1:00 -1:30 P.M. Nurse #2 said no medications from the facility were sent with Resident #22, and that the medications scheduled to be administered in the morning (8:00 A.M., 8:30 A.M., and 9:00 A.M.), when the Resident was out at dialysis, would be administered when he/she returned from dialysis treatment at 1:00 P.M.-1:30 P.M. Nurse #2 further said the Resident's MAR should reflect the times that the Resident's medications were administered and currently the MAR was not accurate relative to the time the medications were administered. During an interview on 6/18/25 at 2:30 P.M., Unit Manager (UM) #2 said no medications were sent from the facility with Resident #22 to dialysis. The surveyor and UM #2 reviewed Resident #22's June 2025 MAR which indicated the Resident was being administered morning medications at scheduled times (scheduled for 8:00, 8:30 and 9:00 A.M.), when he/she was not in the facility and UM #2 said she would have to look into this. During an interview on 6/25/25 at 11:49 A.M., the Regional Nurse said the facility policy should have been followed relative to dialysis and medication timing for Resident #22. The Regional Nurse said the facility should have coordinated with the Resident's dialysis clinic relative to his/her medications and should have made adjustments to the medication administration times on dialysis days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #91 was admitted to the facility in May 2025 with diagnoses of Type 2 Diabetes, Essential Hypertension, and Unspecified Fall. Review of the facility policy titled Comprehensive Assessments and the Care Delivery System, effective 4/17 revised 2/2025, included but was not limited to: -Assessment and information collection includes (what, where, and when). The objective of the information collection (assessment) phase is to obtain, organize, and subsequently analyze information about a patient. -Assess the individual: observation; physical assessment; consultant reports. Review of Resident 91's Nursing Evaluation, dated 5/12/25, indicated that the Resident had no pressure injury and the goal would be for the Resident's skin to remain intact. Review of the Resident's MDS Assessment, dated 5/18/25, indicated that the Resident was severely impaired cognitively as evidenced by a BIMS score of two out 15 possible points and that the Resident did not have any pressure injuries noted on his/her skin. Review of the Resident's clinical record included a Nursing Progress Note, dated 5/22/25, which noted .one cm (centimeter) open area observed on coccyx, uneven borders, red, 0 (no) s/sx (signs and symptoms) infection, triad (a cream that creates a moist wound healing environment) applied, nsg (nursing) and cna (Certified Nursing Assistant) to inform colleagues to monitor. Note left in dr (Doctor) book for evaluation and tx (treatment) . Review of Resident #91's May 2025 Physician's orders and Treatment Administration Record (TAR) included: -apply zinc paste to coccyx 2x day, two times a day for skin integrity, Start Date 5/23/25, D/C (discontinue) 5/27/25. The treatment was noted as done daily 5/23/25 through 5/27/25. -coccyx, cleanse with N/S (normal saline) pat dry gently, apply silver alginate (a dressing that is absorbent with antimicrobial silver) to wound bed f/b (followed by) dcd (dry clean dressing) daily and prn (as needed). Start Date 5/28/25. The treatment was noted as done daily 5/28/25 through 5/31/25. Review of the Resident's June 2025 TAR indicated that the treatment to the coccyx started on 5/28/25 was still in place and noted as done daily on the TAR through 6/23/25. Review of the Resident's Care Plan included: -Alteration in skin integrity on the coccyx, Stage 3, initiated 5/27/25 revised 6/9/25, Review of the Wound Consultant Initial Progress Note, dated 5/27/25, indicated the Resident was seen for a Stage 3 pressure ulcer to the coccyx. Review of the clinical record included Skin Observation Tools, skin assessments completed by nursing, which indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/28/25 skin intact -5/30/25 skin intact -6/3/25 noted skin tear on right elbow, no other open areas Review of the Nursing Evaluation Skin Assessment, dated 6/9/25, indicated the Resident had no pressure injuries present. During an interview on 6/23/25 at 9:16 A.M., the Assistant Director of Nursing (ADON) said the Skin Observation Tools, dated 5/28/25, 5/30/25, and 6/3/25, and the Nursing Evaluation Skin assessment dated [DATE], which were completed by the Nurses, were inaccurate. The ADON said that the Resident continued to have an open pressure area on his/her coccyx, which was first identified on 5/23/25. The ADON said that the Resident was still evaluated weekly by the Wound Consultant, and was receiving a daily treatment for the ongoing open area on his/her coccyx. The ADON said that the pressure area on the Resident's coccyx should have been noted on the Skin Assessments dated 5/28/25, 5/30/25, and 6/3/25, as well as the Nursing Evaluation completed on 6/9/25, but they had not been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on one unit (Unit Four), out of three units and for two Residents (#37 and #70) residing on Unit Four. Specifically, the facility failed to implement Enhanced Barrier Precautions (EBP) when providing care on Unit Four: 1. For Resident #37, when the facility staff failed to wear the appropriate Personal Protective Equipment (PPE) when providing direct care for the Resident on EBP due to foot wound and a recent amputation. 