STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225264	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review and interview, the facility failed for one Resident (#106), in a sample of three closed records, to:-Establish and follow a written policy on permitting the Resident to return to the facility after being transferred to the hospital for evaluation; and -Through communication with the hospital, determine the treatments, medications, and services the facility would need to provide to meet the resident's needs upon returning to the facility and document why they could no longer meet those needs.Specifically, when Resident #106 was transferred to the hospital he/she was provided with a notice indicating he/she would have a bed hold. The following day, the facility informed the hospital that Resident #106 would not be allowed to return to the facility. Resident #106 has remained in the hospital (after 25 days) because he/she had nowhere to be discharged and had not been permitted to return to the facility. This has caused Resident #106 emotional distress. Findings include:Review of the Facility Assessment Tool, dated as revised in February 2026, indicated common diagnoses the facility would accept residents with or residents may develop, including Substance Use Disorder (SUD). Resident #106 was admitted to the facility in September 2025 with a diagnosis of history of SUD including alcohol and heroin. Review of the Minimum Data Set (MDS) assessment, dated 1/7/26, indicated Resident #106 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. The MDS indicated Resident #106 needed partial to moderate assist with activities of daily living (ADLs) and independently ambulated with a rolling walker. Review of the Care Plans indicated Resident #106 received assistance with ADLs, was at risk of falls and was at risk of complications related to cirrhosis. In addition, the care plans indicated Resident #106 had a history of SUD including heroin and was taking Suboxone (used to treat opioid use disorder) when admitted to the facility. A care plan update, dated 12/8/25, indicated the Suboxone had been discontinued. Review of the nursing progress notes, indicated on 3/1/26 Resident #106 was found using an illegal substance in his/her room and the police and Emergency Medical Services (EMS) were contacted. Resident #106 was transferred to the hospital at that time. The nursing progress note indicated the police recommended a No Trespass Order and one was initiated. During an interview on 3/26/26 at 3:13 P.M., Resident #106 said, They kicked me out. The Resident said he/she had used illegal substances and was sent to the hospital on 3/1/26. The Resident said the facility told the hospital that he/she was not allowed to return to the facility. He/she said the facility had gotten a No Trespass Order. The Resident said he/she did not think this was right and that he/she was now homeless. Resident #106 said the facility had been working with him/her on discharge planning and now had nowhere to go; he/she had been in the hospital since March 1st. The Resident said the facility would not take him/her back and now other facilities would not take him/her and believed the information about substance use was put out on the internet. The Resident said they were not provided with any paperwork regarding their right to appeal the discharge and did not know anything about this. The Resident said he/she had a problem with not being able to return to the facility, was depressed and added this is a lot. Review of Resident #106's paper and electronic medical record failed to include a No Trespass Order had been obtained. Review of the transfer paperwork included a Resident Notification Regarding Facility Bed Hold Notice and a 30-Day (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 0627 Level of Harm - Actual harm Residents Affected - Few	Notice of Intent to Transfer Resident, both dated 3/1/26. The 30-Day Notice of Intent to Transfer Resident form contained a section for Reasons for Discharge with multiple options, none of the reasons were checked off. There were no further notices in regard to discharge in the medical record or in the Medical Record office. During an interview on 3/26/26 at 4:28 P.M., Social Worker #1 said the two notices provided to the surveyor dated 3/1/26 were sent when the Resident transferred to the hospital. She said the facility had determined Resident #106 was not allowed to return to the facility due to illegal substance use and she was not involved in any discharge notices being provided to the Resident when this determination was made. She said the Resident had previously been referred to Elder Services for help with returning to the community and had been working on transitional services prior to the hospital transfer as the Resident did not have a place to discharge to. Review of the nursing progress notes indicated on 11/6/25 a nurse reached out to a family member of Resident #106 and was notified the Resident had no where to live. Review of the Social Service progress notes indicated Resident #106 had been referred to Elder Services in November 2025 to assist with returning to the community. The Social Service progress note on 2/9/26 and 2/16/26 indicated Resident #106 continued to work with Elder Services on transitioning to the community. During an interview on 3/26/26 at 4:49 P.M., the Administrator said on 3/1/26 the staff had found Resident #106 with an illegal substance and the Resident was transferred to the hospital. He said the interdisciplinary team met on 3/2/26 and determined the Resident could not return to the facility based on the use of illegal substances. The Administrator said he thought the original notices sent with the Resident on 3/1/26 were the correct Intent to Discharge form and no one sent any additional notices after the team discussion to not allow the Resident to return on 3/2/26. He said the facility had not pursued a No Trespass Order and there was no legal reason to prevent the Resident from returning to the facility. The Administrator said the facility was not a good fit for the Resident because of the substance use. He said there had been no updated clinical information provided from the hospital to indicate changes to the clinical care of the Resident. He said the facility felt that based on the Resident's substance use the Resident needed more help than a nursing home. He said the facility knew Resident #106 had a history of SUD prior to the original admission. He said the facility did not have a SUD counselor but did have the ability to coordinate services through their iPad and had provided this to other residents in the past. He said he was not sure if this had ever been offered to Resident #106. He said the facility did not have any knowledge of illegal substance use during the Residents stay at the facility from September 2025 through 2/28/26. Review of the Behavioral Health Group progress note from the Psychiatric Nurse Practitioner (11/19/25) and Licensed Independent Clinical Social Worker (11/26/25, 12/26/25, 2/6/26) failed to indicate Resident #106 was receiving counseling for SUD. During an interview on 3/26/26 at 5:19 P.M., the Admissions Coordinator said the process was for the hospital and facility to communicate through the Admissions Coordinators. She said any clinical updates from the hospital would have been uploaded in the electronic medical record and confirmed no clinical updates had been received from the hospital for Resident #106. She said the hospital Emergency Department had reached out at the beginning of March 2026 regarding the Resident returning to the facility and the Admissions Department had informed the hospital that the facility would not be allowing Resident #106 to return to the facility. She said this was why there were no additional updates on the Resident. She said this was a verbal communication and the Admissions Department did not send any written notice of discharge. During an interview on 3/27/26 at 1:23 P.M., the Administrator said he reviewed the policies himself and with the clinical corporate consultant and there was no policy regarding permitting residents to return to the facility following hospitalization. Review of the medical record failed to indicate why the facility could no longer care for the Resident. Refer to F628

