STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate and reflective of the resident's status at the time of the assessment, for five Residents (#51, #11, #10, #3 and #4), out of a total sample of 21 residents. Specifically, the facility failed to:For Resident #51, accurately code that insulin injections were administered in the MDS assessment dated [DATE].For Resident #11, accurately code that insulin injections and hypoglycemic (used to treat high blood sugar) medication were administered on the MDS assessment dated [DATE], and accurately code hospice services on the MDS assessment dated [DATE].For Resident #10, accurately code that the Resident utilized tobacco and had sustained two falls during the reference period for the MDS assessment dated [DATE].For Resident #3, accurately code urinary continence status as not rated due to his/her indwelling catheter and that he/she receives nutrition/hydration interventions to manage skin problems on the MDS assessment dated [DATE]. For Resident #4, accurately code the use of hypoglycemic medication and antipsychotic (used to treat mental illness) medication on the MDS assessment dated [DATE]. Findings include: 1.ˆResident #51 was admitted to the facility in April 2021 with diagnoses including Dementia and Type 2 Diabetes.ˆ ^^ Review of Resident #51's MDS Assessment, datedˆ4/8/25, indicated the following: -Seven day look back period captured Resident data from 4/2/25 through 4/8/25 -use of hypoglycemics,ˆincluding insulinˆ(a specific type of hypoglycemic),ˆwas not indicated.ˆ ˆ Review of Resident #51's April 2025 Medication Administration Record (MAR)ˆindicatedˆthe following:ˆ -Lantus (a type of insulin) was received dailyˆfrom 4/2/25 through 4/8/25 ^^ During an interview on 12/18/25ˆatˆ12:08 P.M., MDS Nurse #1 said the MDS assessment dated [DATE] was coded inaccurately and should haveˆindicatedˆthat Resident #51 was administered insulinˆonˆseven days during the assessment reference period.ˆˆ (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ˆ ˆ2. Resident #11 was admitted to the facility in November 2022 with diagnoses including cerebral infarction (stroke),ˆDiabetesˆand frontotemporal neurocognitive disorder.ˆˆ ˆ a. Reviewˆof Resident #11's MDS assessment dated [DATE],ˆindicated the following: -Seven day look back period captured Resident data from 8/6/25 through 8/12/25 -use of hypoglycemics,ˆincluding insulinˆ(a specific type of hypoglycemic),ˆwas not indicated.ˆ ˆˆ Review of Resident #11'sˆAugust 2025 MARˆindicated the following: ˆ -Lantus was received daily 8/6/25 through 8/12/25ˆ ˆ b. Review of the MDS assessment dated [DATE],ˆindicatedˆResident #11 had severe cognitive impairment asˆevidencedˆby a Brief Interview of Mental Status (BIMS) score of seven out of 15 and was not receiving hospice services.ˆ ˆˆˆ Review of theˆDecember 2025 Physician'sˆordersˆindicatedˆtheˆResidentˆwasˆadmitted toˆhospiceˆservicesˆon 10/23/25.ˆ ˆ Review of the Hospice/Palliative Care Plan,ˆinitiatedˆ10/23/25,ˆindicatedˆthe Resident signed on to hospice services related to his/her terminal/end stage disease.ˆ ˆ Duringˆan interview onˆ12/18/25ˆatˆ12:07 P.M., MDS Nurse #1 said the MDS assessment dated [DATE] was inaccurately coded and should haveˆindicatedˆResident #11 received seven days of insulin injections and was onˆhypoglycemicˆmedication. MDS Nurse #1 said the MDS assessment dated [DATE] was also inaccurately coded and should haveˆindicatedˆthe Resident was receiving hospice services.ˆˆ ˆˆ 3.ˆResident #10 was admitted to the facility in September 2019 with diagnoses including abnormal gait and mobility and hemiplegia following a cerebrovascular disease affecting the left side.ˆ ˆ (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewˆof the list of current residents who smoked, provided by the facility upon entrance on 12/16/25,ˆindicatedˆResident #10 was an active smoker.ˆˆ ˆ Review of the Smoking Care Plan,ˆinitiatedˆ11/6/19 and revised 6/25/21,ˆindicatedˆResident #10 was a current smoker.