STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225267	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Place Healthcare	193-195 Pleasant Street Attleboro, MA 02703

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop, implement, and individualize a comprehensive care plan for three Residents (#5, #73, #29), out of a total sample of 24 residents. Specifically, the facility failed:1. For Resident #5, to ensure a comprehensive care plan was developed and implemented related to his/her use of antipsychotic medications;2. For Resident #73, to ensure a comprehensive care plan was developed and implemented related to his/her use of antipsychotic medications; and3. For Resident #29, to ensure a comprehensive care plan was developed and implemented related to his/her smoking status and preferences. Findings include:Review of the facility's policy titled Care Plans, comprehensive Person-centered, dated last revised 1/2024, indicated but was not limited to the following: - A comprehensive, person-centered care plan will be developed for each resident. - The care plan will include objectives that meet the resident's physical, psychosocial and functional needs is developed for each resident. - The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, may assist with the development of a comprehensive, care plan for each resident. - The care plan interventions are derived from information gathered as part of the comprehensive assessment. - The IDT reviews and updates the care plan when there has been a significant change in the resident's condition, when there is a change, and at least quarterly, in conjunction with the required quarterly MDS (Minimum Data Set) assessment. 1. Resident #5 was admitted to the facility in June 2025 with diagnoses including post-traumatic stress disorder, anxiety, and dementia. Review of Resident #5's MDS assessment, dated 9/11/25, indicated he/she utilized antipsychotic medication on a routine basis. Review of Resident #5's Physician's Orders indicated but were not limited to the following: - 6/23/25: Quetiapine Fumarate (Seroquel) tablet 25MG (milligrams); give 12.5MG by mouth two times a day for mood. Review of Resident #5's comprehensive care plans failed to indicate an antipsychotic care plan was developed or implemented. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/25 at 10:17 A.M., Unit Manager (UM) #1 said all residents who utilize antipsychotic medication should have a care plan. UM #1 and the surveyor reviewed Resident #5's comprehensive care plans. UM #1 said there was not a care plan for antipsychotic medication use and there should be. During an interview on 12/10/25 at 11:12 A.M., the Director of Nursing (DON) said all residents who utilize antipsychotic medication should have a care plan reflecting their use. 2. Resident #73 was admitted to the facility in November 2021 with diagnoses including bipolar disorder, dementia with behavioral disturbances and anxiety. Review of the MDS assessment indicated Resident #73 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15 and had utilized antipsychotic medication on a routine basis. Review of Resident #73's Physician's Orders indicated but were not limited to the following: -Risperdal Oral tablet 0.5 MG; give 0.5 MG by mouth at bedtime for paranoia/delusions (dated 12/20/24) Review of Resident #73's Medication Administration Record (MAR) for November 2025 and December 2025 indicated he/she had received Risperdal as ordered. Further review of the physician's orders and medical record did not indicate staff were monitoring for side effects from an antipsychotic medication (Risperdal). Review of Resident #73's comprehensive care plans failed to indicate an antipsychotic care plan was developed or implemented. During an interview on 12/9/25 at 12:15 P.M., the Assistant Director of Nursing (ADON) said all residents who utilize antipsychotic medication should have a care plan. The ADON and the surveyor reviewed Resident #73's comprehensive care plans. The ADON said she did not see a care plan for antipsychotic medication use and there should be one. During an interview on 12/10/25 at 11:12 A.M., the DON said all residents who utilize antipsychotic medication should have a care plan reflecting their use. 3. Resident #29 was admitted to the facility in December 2023 with diagnoses including dementia and chronic obstructive pulmonary disease. Review of Resident #29's MDS assessment, dated 11/14/25, indicated the Resident was cognitively impaired, as evidenced by a BIMS score of 8 out of 15. The MDS assessment indicated the Resident did not use tobacco. Review of the facility's list of residents who smoke, provided to the survey team on 12/5/25, indicated Resident #29 smoked with his/her family only. Review of Resident #29's Smoking Evaluation, dated 5/24/25, indicated the Resident smoked, was safe to smoke with supervision without protective smoking equipment, and was able to light his/her (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	own cigarette with staff assistance. Review of Resident #29's Care Plans failed to indicate a care plan was developed for the Resident's tobacco use. During an interview on 12/9/25 at 10:53 A.M., Nurse #5 said Resident #29 does not routinely smoke during the facility's smoking times but will smoke on occasion during visits with his/her daughter. Nurse #5 said the Resident's daughter assists him/her with smoking outside and that his/her cigarettes and lighter are kept at the nurses' station for when he/she does request to go out to smoke. During an interview on 12/9/25 at 4:21 P.M., Unit Manager #2 said Resident #29 only goes out to smoke when his/her daughter comes to visit. Unit Manager #2 said Resident #29's daughter will assist the Resident outside and they will smoke together. During an interview on 12/10/25 at 10:51 A.M., the DON said Resident #29 smokes with his/her daughter and should have a care plan in his/her medical record to address his/her tobacco use.