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Monitor the dishwasher sanitation chemical agent after switching from high temperature dishwasher to chemical sanitation for 43 days to ensure all dishes were properly sanitized to prevent food borne illnesses; and2. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another) and ensure glove use was limited to a single task. Findings include: 1. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:-4-302.14 Sanitizing Solutions, Testing Devices. Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons: 1. The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitization; and 2. Too much sanitizer in the final rinse water could be toxic.-4-501.114 Machine Washing and Sanitizing - Dishwashing machines use either heat or chemical sanitization methods. Manufacturers' instructions must always be followed. Review of the Manufacturer's directions for the sanitizer used in the facility indicated test procedures were as follows:-Chlorine sanitizer test for low temp dish machines.-Remove a 1.5-inch strip of clean, dry test paper from container below.-At the end of the rinse cycle, dip strip of test paper into the final rinse water from the dish machine. Chlorine papers are dip, blot and read at once.-Immediately compare test paper strip to color chart on the test strip dispenser. Test results may be in the range below.-Test paper reading: Chlorine. 50-100 parts per million (ppm)-Rinse water temperature 120 or above. Review of dishwasher Maintenance Invoice, dated 2/9/26, indicated the work requested for the main kitchen dishwasher was, a chemical dispenser needs to be switched to a bleach sanitizer. The water temperature is not hot enough. During an interview on 3/24/26 at 8:05 A.M., the Food Service Manager (FSM) said the dishwasher booster went last week. During an interview on 3/26/26 at 10:04 A.M., the FSM said he has not been testing the sanitizer level in the dishwasher since they switched over. The FSM said the contractor switched them over to the chemical sanitizer and said he was all set. The FSM said he could call the contractor to have the sanitizing solution tested. During an interview on 3/26/26 at 4:55 P.M., the FSM said the Consultant Service Contractor (CSC) just told him that he must test the dishwasher sanitizer level, and the chlorine level is supposed to be at 50 ppm. The FSM said now that he knows that he will educate the staff on testing the Chlorine sanitizer levels. The FSM said the CSC told him the chemical sanitation level was a little low and provided him with testing instructions. During an interview on 3/26/26 at 5:00 P.M., the CSC said he tested the sanitizer level, and it was trace (too low) as the test strip barely changed color. The CSC said the sanitizer level for low temperature dish machines should have a chlorine level of 50 ppm for this machine. 2. Review of the 2022 Food Code by the U.S. FDA, revised 1/2023, indicated but was not limited to the following:- 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.- 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. On 3/24/26 at 8:05 A.M., the surveyor observed [NAME] #1 during breakfast tray line service and made the following observations:-Cook #1 was wearing a pair of gloves and plating food on the tray line. -Cook #1 left the tray line, turned the stove on and with her gloved hands, cracked (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	two pasteurized eggs in a frying pan, then returned to the tray line. [NAME] #1 did not change her gloves and continued to plate breakfast items and touch the utensils. -Cook #1 while plating food and wearing the same gloves, turned multiple times to open the oven and to retrieve a croissant with her gloved hands and place the croissant on a resident's plate. -Cook #1 finished cooking the eggs, turned off the stove and returned to plating food wearing the same gloves. -Cook #1 for the second time, turned and cracked two more pasteurized eggs in the frying pan, still wearing the same gloves, and returned to the tray line continuing to plate breakfast items. During an interview on 3/24/26 at 8:25 A.M., the FSM said [NAME] #1 should be changing her gloves when she leaves the workstation and before handling the croissants.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on records reviewed and interviews, the facility failed to ensure staff maintained complete and accurate medical records for five Residents (#7, #42, #9, #14, and #4), out of a total sample of 21 residents. Specifically, the facility failed to:1. For Resident #7, ensure physician and nurse practitioner progress notes were accessible in the Resident's medical record; and2. For Resident #42, ensure physician and nurse practitioner progress notes were accessible in the Resident's medical record; and3.For Resident #9, ensure primary physician progress notes were accessible in the Resident's medical record; and4. For Resident #14, ensure primary physician and wound nurse practitioner progress notes were accessible in the Resident's medical record; and5. For Resident #4, ensure his/her monthly behavior sheets were complete and accurate. Review of the facility's policy titled Medical Records Procedure, dated as revised in December 2025 indicated the following should be retained in the medical record:-1 year of physician progress notes-last 6 months of consults 1. Resident #7 was admitted to the facility in February 2026. On 3/24/26 and 3/25/26, the surveyor reviewed the Resident's paper and electronic medical records and was unable to locate any physician or nurse practitioner progress notes. On 3/25/26 at 4:10 P.M., the Director of Nursing (DON) provided the surveyor with progress notes dated 2/10/26, 2/11/26, and 2/27/26, and 3/6/26 from the medical records office that had not been filed in the Resident's medical record. 2. Resident #42 was admitted to the facility in February 2026. On 3/24/26 and 3/25/26, the surveyor reviewed the Resident's paper and electronic medical records and was unable to locate any physician or nurse practitioner progress notes. On 3/25/26 at 4:10 P.M., the DON provided the surveyor with progress notes, dated 2/10/26, 2/11/26, and 3/17/26, from the medical records office that had not been filed in the Resident's medical record. 3. Resident #9 admitted to the facility in May 2025. Review of the paper and electronic medical record for Resident #9 only included progress notes from the NP, there were no progress notes from the Primary Physician. During an interview on 3/25/26 at 4:10 P.M., the DON said Resident #9 had been seen by their Primary Physician and she would need to call them to request the documentation. On 3/25/26 at 5:20 P.M., the surveyor was provided with Primary Physician visits from 5/2/25, 7/1/25, 8/30/25, 10/29/25, 12/28/25 and 2/26/26. During an interview on 3/25/26 at 5:20 P.M., the DON said the Primary Physician had sent over the years' worth of visits and they had not been in the medical record prior. 4. Resident #14 was admitted to the facility in April 2022. Review of the paper and electronic medical record for Resident #14 only included progress notes from (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the NP, there were no progress notes from the Primary Physician. On 3/26/26 at 12:50 P.M., the surveyor was provided with Primary Physician visits from 2/3/25, 4/7/25, 6/2/25, 8/4/25, 10/6/25, 12/1/25, and 2/9/26. During an interview on 3/26/26 at 12:50 P.M., the DON said the Primary Physician for Resident #14 had sent over a years' worth of visits that were not in the medical record. During an interview on 3/26/26 at 1:07 P.M., the Medical Records staff said the process for physician visits was that she received the physician visits from the physicians (MDs and NPs) and uploads them to the electronic medical record. She said she would not have noticed if a physician had not been sending over visits as she was not responsible for tracking visits and thought the MDs only had to see the residents once per year, so she would not have noticed if the visits she received were only from the NPs. She said she started uploading physician visits to the electronic medical record in 2026 and was behind on uploading them. Review of the medical record indicated Resident #14 had a pressure ulcer and was seen by a Wound NP. Review of the medical record indicated the last documentation of a visit with the Wound NP was 12/22/25. During an interview on 3/26/26 at 12:50 P.M., the DON said she receives the Wound NP Progress notes from the consultant, makes any recommended changes and then sends the progress notes over to the