ˆˆ ˆ Review of the QuarterlyˆNurse assessment dated [DATE]ˆindicatedˆrelativeˆto Resident #10ˆwas an activeˆsmoker. ˆ Review of theˆDecember 2025 Physicians orders included the following:ˆ -Supervised smoking at designated times . 10:00 A.M.,ˆ2:00 P.M.,ˆ6:00 P.M.ˆ(max. of 2 cigarettes at each time).ˆAll smoking materials are to be locked in med cart/med room,ˆinitiatedˆ10/30/23ˆ ˆ Reviewˆof Resident #10's progress notesˆindicatedˆthe following Situation Background Appearance and Review/Notify (SBAR) Notes:ˆ -9/3/25: Resident had an unwitnessed fallˆ -11/16/25: Resident had an unwitnessed fallˆ ˆ Review of the MDS assessment dated [DATE],ˆindicatedˆResident #10:ˆ -was not a current tobacco user.ˆ -had not sustained any falls since the last assessment.ˆˆ ˆ Onˆ12/18/25ˆatˆ9:59 A.M., the surveyorˆobservedˆResident #10 smoking outside of the facility in the designated smoking area with a facility staff present.ˆˆˆ ˆ During an interview onˆ12/18/25ˆatˆ12:09 P.M., MDS Nurse #1 said the MDS assessment dated [DATE] was inaccurately coded and should haveˆindicatedˆResident #10 used tobacco as he/she was an activeˆsmokerˆandˆshould haveˆindicatedˆthat the Resident sustained two falls during the assessment reference period.ˆˆˆ (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	^^ 4.ˆResident #3 was admitted to the facilityˆin August 2025 with diagnoses including protein-calorie malnutrition, obstructive and reflux uropathy, and urinary retention.^^ ˆ Review of MDS assessment dated [DATE]ˆindicated the following for Resident #3:ˆ -Seven day look back period captured Resident data from 11/19/25 through 11/25/25 -had an indwelling catheter in placeˆ -was always incontinent of urineˆ -had a pressure ulcer which was not present on admissionˆ -did not receive nutrition/hydration interventions to manage skin problems ^^ Review of the November 2025 MARˆindicatedˆthe following from 11/18/25 through 11/25/25:ˆ -Med Pass Reduced Sugar (nutritional supplement) 120 ml was administered at least daily^^ ^^ Review of the December 2025 Physician's orders included the following:ˆ -MedˆPassˆReducedˆSugar 120ˆml three times daily,ˆinitiatedˆ9/9/25ˆ ˆ-Foley Catheter (type of indwelling urinary catheter)ˆevery night shift, secure and change and flush with 10ˆcubic centimeters (cc)ˆsterile saline . document urinary output 16ˆFrench 10 cc balloon,ˆinitiatedˆ8/21/25ˆ ˆ Onˆ12/17/25ˆatˆ8:35 A.M., the surveyorˆobservedˆResident #3 reclining upright in bedˆeating breakfast. A urinary drainage bag wasˆobservedˆwithin a privacy bag and anchored on the lower section of the bed.^^^ ^^ During an interview onˆ12/18/25ˆatˆ12:03 P.M., MDS Nurse #1 said the MDS assessment dated [DATE] was inaccurately coded for Resident #3 and should haveˆindicatedˆ9 - not rated under urinary continence because the Resident had a urinary catheter. MDS Nurse #1 further said the nutritional supplement should have been coded under the nutrition and hydration interventions to manage skin problems, but it was not accurately coded. (continued on next page)

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	225257	A. Building B. Wing	12/19/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Resident #4 was admitted to the facility in January 2023 with diagnoses including Diabetes, Post Traumatic Stress Disorder (PTSD), Adjustment Disorder, and Vascular Dementia. Review of Resident #4's MDS assessment dated [DATE], indicated the following: -Seven day look back period captured Resident data from 9/26/25 through 10/2/25 -use of hypoglycemics, including insulin, was not indicated -the second use of antipsychotics under section N, (question N0450), was not indicated Review of Resident #4's September 2025 MAR indicated the following: -Lantus was received daily 9/26/25 through 9/30/25 -Seroquel (a type of antipsychotic) was received daily 9/26/25 through 9/30/25 Review of Resident #4's October 2025 MAR indicated the following: -Lantus was received daily 10/1/25 through 10/2/25 -Seroquel was received daily 10/1/25 through 10/2/25 During an interview on 12/19/25 at 9:50 A.M., MDS Nurse #1 said Resident #4 had received seven days of insulin and the use of hypoglycemic box should have been checked on the 10/2/25 MDS assessment but was not. MDS Nurse #1 further said Resident #4 had received seven days of an antipsychotic and the second antipsychotic use section (N0450) should have been checked but was not. MDS Nurse #1 said that it is important to accurately code the MDS so that the Resident's care plan is accurate.