2. For Resident #70, when the facility staff failed to don the appropriate PPE while providing high contact care for the Resident on EBP related to an indwelling urinary catheter. Findings include: Review of the facility's policy titled Enhanced Barrier Precautions (EBP), revised 9/2022, indicated the following: -Enhanced Barrier Precautions are an infection prevention intervention designed to reduce the transmission of multi-drug-resistant organisms (MDROs) in the facility. The precautions involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with MDROs as well as those with an increased risk of contracting MDROs. -Use of EBP includes but was not limited to residents with indwelling medical devices or wounds (regardless of MDRO colonization or infection status in addition) . 1. Resident #37 was admitted to the facility in January 2025 with diagnoses including chronic ulcer of the right heel and mid foot, Type 2 Diabetes with diabetic peripheral angiopathy, infection following a procedure deep incisional surgical site, Type 2 Diabetes with foot ulcers, osteomyelitis of the right ankle and foot. Review of Resident #37's June 2025 Physician orders indicated the following in part: -4th and 5th toe amputation and surgical site to the left foot . -Right foot distal plantar surgical wound . On 6/17/25 at 9:46 A.M., the surveyor observed the following from the doorway of Resident #37's room, located on Unit Four: -An EBP sign posted at the entrance of the Resident's doorway to the room. -A three drawer PPE bin with the necessary PPE required located in the hallway directly outside of the Resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #37 had bilateral bandages on his/her feet. -A Certified Nurses Aide (CNA), wearing a surgical mask and gloves was bent down assisting Resident #37 with putting on his/her shoes. -The CNA was observed assisting the Resident from the bed into the wheelchair and then from the wheelchair into the bathroom. -The CNA exited the bathroom with an empty wheelchair and doffed (took off the gloves, exited the room, and performed hand hygiene). -The CNA was not observed to don (put on) a gown while putting on the Resident's shoes and while assisting with the Resident transfers. During an interview on 6/18/25 at 3:51 P.M., the Assistant Director of Nursing (ADON) said Resident #37 was on EBP due to his/her foot wound and recent amputation. The ADON said a gown and gloves should be worn when providing care for Resident #37. 2. Resident #70 was admitted to the facility in February 2025 with diagnoses including BPH with lower urinary tract symptoms and obstructive and reflux uropathy requiring the use of an indwelling catheter. Review of Resident #70's June 2025 Physician's orders indicated the following in part: -Foley catheter (a medical device that helps drain urine from your bladder) care, initiated 5/7/25 -Change Foley catheter as needed, initiated 5/7/25 On 6/17/25 from 10:08 A.M. until 10:19 A.M., the surveyor observed the following from the doorway of Resident #70's room, located on Unit Four: -An EBP sign posted at the entrance of the Resident's doorway to the room -A three drawer PPE bin with the necessary PPE required located in the hallway directly outside of the Resident's room. -A CNA provided care to Resident #70 behind the closed curtain. -The CNA came out from behind the curtain to gather supplies and was observed donning a surgical mask and gloves. The CNA did not don a gown. During an interview on 6/17/25 at 10:19 A.M., while standing outside of Resident #70's room, the ADON said the Resident was on EBP due to his/her urinary catheter and that staff were required to don full PPE when providing high contact care such as toileting and changing a resident. The surveyor discussed the CNA observation with the ADON, who entered the room to observe the CNA providing care. When the ADON exited the room, she said the CNA providing care worked with Hospice Services and was providing patient care. The ADON further said the CNA donned gloves and a surgical mask but did not don a gown as required, when providing high contact care.