Unit Managers to put in the medical record. During an interview on 3/26/26 at 2:03 P.M., Unit Manager #2 said she receives the Wound NP Progress notes and then leaves them for the Primary Physician or NP to review and sign. She said she was not sure who was responsible for putting them in the medical record after that. 5. Resident #4 was admitted to the facility in April 2025 with diagnoses which included mood disorder, depression, and schizophrenia. Review of the Minimum Data Set (MDS) assessment, dated 3/22/26, indicated Resident #4 displayed wandering behaviors on one to three days during the assessments look back period. Further Review of the MDS assessment indicated he/she received antipsychotic medication during the look back period. Review of Resident #4's Physician's Orders indicated but was not limited to: -Clozapine (antipsychotic) 50 milligrams (mg) every 12 hours, dated 4/30/25 Review of Resident #4's February 2026 and March 2026 Medication Administration Records (MAR) indicated he/she received Clozapine as ordered. Review of Resident #4's February 2026 monthly behavior sheets, on 3/25/26, indicated the Resident should be monitored each shift for hypersexual behaviors, depressed behaviors, and anxiety. Further review of Resident #4's February 2026 monthly behavior sheets indicated the facility failed to the document the presence or absence of behaviors as evidenced by 77 out of 84 opportunities left blank and were incomplete. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's March 2026 monthly behavior sheets, on 3/25/26, indicated the Resident should be monitored each shift for hypersexual behaviors, withdrawn/depressed behaviors, and resistance to care. Further review of Resident #4's March 2026 monthly behavior sheets indicated the facility failed to the document the presence or absence of as evidenced by 68 out of 72 opportunities left blank and were incomplete. During an interview on 3/26/26 at 1:52 P.M., Nurse #5 said residents on medications used to manage behaviors required a monthly behavior sheet. Nurse #5 said nursing should document the number of identified behaviors every shift. Nurse #5 said if there were no behaviors the nurses should document a zero for accurate monitoring and to show that interventions were working. During an interview on 3/26/26 at 3:03 P.M., the DON said nurses should be completing the behavior sheets at the end of every shift.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the Resident Representative (guardian) was not extended authority of decision making beyond the extent required by the court to consent to the administration of an antipsychotic medication for one Resident (#81), from a total sample of 21 residents. Specifically, the court approved Treatment Plan allowed Resident #81 to be treated with Seroquel and Rexulti (antipsychotics) and the Resident Representative consented for Resident #81 to be administered Zyprexa, which was not an approved antipsychotic medication on the Treatment Plan. Findings include:An Incapacitated Person (I.P.) is someone who is determined by the Court to have a clinically diagnosed condition that leaves them unable to make or communicate decisions affecting their physical health, safety, or self-care. The Guardian appointed by the court for an I.P. will make some or all decisions for the I.P. If the I.P. requires medical treatments or care that the court considers extraordinary, a guardian must obtain the Court's permission before authorizing the treatment. At a [NAME] guardianship hearing, the Court is asked to authorize extraordinary medical treatment for an Incapacitated Person. This usually refers to treatment with antipsychotic medication. Resident #81 was admitted to the facility in January 2024 with a diagnosis of dementia with behavioral disturbance. Review of the medical record indicated Resident #81 had a family member appointed as their permanent legal guardian and a Treatment Plan for the use of antipsychotics was implemented. Review of the court approved Treatment Plan for Resident #81 indicated in July 2025 the approved antipsychotic medications included Seroquel and Rexulti. Review of the Behavioral Health Group progress notes indicated on 8/19/26 the Psychiatric Nurse Practitioner recommended to discontinue Seroquel and to start Zyprexa (Olanzapine) 5 milligrams (mg) twice daily. Review of the Informed Consent for Psychotropic Administration form indicated the guardian of Resident #81 consented to the use of Zyprexa on 10/9/25. Review of the medical record included an order to start Zyprexa 5 mg twice daily on 10/10/25. On 11/25/25, the Zyprexa increased to 7.5 mg twice daily. Review of the medical record, including progress notes, failed to indicate the facility had submitted any documentation to the court to change the Treatment Plan to include Zyprexa. During an interview on 3/27/26 at 2:50 P.M., Social Worker #2 said Zyprexa was not listed on the court approved Treatment Plan and the court approved Treatment Plan should be followed. She said she had contacted the facility attorney, and the facility will submit to the court for an amendment to the Treatment Plan. She said, prior to the surveyor inquiry, the facility had not requested an amendment to the Treatment Plan to include the antipsychotic medication that was being administered outside of the Treatment Plan.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure the Resident's Health Care Proxy (HCP, individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications) about changes in their condition and potential need to alter the treatment plan for one Resident (#6), from a total sample of 21 residents. Specifically, the facility failed to notify the HCP of a change in the Resident's condition requiring transfer to the hospital and a significant weight loss.Findings include:Review of the facility's policy titled Resident Change in Condition, reviewed February 2024, indicated but was not limited to:-To facilitate nursing response for residents exhibiting change in condition.-The resident's Physician, legal representative and/or responsible party is to be notified.Review of the facility's policy titled Resident Nutritional Policy and Procedure, reviewed June 2025, indicated but was not limited to:-Weight Monitoring: -If a significant weight loss occurs, defined as five percent (5%) in one month, seven- and one-half percent (7.5%) in three months, or ten percent (10%) six months. -Ensure the family/next of kin/responsible party is notified regarding the significant change.Resident #6 was admitted to the facility in April 2025 with diagnoses including anoxic brain injury (occurs when the brain is completely deprived of oxygen, causing cell death within minutes) and quadriplegia (paralysis caused by illness or injury to the brain or spinal cord (typically C1-C8 vertebrae), resulting in partial or total loss of function in all four limbs and the torso).Review of the Minimum Data Set (MDS) assessment, dated 3/11/26, indicated Resident #6 had a moderate cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Further review of Resident #6's MDS indicated he/she had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months not prescribed by the physician and his/her HCP was activated.Review of Resident #6's medical record indicated he/she had cognitive impairment, and his/her HCP was invoked on 1/6/26.During a telephonic interview on 3/24/26 at 3:14 P.M., the HCP said the last time Resident #6 was transferred to the hospital the facility did not notify them and they were notified by the social worker from the hospital. The HCP said she was not aware of Resident #6 having a weight loss and they did not think Resident #6 had a weight loss.a. Review of Resident #6's medical record indicated he/she was transferred to the hospital for a change in condition.Review of Resident #6's Nursing Note, dated as late entry for 1/29/26, indicated but was not limited to:-Resident not feeling well this shift. Resident was lethargic and not being able to voice their needs when asked a question. Resident would just mumble their words. Resident did not eat breakfast this morning. This Nurse (#4) called the Nurse Practitioner and was told to send the Resident to the hospital. Resident was transferred to the hospital.Review of the Nursing Home to Hospital Transfer Form and the Situation-Background-Assessment-Recommendation (SBAR) Communication Form, undated, indicated but was not limited to:-Change in condition, symptoms, or signs observed and evaluated is/are: Lethargic and dark urine-This started on: 1/27/26-Since this started, symptoms have gotten worse.