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure one Resident (#8) of three applicable residents reviewed for incontinence, out of a total sample of 21 residents, was fully assessed and interventions implemented to assist in improving the Resident's episodes of incontinence. Specifically for Resident #8, the facility failed to: -accurately assess for bladder incontinence, and -complete a bladder retraining program Findings include: Review of the facility policy titled Urinary Continence and Incontinence- Assessment and Management, revised August 2022, indicated the following: -the staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence -the physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible -as part of the ongoing assessments, the nursing staff and physician will screen for information related to urinary incontinence. Examples of sources of such information may include the resident. -relevant information related to urinary continence includes: >history of urinary incontinence; factors precipitating incontinence; and associated symptoms >previous treatment/management attempts and response to interventions >pertinent diagnoses. >observations. >functional and/or cognitive capabilities or limitations that could affect continence. >environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet. -as part of its assessment, nursing staff will seek, and document results related to continence. Relevant details include: >voiding patterns. >associated pain or discomfort >types of incontinence: stress, urge, mixed, overflow, transient, functional -the evaluation will include a review for medications that might affect continence. -the staff and physician will summarize an individual's continence status. For residents deemed incontinent, this includes categorizing incontinence as urge, stress, overflow, mixed, or functional, and relevant causes, risk factors, and complications -the physician and staff will address treatable causes or contributing factors related to urinary incontinence. -as indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan -the staff will document the results of the toileting trial in the resident's medical record. -the staff and physician will evaluate the effectiveness of interventions and implement additional pertinent interventions as indicated Resident #8 was admitted to the facility in June 2025 with diagnoses including Congestive Heart Failure (CHF), abnormal gait and mobility, and overactive bladder. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #8:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15.-required substantial/maximum assistance from staff with toileting.-was frequently incontinent. On 12/16/25 at 9:27 A.M., Resident #8 was observed dressed and seated in a wheelchair in his/her room. During an interview at the time, Resident #8 said he/she would ring his/her call bell and have to wait up to 30 minutes for staff to respond so that he/she could be assisted to the bathroom. Resident #8 said this occurred frequently during all shifts, that he/she wore an incontinence brief, but sometimes could not wait for staff to assist him/her and would become incontinent in the brief. Review of the Urinary Incontinence Care Plan initiated 6/29/25, indicated Resident #8 had impaired mobility, overactive bladder, physical limitations and medications that contributed to his/her incontinence. The plan of care included the following interventions: -provide assistance with toileting or incontinence care as needed. -use absorbent products as needed (briefs). Review of the Quarterly Nursing Assessments dated 9/17/25 and 12/17/25 indicated Resident #8: -was incontinent of bladder -the facility was unable to determine the type of incontinence-did not present with