-The following sections were left blank: Contact Person, relationship to resident, contact information, notified of transfer, and they are aware of clinical situationThe SBAR form failed to indicate the HCP was notified of the transfer.During an interview on 3/26/26 at 9:31 A.M, Nurse #4 said when a resident needs to be sent to the hospital the HCP must be notified of the transfer and documented on the hospital transfer forms and in the medical record. Nurse #4 reviewed the undated Nursing Home to Hospital Transfer Form and the SBAR Communication Form and the nurse's note, dated as late entry for 1/29/26. She said she completed the Nursing Home to Hospital Transfer Form and the SBAR Communication Form for Resident #6 on 1/26/26 and wrote the nursing note, dated 1/29/26, she did not document if she notified Resident #6's HCP of his/her transfer to the hospital.During an interview on 3/26/26 at 1:10 P.M., the Director of Nursing (DON) said anytime a resident was sent to the hospital the HCP must be (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified and it must be documented in the medical record. She said if it was not documented then there was no way to ensure they were notified.b. Review of Resident #6's Dietitian's notes indicated but was not limited to:-1/7/26 Weight loss significant. See assessment.-1/23/26 Resident with visible weight losses. Reviewed with nursing.Review of the Nutrition Assessment, dated 2/26/26, indicated but was not limited to:-Percent of weight loss: -6.6% in one month -16% in three monthsFurther review of Resident #6's medical record failed to indicate his/her HCP was notified of his/her significant weight loss.During an interview on 3/26/26 at 9:31 A.M, Nurse #4 reviewed Resident #6's medical record and said once a weight loss was identified, the Dietitian would write recommendations, and then nursing would call the Physician/ Nurse Practitioner and call the HCP to notify them of a significant weight change. She said nursing was responsible for notifying the HCP. She said she did not see any documentation of Resident #6's weight loss notification. During a telephone interview on 3/26/26 at 12:39 P.M., the Dietitian said Resident #6 had a significant weight loss. She said when a weight loss was identified she would make recommendations and update the care plan. She said nursing was responsible for notifying the HCP.During an interview on 3/26/26 at 1:10 P.M., the DON said weight loss was reviewed daily in morning meeting, and weekly at the facility's risk meeting. She said the Dietitian would make recommendations, but it was nursing's responsibility to notify the Resident's HCP and the notification must be documented in the medical record.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed for one Resident (#106), out of three closed records reviewed, to provide in writing, the reason for discharge to the Resident, and failed to send a copy of the notice to the Ombudsman office. Specifically, after transferring Resident #106 to the hospital, the facility determined they would not allow the Resident to return from the hospital and did not send any written notices to the Resident or the Ombudsman. Resident #106 remained in the hospital as of 3/26/26. Findings include:Review of the facility's policy titled Notification of Transfer/Discharge and Bed Hold, revised in December 2025, indicated the following:-When the transfer/discharge of a resident occurs to the hospital, the Social Worker is to complete a Notice of Intent to Transfer Resident with Less than 30 Days' Notice or 30-Day Notice of Intent to Transfer Resident, these are facility specific, and send it along with the Facility Bed Hold Policy and Resident Notification Regarding Facility Bed Hold cover letter, with the resident to the hospital- When the discharge of a resident occurs due to a discharge home, a discharge for nonpayment, the Social Worker is to complete a Notice of Intent to Discharge Resident with Less than 30 Days' Notice (Expedited Appeal) or Notice of Intent to Discharge Resident. The notice is to be issued prior to the discharge or on the next business day following the discharge. A note must be made in the social service section of the chart. Resident #106 was admitted to the facility in September 2025 with a diagnosis of history of substance use disorder (SUD) including alcohol and heroin. Review of the Minimum Data Set (MDS) assessment, dated 1/7/26, indicated Resident #106 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. The MDS indicated Resident #106 needed partial to moderate assist with activities of daily living (ADLs) and independently ambulated with a rolling walker. Review of the Care Plans indicated Resident #106 received assistance with ADLs, was a fall risk, was at risk for complications related to cirrhosis, and had a history of SUD. Review of the nursing progress notes indicated on 3/1/26 Resident #106 was found using an illegal substance in his/her room and the police and Emergency Medical Services (EMS) were contacted. Resident #106 was transferred to the hospital at this time. During an interview on 3/26/26 at 3:13 P.M., Resident #106 said, They kicked me out. The Resident said the facility told the hospital that he/she was not allowed to return to the facility. The Resident said he/she did not think this was right and that he/she was now homeless. Resident #106 said the facility had been working with him/her on discharge planning and now had nowhere to go and had been in the hospital since March 1st. The Resident said they were not provided with any paperwork regarding their right to appeal the discharge and did not know anything about this. During an interview on 3/23/26 at 11:02 A.M., the Ombudsman said she had concerns regarding the transfer/discharge process and had not received any notices from the facility since December 2025. During an interview on 3/26/26 at 3:44 P.M., Social Worker #1 said she worked for a consultant and had started working at the facility in February 2026. She said she had just found out the week prior that notices of transfer and discharge were not being sent to the Ombudsman. She said she was unfamiliar with Resident #106 and would have to review the discharge and follow up on notices provided. Review of the transfer paperwork included a Resident Notification Regarding Facility Bed Hold Notice and a 30-Day Notice of Intent to Transfer Resident, both dated 3/1/26. The 30-Day Notice of Intent to Transfer Resident contained a section for Reasons for Discharge with multiple options, none of the reasons were checked off. There were no further notices in regard to discharge in the medical record or in the Medical Record office. During an interview on 3/26/26 at 4:28 P.M., Social Worker #1 said the notices for Bed Holds and Transfers were kept in a binder in the Medical Record office. She said the two notices provided to the surveyor were dated 3/1/26 and were sent with the transfer forms when the Resident transferred to the hospital. She said the 30-Day Notice of Intent to Transfer Resident form should have been a Less than 30-Day Notice form as the Resident was not provided with 30 days. She said the facility had (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined that Resident #106 was not allowed to return to the facility after the Resident was sent to the hospital and she was not involved in any discharge notices being provided to the Resident when this determination was made. She said the Intent to Discharge form with appeal rights should have been sent directly to the Resident at the hospital. During an interview on 3/26/26 at 4:49 P.M., the Administrator said on 3/1/26 the staff had found Resident #106 with an illegal substance and the Resident was transferred to the hospital. He said the interdisciplinary team met on 3/2/26 and determined the Resident could not return to the facility. The Administrator said he thought the original notice sent with the Resident on 3/1/26 was the correct Intent to Discharge form and no one sent any additional notices after the team discussion to not allow the Resident to return on 3/2/26. During an interview on 3/26/26 at 5:19 P.M., the Admissions Coordinator said the process was for the hospital and facility to communicate through the Admissions Coordinators. She said the Emergency Department had reached out at the beginning of the month regarding the Resident returning to the facility and the Admissions Department had informed the hospital that the facility would not be allowing Resident #106 to return to the facility. She said this was a verbal communication and the Admissions Department did not send any written notice of discharge. During an interview on 3/27/26 at 11:15 A.M., Social Worker #2 said she had worked at the facility on 3/4/26 and was unfamiliar with Resident #106 being sent to the hospital and unable to return. She said she had not sent any intent to discharge notices to the Resident or the hospital. During an interview on 3/27/26 at 1:09 P.M., Social Worker #3 said she had worked at the facility on 3/3/26 and had heard that staff found drug paraphernalia in the room of Resident #106 and the Resident was transferred to the hospital. She said she did not issue any discharge notes to the Resident or the hospital.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement the person-centered plan of care for two Residents (#40, #7), out of 21 sampled residents. Specifically, the facility failed to:1. Implement interventions identified on Resident #40's care plan for falls; and2. Develop and implement interventions to address Resident #7's history of suicidal ideations.Findings include:Review of the facility's policy titled Care Plan Policy, revised 5/2025, indicated, but was not limited to, the following:Care Planning - Comprehensive:-Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers.-Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.Behavior Care Plans:-Any resident exhibiting behaviors/symptoms must have an individualized behavior care plan in place that addresses specific behaviors.-All behavior care plans are to be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.1. Resident #40 was admitted to the facility in September 2021 with diagnoses including dementia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and atrial fibrillation with long term use of anticoagulants.Review of Resident #40's Minimum Data Set (MDS) assessment, dated 2/22/26, indicated the Resident was cognitively impaired, as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. Further review of the MDS assessment indicated the Resident sustained one fall with major injury since the previous assessment.Review of Resident #40's medical record indicated that on 2/22/26, the Resident sustained a fall resulting in a nasal fracture. Review of Resident #40's Physician's Orders indicated, but was not limited to, the following:-Chair alarm while out of bed every shift (order date 3/2/26)Review of Resident #40's care plans indicated, but was not limited to, the following:-Problems/Strengths: At risk for falls: weakness-Interventions: 8/16/23: S/P (status post) fall do not leave unsupervised in bathroom, clip alarm at HS (bedtime) only3/3/26: (3/2/26)- Chair alarm in place when OOB (out of bed) (staff to check function and placement when in use)The surveyor made the following observations:-3/25/26 at 2:49 P.M. - Resident #40 was sitting in his/her wheelchair in the unit activity room. The Resident's chair alarm was not in place.-3/26/26 at 9:42 A.M. - Resident #40 was sitting in his/her wheelchair in the unit activity room after breakfast. The Resident's chair alarm was not in place.-3/26/26 at 12:25 P.M. - Resident #40 was in the unit activity room eating lunch in his/her wheelchair. The Resident's chair alarm was not in place.During an interview on 3/26/26 at 12:26 P.M., Unit Manager #2 said Resident #40 had recently had a fall with nasal fracture and should have a chair alarm in place when he/she is out of bed.During an interview on 3/27/26 at 3:42 P.M., the Director of Nursing (DON) said Resident #40's chair alarm was an intervention and should have been in place.2. Resident #7 was admitted to the facility in February 2026 with diagnoses including depression, bipolar disorder, and suicidal ideation.Review of the MDS assessment, dated 2/9/26, indicated Resident #7 was usually understood and usually understands, but no BIMS assessment was completed due to the Resident being rarely/never understood. Further review of the MDS assessment indicated the Resident had diagnoses including dementia, depression, and bipolar disorder and received antidepressant and antipsychotic medication.Review of Resident #7's Hospital Discharge summary, dated [DATE], indicated the Resident had a history of suicidal ideation and inpatient psychiatric hospitalization in September 2025.Review of Resident #7's Physician's Orders indicated, but was not limited to, the following:-Activate HCP (health care proxy) (order date 2/3/26)-Wellbutrin XL (antidepressant medication) 150 mg (milligrams) Give one tab oral every day (order date 2/3/26)-Trazodone (antidepressant medication) 50 mg nightly-Olanzapine (antipsychotic medication) 10 mg nightly (order (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date 3/9/26)-Lamictal (anti-seizure medication also used to manage bipolar disorder) 150 mg twice daily (order date 2/3/26)Review of Resident #7's consultant Behavioral Health Group progress notes indicated the Resident had diagnoses of dementia with psychotic disturbance and major depressive disorder requiring psychiatric medication but failed to include information regarding Resident's history of suicidal ideation requiring psychiatric hospitalization.Review of Resident #7's Social History assessment, dated 2/4/26, failed to indicate the Resident's history of suicidal ideation requiring psychiatric hospitalization in September 2025.Review of Resident #7's care plan indicated, but was not limited to, the following-Problems/Strengths: Psychotropic medication: Bipolar, depression, dementia with mood disturbance-Interventions: Medicate per MD orders; Observe for onset/worsening of adverse S/Es (side effects); AIMs (Abnormal Involuntary Movement Scale) test Q6M (every six months) and PRN (as needed); Monitor mood and behavior; Notify physician of changes in mood, behavior, and/or for onset/worsening of adverse S/EsReview of Resident #7's care plan failed to include care planning interventions to address the Resident's history of suicidal ideations requiring psychiatric hospitalization in September 2025.During an interview on 3/26/26 at 1:42 P.M., Unit Manager #2 said Resident #7 had not expressed his/her history of suicidal ideation as a concern at the facility. During an interview on 3/27/26 at 3:42 P.M., the DON said Resident #7 should have a care plan for suicidal ideation so that facility staff could monitor the Resident appropriately.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, for two Residents (#7 and #40), of 21 sampled residents, the facility failed to ensure care was provided to residents in accordance with professional standards of practice. Specifically, the facility failed:1. For Resident #7, to document the Resident's 8 P.M. blood sugar levels, amount of sliding scale insulin administered, and the sites of insulin administration;2. For Resident #40, to ensure physician's orders were implemented:a. in response to accepted pharmacy recommendations; andb. for prosthetic eye care.Findings include:Review of [NAME], Manual of Nursing Practice 11th edition, 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 prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility's policy titled Medication Orders, revised November 2014, indicated, but was not limited to, the following:-A current list of orders must be maintained in the clinical record of each resident.