transient, reversible or potentially treatable condition related to incontinence-was cognitively intact and that bladder retraining program should be initiated Review of Resident #8's clinical record failed to indicate that any bladder retraining program was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated for the Resident. ˆ ˆ Review of the Occupational Therapy (OT) Discharge summary dated [DATE], indicated Resident #8:-required assistance of one staff for all activities of daily living (ADL) tasks including toileting. -required supervision for all transfers and mobility using a rolling walker. ˆ Review of the Certified Nurse Aide (CNA) Care Card on 12/18/25 at 7:27 A.M., indicated Resident #8 required assistance of one staff with toileting.ˆˆ During an interview on 12/18/25 at 10:19 A.M., Resident #8 said that toileting had improved during the night with staff assisting him/her to the bathroom, but he/she continued to have incontinent episodes when he/she rings the call bell, and staff cannot assist him/her on time. Resident #8 further said he/she would like to be more independent with toileting and had a difficult time managing the adult incontinence briefs that were utilized. Resident #8 also said that one facility staff member uses adult pull-up style incontinence brief which was easier for him/her to manage because the adult pull-up style incontinence briefs were thinner and work like underwear. Resident #8 said he/she was not incontinent prior to coming to the facility and that he/she would like to have fewer to no episodes of incontinence. Resident #8 said he/she was not aware of any plan to decrease his/her incontinence, would like to have this looked into by the facility, and would like to be more independent with toileting. ˆ During an interview on 12/18/25 at 10:23 A.M., CNA #2, who is a regular staff and worked all shifts, said Resident #8 required assistance of one staff with toileting and wears an adult brief. CNA #2 said the Resident was able to indicate when he/she needed to use the bathroom and will ring the call bell for staff assistance. CNA #2 said Resident #8 was continent of both bowel and bladder and has had no episodes of incontinence when CNA #2 has worked with him/her. During an interview on 12/18/25 at10:27 A.M., Unit Manager (UM) #1 said residents were assessed on admission for bowel and bladder status and a determination is made relative to a plan for toileting. UM #1 said Resident #8 will ring his/her call bell for staff assistance with toileting due to his/her Oxygen use and diuretic medication (medication to assist with removing fluid accumulation in the body) and was currently not on a toileting plan. UM #1 said Resident #8 has not had bladder patterning completed to assess when there were episodes of incontinence and there has been no discussion with the facility staff/Resident #8 to see if interventions could be implemented that may decrease the Resident's episodes of incontinence. During an interview on 12/18/25 at 12:30 P.M., with the Director of Nursing (DON) and Consulting Staff #1, the DON said Resident #8 was assessed and determined to be frequently incontinent since admission and that this had not changed. The DON said the Resident was also on diuretic medication and that the facility staff were not aware that he/she had expressed concerns about his/her incontinence. Consulting Staff #1 said that bladder and bowel status was assessed on admission, quarterly and when there was a condition change. Consulting Staff #1 reviewed the most recent Quarterly Nursing assessment dated [DATE] and said she could understand why there were questions about the assessment. Consulting Staff #1 said upon completing the Quarterly Nursing Assessment, the Nurses should review the relevant documentation but also involve the Resident in the completion of the assessment. Consulting Staff #1 said the most recent Nursing Assessment (12/17/25) was incomplete and did not indicate that a bladder retraining program should be initiated when the Resident was determined to be cognitively intact and incontinent.