-Orders must be written and maintained in chronological order.1. Resident #7 was admitted to the facility in February 2026 with diagnoses including hyperglycemia and diabetes.Review of the Minimum Data Set (MDS) assessment, dated 2/9/26, indicated Resident #7 had a diagnosis of diabetes. Further review of the MDS assessment indicated the Resident received insulin injections and was administered hypoglycemic medications (medications that lower blood sugar levels).Review of Resident #7's Hospital Discharge summary, dated [DATE], indicated the Resident was hospitalized for uncontrolled type 2 diabetes requiring adjustment of his/her diabetic medication regimen and treatment with insulin.Review of Resident #7's care plan indicated, but was not limited to, the following:-Problems/Strengths: Alteration in metabolic function: DM (diabetes mellitus)-Interventions: Medicate as ordered; Monitor blood sugar as ordered per MD's ordered [sic]Review of Resident #7's Physician's Orders indicated, but was not limited to, the following:-Humalog (fast-acting insulin) 100 units / 1 ml (milliliter) solution - Injection per sliding scale half hour before meals and per sliding scale every night at 8 P.M. (order date 2/5/26)Review of Resident #7's progress notes failed to include consistent documentation of the Resident's 8 P.M. blood sugar levels and units of Humalog administered. Review of Resident #7's Physician's progress note, dated 2/11/26, indicated the Resident's A1C (a blood test that provides an average of blood sugar levels over two to three months used to monitor how well the diabetes treatment plan is working) was elevated. Further review indicated the Resident's prescribed Glargine (a long-acting insulin) was increased from 20 units to 22 units and his/her sliding scale insulin was continued.Review of Resident #7's Nurse Practitioner (NP) progress note, dated 2/27/26, indicated the Resident's blood sugar levels were elevated in the 300's despite the use of Glargine 22 units and sliding scale insulin. The NP prescribed an oral hypoglycemic medication, Tradjenta 5 milligrams (mg) daily and blood sugar levels were to be evaluated in one week.Review of Resident #7's NP progress note, dated 3/6/26, indicated the Resident's medications and labs were reviewed. No medication changes were made at that time. The progress note did not indicate if the Resident's blood sugar levels had improved after the addition of an oral hypoglycemic medication.Review of Resident #7's February 2026 and March 2026 Medication Administration Records (MARs) failed to indicate the Resident's 8 P.M. blood sugar levels, number of Humalog units administered at 8 P.M. when/if insulin was required per the Resident's sliding scale order, and site of administration for any 8 P.M. Humalog administrations. During an interview on 3/25/26 at 12:38 P.M., Nurse #8 said the electronic medical (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record should populate with a box to enter the Resident's blood sugar level, number of units of insulin administered, and site of administration for all sliding scale insulin administrations. Nurse #8 reviewed Resident #7's 8 P.M. Humalog sliding scale order and confirmed that no blood sugar levels, number of units, and sites of administration were documented. Nurse #8 said the order must have been entered incorrectly.During an interview on 3/26/26 at 1:42 P.M., Unit Manager #2 said Resident #7's blood sugar level and number of Humalog units administered should be documented and if it was not there, the order was not entered correctly and needed to be fixed. During an interview on 3/27/26 at 3:42 P.M., the Director of Nursing (DON) said that for Resident #7's 8 P.M. sliding scale insulin, there should have been a place for the nurses to document what the blood sugar level was. The DON confirmed that there had not been documentation of the Resident's 8 P.M. blood sugar levels on the MAR. 2. Resident #40 was admitted to the facility in September 2021 with diagnoses including dementia with behavioral disturbance and depressive episodes.a. Review of Resident #40's consultant pharmacist medication regimen review recommendation forms indicated, but was not limited to, the following:-On 2/4/26, the consultant pharmacist indicated the Resident was prescribed two antidepressant medications (Trazodone and Citalopram) that were due to be reviewed for gradual dose reductions and suggested the prescriber consider a gradual dose reduction of Trazodone to 25 mg at bedtime or Citalopram to 5 mg daily. The physician signed the form on 2/11/26 and indicated he accepted the recommendation to reduce the Resident's Citalopram to 5 mg daily. -On 3/10/26, the consultant pharmacist indicated the Resident's prescriber had accepted the pharmacy recommendation to decrease Citalopram to 5 mg daily on 2/11/26, but the order had not yet been processed.-On 3/10/26, the consultant pharmacist indicated the Resident had an as needed Trazodone order without a stop date and recommended the as needed Trazodone be discontinued or that the facility add a stop date that was less than 14 days from the order's initiation. The physician signed the form on 3/13/26 and indicated that he accepted the recommendation to re-evaluate the medication in 14 days.Review of Resident #40's paper medical record indicated that on 3/13/26, an interim/telephone order had been written to discontinue the Resident's Trazodone order and re-evaluate in 14 days per pharmacy recommendation and decrease the Resident's Citalopram to 5 mg daily. The interim/telephone order form was not signed by a receiving nurse. Review of Resident #40's active Physician's Orders, printed from the electronic medical record, indicated, but was not limited to, the following:-Citalopram 10 mg one tab oral every day (order date 1/16/25)-Trazodone 12.5 mg twice daily as needed for agitation (order date 2/28/26)Review of Resident #40's care plan indicated, but was not limited to, the following:-Problems/Strengths: Alteration in mood: anxiety-Interventions: Medicate as ordered-Problems/Strengths: Psychotropic medication: Trazodone due to dx (diagnosis) depressive episodes, insomnia-Interventions: will be on the lowest dose with improved effectReview of Resident #40's February 2026 and March 2026 MARs indicated:-Resident #40 received Citalopram 10 mg daily-Resident #40 had an order for as needed Trazodone, initiated 2/28/26, with no stop dateDuring an interview on 3/26/26 at 1:42 P.M., Unit Manager #2 reviewed the interim/telephone orders in Resident #40's paper chart with the surveyor. Unit Manager #2 said she had written the order to discontinue the Resident's Trazodone order and re-evaluate in 14 days per pharmacy recommendation and decrease the Resident's Citalopram to 5 mg daily and left it flagged for a nurse assigned to the Resident to implement. Unit Manager #2 did not know why the orders were not implemented. b. Review of Resident #40's medical record indicated the Resident had a prosthetic left eye.Review of Resident #40's paper medical record indicated that an interim/telephone order had been written for the Resident's prosthetic eye care weekly. The interim/telephone order was not dated or signed by a receiving nurse.Review of Resident #40's active physician's orders failed to include orders for the Resident's prosthetic eye care.Review of Resident #40's care plan indicated, but was not limited to, the following:-Problems/Strengths: Vision impairment, r/t (related to) false L (left) eye-Interventions: Remind and assist resident to don (put on) visual appliances daily; keep visual appliances cleanFurther review of Resident #40's care plan failed to include further (continued on next page)

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Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructions for care for the Resident's prosthetic eye. Review of Resident #40's February 2026 and March 2026 MARs indicated the Resident was not administered prosthetic eye care. Further review of the March 2026 MAR indicated the Resident received an ophthalmic antibiotic (Ciprofloxacin) and artificial tears 3/1/26-3/4/26. During an interview on 3/26/26 at 1:42 P.M., Unit Manager #2 reviewed the interim/telephone orders in Resident #40's paper chart with the surveyor. Unit Manager #2 said she had written the order for the Resident's prosthetic eye care and left it flagged for a nurse assigned to the Resident to implement. Unit Manager #2 could not recall when she had written the undated interim/telephone order and did not know why the order was not implemented.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to address high blood glucose levels over a period of 34 days for one Resident (#66), out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Diabetes-Clinical Protocol, revision date March 2025, indicated but was not limited to the following:-The provider and staff will summarize factors contributing to, or conditions affected by, the resident's diabetes or glucose intolerance and will assess the impact of diabetes on the individual's function and quality of life.-Based on the preceding assessment, including causes and complications, the provider will order individualized interventions, which may include:a. Treatment of underlying condition causing impaired glucose intolerance;b. Physical activity, diet, lifestyle modifications, where feasible and accepted by resident;c. Oral hypoglycemic agents; and/ord. Insulin-The provider will order desired glucose targets and monitoring regimes, as well as parameters for reporting information related to blood sugar management.-The provider will adjust treatments based on these results and other factors such as glycosuria, weight gain or loss, hypoglycemic episodes, etc.-The provider will follow up on any acute episodes associated with a significant sustained change in blood sugars or significant deterioration of previous glucose control and document resident status at subsequent visits until the acute situation is resolved.-Staff will notify the practitioner as soon as possible when:b. The resident has blood glucose readings higher than 300 milligrams per deciliter (mg/dl) during all or part of two consecutive days. Resident #66 was admitted to the facility in February 2026 with diagnoses which included Type 2 diabetes mellitus (DM) with hyperglycemia (High blood sugar). Review of the Minimum Data Set (MDS) assessment, dated 3/12/26, indicated Resident #66 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating Resident was cognitively intact. Section N indicated Resident #66 was receiving insulin injections. Review of Resident #66's Physician's Orders indicated but was not limited to the following:-House controlled carbohydrate (HCC), cardiac, double portion breakfast, lunch, and supper, regular, thin, date initiated 3/4/26.-Semglee (insulin glargine) pen 100 IU/1ML solution, inject 30 units subcutaneous every night at 8:00 PM, date initiated 2/20/2026.-Semglee pen 100 IU/1ML solution, inject 15 units subcutaneous twice (BID) daily at 8: AM and 12:00 P.M., date initiated 2/20/26.-Insulin Aspart Flex Pen 100U/1ML solution, inject 15 units at breakfast, lunch, supper. With meals. Date initiated 2/20/26.-Semglee pen 100 IU/1ML solution, inject 15 units subcutaneous every day at 8: AM, date initiated 3/2/2026 Discontinued 3/3/26. Review of Resident #66's March 2026 Medication Administration Record (MAR) indicated medications were administered as ordered. Review of Resident #66's Physician's Orders for obtaining Fasting Blood Sugars (FBS) indicated the following: -Obtain FBS Breakfast, lunch, supper, date initiated 2/20/26 and discontinued on 3/26/26.-Obtained FBS every night at 8:00 P.M., date initiated 2/20/26 and discontinued on 3/26/26. Review of Resident #66's MAR from 2/20/26 through 2/28/26 indicated FBS readings above 300 mg/dL 14 times out of 32 FBS. Review of Resident #66's MAR from 3/1/26 through 3/26/26 indicated FBS readings above 300 mg/dL 24 times out of 97 FBS. Review of Physician and Nurse Practitioner (NP) notes, dated 2/27/26, 2/28/26, 3/17/26 and 3/20/26, did not indicate Resident #66's consistently elevated blood sugars were addressed. During an interview on 3/26/26 at 1:54 P.M., Unit Manager #1 (UM) said she was never made aware of Resident #66's blood sugars being over 300 and they did not show up on the dashboard (electronic medical record alert). UM #1 said if the blood sugars were above 300 it should have flagged and shown on the dashboard which she reviews every morning. Then she would have addressed the high blood sugar levels with the physician or NP. UM #1 said Resident #66 did not have parameters for reporting high blood sugars because he/she was not a sliding scale with the insulin. During an interview on 3/26/26 at 1:59 P.M., Nurse #6 said Resident #66's high blood sugars should have flagged on the dashboard. Nurse #6 reviewed the dashboard and said the high blood sugars never showed as an alert. During an interview on 3/26/26 at 4:24 P.M., the Director of Nurses (DON) said she would have expected the nurses to communicate and document in their nursing notes for any (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident with blood sugars over 300. The DON said any blood sugar reading over 300 should have shown up on the dashboard and Resident #66's readings over 300 did not. The DON said the physician was notified today but should have been notified after one week of high blood sugars. During a telephonic interview on 3/26/26 at 4:29 P.M., Physician #1 reviewed her notes and the NP's notes and said they were never notified of Resident #66's high blood sugars and never changed the Resident's insulin dosages. Physician #1 said she would expect the nurses to notify her if a resident's blood sugars were running over 300 for more than a week.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, and record reviews, the facility failed to ensure one of one sampled resident with a pressure ulcer (Resident #14), out of a total sample of 21 residents, was provided accurate interventions and treatments to promote healing. Specifically, for Resident #14, the facility failed to:a. Set the air mattress per the physician's orders; andb. Ensure treatments for a left heel pressure ulcer were documented and consistent with current physician's orders. Findings include:Resident #14 was admitted to the facility in April 2022 with a diagnosis of advanced dementia and was receiving hospice services. Review of the Minimum Data Set (MDS) assessment, dated 1/28/26, indicated Resident #14 had long-term and short-term memory problems, was dependent on staff for care, had one stage 3 (full thickness loss of skin) pressure ulcer, had a pressure reducing device on the bed, and received pressure ulcer/injury care. Review of the Care Plans indicated Resident #14 was at risk for skin breakdown and had active pressure ulcers with interventions including: an air mattress and providing treatments as ordered a. On 3/24/26 at 8:28 A.M., the surveyor observed Resident #14 lying on an air mattress. The air mattress was set above 320 pounds. During an interview on 3/24/26 at 12:04 P.M., the Family Member of Resident #14 said the Resident had developed a new pressure ulcer on their buttocks this past week and she had requested that Resident #14 not get out of bed to avoid increased pressure while sitting in the wheelchair. She said she would rather have the staff reposition the Resident on the air mattress to alleviate the pressure. Review of the Wound Nurse Practitioner's (NP) Progress Note, dated 3/23/26, indicated Resident #14 had developed a new stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) to the right buttock. The assessment/plan indicated to use the pressure redistribution mattress per facility protocol. Review of the Physician's Orders included an order to monitor that the air mattress was set to 175-pound weight every shift. The surveyor observed the air mattress set over 320 pounds on the following days: -3/25/26 at 11:09 A.M. -3/25/26 at 3:15 P.M.-3/26/26 at 8:00 A.M. Review of the Treatment Administration Record (TAR) indicated the nurse signed off that the air mattress was set to 175 pounds on 3/24/26, 3/25/26 and 3/26/26. During an interview on 3/26/26 at 12:50 P.M., the Director of Nurses (DON) said the air mattress for Resident #14 should be set at his/her weight as indicated on the order. She said the air mattress should not be set at over 320 pounds. During an interview on 3/26/26 at 2:10 P.M., Unit Manager #2 said the air mattress should have been checked every shift as indicated on the order and set to the correct settings. b. Review of the medical record indicated Resident #14 had developed a stage 3 pressure ulcer to the left heel in December 2024. Review of the Wound NP's Progress Note, dated 2/9/26, included a recommendation to change the left heel treatment to an antimicrobial cleanser, followed by Calcium Alginate, to secure with an ABD pad (gauze pad) and then rolled gauze. Review of the Physician's Orders indicated the treatment to the left heel was changed as recommended on 2/9/26. Review of the TAR indicated there was no assigned time to administer the new treatment and there was no documentation to indicate the treatment was completed from 2/10/26 through 2/15/26. Review of the Wound NP's Progress Note, dated 2/16/26, included a recommendation to change the left heel treatment to cleanse with wound cleanser, followed by anasept gel (a gel designed to maintain a moist wound environment that promotes healing while providing broad-spectrum antimicrobial activity), followed by an ABD pad and then a gauze roll. Review of the TAR indicated there was no assigned time to administer the new treatment and there was no documentation to indicate the treatment was completed from 2/17/26 through 3/22/26 when the treatment was changed again. Review of nursing notes under treatments indicated a