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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 interviews, and record reviews, the facility failed to implement a system of infection control surveillance relative to COVID-19 testing for four Residents (#23, #96, #31, #41) out of a total sample of 21 residents and on two (Federal and Elm) Units out of three Units. Specifically, the facility failed to test four Residents #23, #96, #31, #41 on the Federal Unit and Elm Unit, who were experiencing respiratory symptoms to rule out COVID-19 infection, placing other residents and staff at potential risk for infection. Findings include:Review of the CDC Viral Respiratory Pathogens Toolkit for Nursing Homes, dated 12/11/25 at <https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html> indicated the following:-Test residents and Health Care Provider (HCP) with new respiratory illness signs or symptoms.-Selection of diagnostic tests will depend on the suspected cause of the infection (e.g., which respiratory viruses are circulating in the community or the facility, recent contact with someone confirmed to have a specific respiratory infection) and if the results will inform clinical management (e.g., treatment, duration of isolation). -At a minimum, testing should include SARS-CoV-2 and influenza viruses with consideration for other causes (e.g., RSV). Review of the CDC Guidance for Symptoms of COVID-19, dated 3/10/25 at <https://www.cdc.gov/covid/signs-symptoms/index.html>, indicated the following:-Signs and Symptoms:-The following list does not include all possible symptoms. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. Possible symptoms include:<Fever or chills<Cough<Shortness of breath or difficulty breathing<Sore throat<Congestion or runny nose<New loss of taste or smell<Fatigue<Muscle or body aches<Headache<Nausea or vomiting<Diarrhea Review of the facility policy titled Coronavirus Disease (COVID-19) - Testing Residents, revised June 2023, indicated the following:-Testing Residents with signs or symptoms of COVID-19:1. Any resident (regardless of vaccination status) with even mild symptoms of COVID-19 receives a viral test as soon as possible.a. Because it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections based on symptoms alone, testing for pathogens other than SARS-CoV-2 may be conducted based on recommendations from the Infection Preventionist (IP) and Providers. During the initial pool screening on 12/16/25 from 7:40 A.M. through 8:50 A.M., the surveyor observed residents coughing on the Elm unit. During an interview on 12/17/25 at 3:47 P.M., the Infection Preventionist (IP) said there had been residents on the Elm and Federal Units with upper respiratory symptoms such as cough and congestion. The IP said that she tracked and monitored facility infections via a line listing process which monitored resident symptoms, date of onset, testing including diagnostic criteria used to determine infection, and prescription medication use. At this time, the surveyor requested a copy of the facility line listing for survey team to review. Review of the infection control line listing for November 2025 and December 2025 provided by the facility indicated the following:-Resident #23 developed signs and symptoms of cough, difficulty breathing, and shortness of breath on 11/29/25.-Resident #96 developed signs and symptoms of cough and shortness of breath on 12/8/25.-Resident #31 developed signs and symptoms of cough and chest congestion on 12/12/25.-Resident #41 developed signs and symptoms of cough, chest congestion, and fever on 12/17/25. Review of Resident #23's medical record failed to indicate a COVID-19 test was performed once respiratory symptoms were identified on 11/29/25.Review of Resident #96's medical record failed to indicate a COVID-19 test was performed once respiratory symptoms were identified on 12/8/25.Review of Resident #31's medical record failed to indicate a COVID-19 test was performed once respiratory symptoms were identified on 12/12/25.Review of Resident #41's medical record indicated the following:-Active Physician's Order for COVID-19 Antigen testing as needed for regulatory compliance or symptoms as needed, started 9/25/23Further review of Resident #41's medical record failed to indicate that a COVID-19 test was performed once respiratory symptoms were identified on 12/17/25. During interviews on 12/18/25 at 10:33 A.M. and (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interviews, and record review, the facility failed to ensure that an antibiotic stewardship program was implemented for one Resident (#51), of two applicable residents reviewed for antibiotics, out of a total sample of 21 residents.Specifically, for Resident #51, the facility failed to obtain culture and sensitivity results timely to evaluate the appropriateness of the prescribed and administered antibiotic to treat a urinary tract infection (UTI) to ensure it would be effective in treating the specific bacteria identified from laboratory results. Findings include: Review of the facility policy titled Antibiotic Stewardship, revised December 2016, indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The policy also included the following: -the purpose of the antibiotic stewardship program is to monitor the use of antibiotics -when a culture and sensitivity is ordered, lab results and the current clinical situation will be communicated with the Prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Review of the facility policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, indicated the following: -antibiotic usage and outcome data will be collected and documented using the facility approved antibiotic surveillance tracking form. -the data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship. -all clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP). -the IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. -therapy may require further review and possible changes if: >the organism is not susceptible to antibiotic chosen >the organism is susceptible to narrower spectrum antibiotic -at the conclusion of the review, the Provider will be notified of the review findings Resident #51 was admitted to the facility in April 2021 with diagnoses including Dementia and Chronic Kidney Disease. ^ Review of the Minimum Data Set (MDS) Assessment, dated 9/30/25, indicated Resident #51:-had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of four out of 15-had no behaviors -was incontinent of urine ^^^ Review of Resident #51's clinical record indicated the following: -Nursing Notes dated 12/11/25: <Resident #51 noted to be increasingly confused and more difficult to redirect, consistent with symptoms typically observed during previous UTIs. <The Resident was incontinent of urine, denied pain or burning with urination and was without a fever. <The Provider was updated and gave a new order for a urine specimen to rule out a UTI. Urine obtained via straight catheterization. Urine analysis results show 3+Leukocytes and negative for Nitrates. Provider was updated and wanted to wait for culture results to come back. -Provider Note on 12/12/25: <preliminary urine was >100,000 streptococci, awaiting final culture, <start Macrobid (antibiotic) 100 milligrams (mg) twice daily for five days and Culturelle (probiotic) daily for seven days. <Will review the culture and sensitivity once resulted. Review of the December 2025 Medication Administration Record (MAR) indicated Macrobid 100 mg was administered once on 12/11/25, twice daily from 12/12/25 through 12/15/25, and once on 12/16/25. Review of Resident #51's clinical record on 12/16/25 at 3:00 P.M. failed to indicate any urine culture and sensitivity results from the urine specimen obtained on 12/11/25. During an interview on 12/16/25 at 3:18 P.M., the surveyor and Nurse #1 reviewed Resident #51's clinical record. Nurse #1 said laboratory results should be in the Resident's record but was unable to find them and would have to ask the Unit Manager (UM #1). Nurse #1 said Resident #51 was started on an antibiotic for a UTI on 12/11/25 and that it usually takes about 48 hours to receive the urine culture and sensitivity results. During an interview on 12/16/25 at 3:27 P.M. and 4:00 P.M., UM #1 said she contacted the lab and requested the Resident's urine culture and sensitivity results. UM #1 said the urine culture and sensitivity results should have been requested on 12/15/25, but they were not requested until 12/16/25 after the surveyor had inquired. UM #1 said the Provider was updated today (12/16/25) of the Resident's urine (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225257	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Northampton	548 Elm Street Northampton, MA 01060

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	culture and sensitivity results and changed the Resident's antibiotic to Rocephin 1 gram (gm) to be given intramuscularly daily for five days. UM #1 said it was the nursing staff's responsibility to follow up with the Resident's laboratory results. Review of the Urine Culture and Sensitivity result, printed on 12/16/25, indicated the specimen was collected on 12/11/25 and had verified results on 12/13/25 (48 hours later). During interviews on 12/18/25 at 2:36 P.M. through 2:50 P.M., with the IP and Consulting Staff #1, the IP said resident infections were monitored and tracked, and if antibiotics were administered, they would usually not be started until the culture and sensitivity was obtained. Consulting Staff #1 said an Antibiotic Time Out Assessment would be completed by the Unit Managers when an antibiotic was started and that this form assists with assessing if an antibiotic was appropriate to be administered. The IP said she reviewed the infection control dashboard daily for type of resident infection and if an antibiotic was started, did it meet the specific criteria to be started, and the overall facility picture to assess for patterns. Consulting Staff #1 said relative to Resident #51, the Antibiotic Time Out assessment was not completed which could have potentially caught that the antibiotic prescribed/administered (Macrobid) was not the correct antibiotic based on the Resident's urine culture and sensitivity results. When the surveyor asked about the facility's infection surveillance process involving the IP and resident antibiotic use, the IP said she missed that Resident #51 had been placed on an antibiotic.