treatment to the left heel was completed on 2/10/26 and 2/17/26 but failed to indicate which treatment was provided. During an interview on 3/26/26 at 10:02 A.M., Nurse #3 said she frequently works on the unit where the Resident resides but was not always assigned to Resident #14. She said she had last worked on that assignment about two weeks prior. She said she knew that the Resident received treatments to the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left heel daily but could not be sure which treatments were completed. She reviewed the medical record and could not say where it would be documented which treatment was provided if it was not on the TAR. Review of the medical record indicated Nurse #3 provided care to Resident #14 on 2/20/26, 2/27/26, 3/3/26, 3/6/26, 3/7/26, 3/10/26, and 3/13/26. During an interview on 3/26/26 at 2:10 P.M., Unit Manager #2 said the treatment changes on 2/9/26 and 2/16/26 were not entered into the electronic medical record correctly and were not showing up for the nurses to be informed of what the treatment was and to sign off that the treatment was complete. She said the nurses were completing treatments every day to the left heel, but she couldn't be sure of what the treatment was since there were two changes in February. During an interview on 3/27/26 at 10:41 A.M., Nurse #7 said she worked on the unit every weekend. She said the top of the electronic medication treatment page would tell the staff which treatment to complete. Review of the page with the surveyor failed to indicate the current treatment order for Resident #14. She said she was not sure how some treatments were listed at the top of the page and others were not. She said she had completed a treatment for Resident #14 on the weekends, and it was the treatment with the ABD pad. She said she could not remember which treatment with the ABD pad, as both recent treatments included an ABD pad. During an interview on 3/26/26 at 12:50 P.M., the DON said the staff had been working very hard to get the heel wound healed and had been doing treatments daily. She said, based on the medical record there was no way to tell which treatment was being provided to the Resident. She said both treatment orders should have had an assigned shift to provide the treatment to allow the staff to see the correct treatment and sign off.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interviews and record review, the facility failed to develop a person-centered plan of care which included trauma informed approaches and identified triggers to avoid potential re-traumatization for one Resident (#32) with a history of trauma, out of a total sample of 21 residents. Findings include:Review of the facility's policy titled Primary Care Post-Traumatic Stress Disorder (PC- PTSD-5) Screen Assessment Procedure, dated 1/2024, included but was not limited to:-The PC- PTSD-5 screen is a five item screen designed to identify individuals with probable PTSD. Those screening positive require further assessment, preferably with a structured interview, and care planning.-Procedure:a. To be completed by Social Services or clinical designee on admission and annually thereafterb. If the respondent indicates a trauma history - experiencing a traumatic event over the course of their life the respondent is instructed to answer five additional yes/no questions about how that trauma has affected them over the past monthc. If there are any yes responses, care plan goals and interventions must be in place to address experiences and preferences in order to eliminate or mitigate triggers. Resident #32 was admitted to the facility in March 2026 with diagnoses which included PTSD (a mental health condition triggered by witnessing or experiencing terrifying events, causing long-lasting, severe distress). Review of Resident #32's Social History Assessment, dated 3/10/26, failed to identify a history of a traumatic event. Further review of the medical record failed to indicate that a PTSD Screen/Assessment was completed. Review of Resident #32's care plans failed to indicate he/she had a history of a traumatic event. Review of the Behavior Health Group, Medication Management visit notes, dated 3/17/26 and 3/24/26, indicated Resident #32 had a medical history that included PTSD. Review of the Behavior Health Group Therapy visit note, dated 3/20/26, indicated Resident #32 had a medical history that included PTSD and he/she discussed some personal history, including trauma he/she had experienced in his/her life. Further review of the Behavior Health Group visit notes failed to indicate potential triggers for Resident #32. During an interview on 3/26/26 at 8:47 A.M., Nurse #5 said she does not know about Resident #32's PTSD, previous trauma, or triggers. Nurse #5 reviewed Resident #32's medical record and said there was no assessment related to his/her history of trauma. During an interview on 3/26/26 at 1:18 P.M., Social Worker #1 said Resident #32 had a history of PTSD. Social Worker #1 reviewed Resident #32's medical record and said the PTSD Assessment should have been completed on admission, and a care plan should have been developed for PTSD. Social Worker #1 said the assessment and care plan should have been completed to identify potential triggers and to prevent potential re-traumatization. During an interview on 3/26/26 at 3:03 P.M., the Director of Nurses said nursing did not complete an assessment for PTSD, but a resident-specific care plan should be developed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review, the facility failed to ensure staff stored drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to properly secure Xanax (a controlled substance prescribed for anxiety and panic disorders) for one Resident (#44), out of a total sample of 21 residents.Findings include: Review of the facility's policy titled Medication Labeling and Storing, undated, indicated but was not limited to the following:-Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to the following:-Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined they have the decision-making capacity to do so safely.Resident #44 was admitted to the facility in July 2025 with diagnoses including anxiety and panic disorder.Review of the Minimum Data Set (MDS) assessment, dated 1/21/26, indicated Resident #44 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15.Review of Resident #44's Self-Administration Medication assessment, dated 7/28/25, indicated he/she was not capable of self-administering his/her medications. Review of Resident #44's Physician's Orders included but were not limited to:-2/16/26: Xanax 0.25 milligrams (mg) tablet daily as needed.On 3/24/26 at 9:25 A.M., the surveyor observed Resident #44 in bed with a plastic medication cup on his/her nightstand containing a white oval tablet. During an interview on 3/24/26 at 9:26 A.M., Resident #44 said that the white oval tablet was Xanax. During an interview on 3/24/26 at 9:30 A.M., Nurse #1 said she was unsure if Resident #44 was cleared to self-administer medications. Nurse #1 retrieved the white tablet from Resident #44's room and confirmed the white oval tablet was Xanax. Nurse #1 said she was unsure how long the tablet had been in Resident #44's room.During an interview on 3/24/26 at 9:35 A.M., Unit Manager #1 (UM) said Resident #44 was not cleared to self- administer medications. UM #1 reviewed the first-floor unit narcotic book and said the last time Xanax was signed out to Resident #44 was on 3/17/26. During an interview on 3/24/26 at 2:19 P.M., UM #1 said she had confirmed the medication was last administered to Resident #44 on 3/17/26 and that Resident #44 told her he/she had been keeping it in a drawer. Review of the first-floor unit narcotic book on 3/24/26 at 2:40 P.M., indicated for Resident #44 that Xanax one 0.25 mg tablet was signed out on 3/17/26 at 10:24 A.M. During an interview on 3/25/26 at 11:25 A.M., Resident #44 said that he/she had the Xanax tablet since some time last week. Resident said he/she had requested the tablet, and he/she had saved it because the last time he/she had needed the Xanax it took several hours for the nurse to dispense it. Resident #44 said he/she wanted to make sure to have one on hand if needed again.During an interview on 3/25/26 at 12:10 P.M., the Director of Nursing (DON) said that it would be her expectation that the nurses stay with the residents until they finish taking their medications as this is best nursing practice.