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards for four Residents (#23, #6, #2, #12), out of a total sample of 24 residents. Specifically, the facility failed:1. For Resident #23, to implement physician's orders for air mattress settings;2. For Resident #6, to transcribe and implement Urology orders (a) for change in Foley catheter size, and (b) for frequency of Foley catheter changes;3. For Resident #2, to obtain a physician's order for treatment to the Resident's right thigh surgical wound; and4. For Resident #12, to follow physician's orders to notify the Resident's cardiologist for systolic blood pressure below 90 mmHg (millimeters of mercury) and/or heart rate below 60 bpm (beats per minute). 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. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Medication and Treatment Orders, revised 9/2024, indicated, but was not limited to, the following:-Orders for medications and treatments will be consistent with regulatory standards.-Medications shall be administered only upon the written order of a person licensed and authorized to prescribe such medications in this state.-Verbal orders must be recorded in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order. 1. Resident #23 was admitted to the facility in September 2022 with diagnoses including dementia, history of falling and osteoporosis. Review of Resident #23's Minimum Data Set (MDS) assessment, dated 10/24/25, indicated he/she had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Furthermore, the MDS assessment indicated he/she was dependent for all mobility and had a pressure-reducing device on their bed. Review of Resident #23's Physician's Orders indicated but was not limited to: - 2/2/24: maintain resident on a pressure reducing mattress while in bed, set at number 4 (check function QSHIFT (every shift)); every shift for skin care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the following dates and times, the surveyor made the following observations of Resident #23's air mattress settings: - 12/5/25 at 10:18 A.M.: air mattress set to level 6. - 12/9/25 at 7:57 A.M.: air mattress set to level 6. - 12/9/25 at 12:51 P.M.: air mattress set to level 6. Review of Resident #23's December Treatment Administration Record (TAR) failed to indicate his/her air mattress settings were checked every shift. During an interview on 12/9/25 at 2:43 P.M., Nurse #2 said each shift air mattress settings and function are checked and recorded on the TAR for those residents utilizing the devices. Nurse #2 reviewed Resident #23's medical record and said he/she had an air mattress, and it should be set to level four. Nurse #2 reviewed Resident #23's TAR and said there were no orders on the TAR to check the setting or air mattress function and it was not being checked off by nursing staff. Nurse #2 and the surveyor checked Resident #23's air mattress setting. Nurse #2 said the air mattress was set to level 6 and lowered it to level 4 before exiting the room. During an interview on 12/9/25 at 3:24 P.M., the Assistant Director of Nursing (ADON) said all residents with orders for air mattresses should have their setting and function checked each shift by the nurse. The ADON said the orders should populate to the TAR. The ADON and the surveyor reviewed the observations made throughout the survey. The ADON said the Resident's air mattress should have been set correctly and marked on the TAR by the nursing staff. 2. Resident #6 was admitted to the facility in August 2021 with diagnoses including cerebral infarction and obstructive and reflux uropathy. Review of Resident #6's MDS assessment, dated 11/14/25, indicated he/she had a moderate cognitive impairment as evidenced by a BIMS score of 12 out of 15. Furthermore, the MDS assessment indicated he/she was dependent for functional mobility and had an indwelling catheter. Review of Resident #6's Physician's Orders indicated but were not limited to: - 7/25/24: Foley catheter 18FR (French)/10mL (milliliter) continuous to drainage bag every shift. - 7/25/24: Foley care every shift. - 4/13/25: Change Foley catheter bag every other Sunday 11-7 shift. a. Review of Resident #6's Urology consult report, dated 11/21/25, indicated the following: - Catheter change every four weeks with 20 French. - Changed today, due again on 12/21/25. Review of Resident #6's comprehensive care plan for an indwelling Foley catheter (initiated 8/24/21), indicated but was not limited to the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Catheter: change catheter (as needed/clogged) (18FR/10mL) (Foley). - Catheter: Resident has 18FR/10mL; position catheter bag and tubing below the level of the bladder and away from entrance room door. Review of Resident #6's medical record failed to indicate documentation showing a change in Resident #6's Foley catheter size from an 18FR to 20FR. During an interview on 12/9/25 at 2:49 P.M., Nurse #2 said the Resident has had a Foley catheter for some time. Nurse #2 said he/she goes to Urology, but they did not go regularly. Nurse #2 and the surveyor reviewed Urology recommendations from 11/21/25 and Resident #6's medical record. Nurse #2 said the medical record should have been updated to reflect the change in Resident #6's Foley catheter size and it was not. During an interview on 12/9/25 at 3:26 P.M., the ADON said the Resident's orders should have been updated to reflect the change in Foley catheter size after the Urology appointment. b. Review of Resident #6's Urology consult report, dated 8/18/25, indicated the following: - Continue to change catheter every 4 weeks. Review of Resident #6's Urology consult report, dated 11/21/25, indicated the following: - Catheter change every four weeks with 20 French. - Changed today, due again on 12/21/25. Review of Resident #6's TAR from August 2025 to November 2025 failed to indicate his/her Foley catheter was changed every four weeks. During an interview on 12/9/25 at 2:49 P.M., Nurse #2 and the surveyor reviewed the Urology consult reports and Resident #6's medical record. Nurse #2 said Resident #6's Foley catheter should be changed every four weeks per the Urology report but it was not reflected in the medical record. During an interview on 12/9/25 at 3:26 P.M., the ADON said Resident #6 should have an order to change the Foley catheter every four weeks and did not. 3. Resident #2 was admitted to the facility in March 2025 with diagnoses including end-stage renal disease dependent on hemodialysis. Review of Resident #2's MDS assessment, dated 9/5/25, indicated the Resident was cognitively intact, as evidenced by a BIMS score of 14 out of 15. Review of Resident #2's medical record indicated the Resident had sustained a fall and was transferred to the hospital on [DATE]. Further review indicated the Resident was found to have a right hip fracture and underwent surgical repair of the fracture on 11/24/25. The Resident returned to the facility on [DATE]. Review of Resident #2's Physician's Orders indicated, but was not limited to, the following:-Dressing (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on right hip site should remain in place till follow appointment [sic] in 2 weeks with [Orthopedic Surgeon] in 2 weeks every shift for monitoring for 14 days (order date 11/26/25) Review of Resident #2's Progress Notes indicated, but was not limited to, the following:-12/4/25 at 6:06 A.M.: Resident has left the facility with [ambulance company] transport via stretcher. He/she ate 100% of early breakfast. His/her vital signs are stable. He/she continues with healing right hip fracture pulses were palpated and CSM (circulation, sensation, motion) positive. Dress [sic] on the right thigh had fallen off. Staples were intact and skin well approximated. I put Abd pad on him/her for now. Further review of the Resident's Physician's Orders and Progress Notes failed to indicate the physician was notified the dressing had fallen off or new treatment orders were obtained for care of the surgical wound. During an interview on 12/9/25 at 7:38 A.M., Nurse #3 said on 12/4/25, one of the Resident's surgical dressings had come off. Nurse #3 said at that time, she put another dressing over the surgical wound, but now it is open to air. Nurse #3 said she did not notify the physician and wasn't sure if the physician or orthopedic surgeon's office was notified that the Resident's right hip dressing had come off before his/her follow-up appointment. On 12/9/25 at 11:24 A.M., the surveyor observed Nurse #2 applying an abdominal pad (an absorbent dressing) secured with tape on Resident #2's right lateral thigh over two surgical incisions closed with staples. Nurse #2 said Resident #2 was going out to an appointment with the orthopedic surgeon later that day. During an interview on 12/10/25 at 10:42 A.M., Physician #1 said it is his expectation that the facility's nursing staff contact the provider for new dressing or treatment orders. During an interview on 12/10/25 at 10:51 A.M., the Director of Nursing (DON) said the physician should have been notified when Resident #2's right hip dressing came off, and new treatment orders should have been obtained before a new dressing was applied. 4. Resident #12 was admitted to the facility in January 2019 with diagnoses including heart failure. Review of Resident #12's MDS assessment, dated 9/12/25, indicated the Resident was cognitively intact, as evidenced by a BIMS score of 15 out of 15. Review of Resident #12's Physician's Orders indicated, but was not limited to, the following:-Metoprolol tartrate 25 milligrams (mg) Give one tablet by mouth one time a day for coronary artery disease notify MD if SBP (systolic blood pressure) below 90 and or HR (heart rate) below 60 (order date 6/18/25) Review of Resident #12's Medication Administration Record (MAR) indicated, but was not limited to the following:-On 7/3/25, the Resident's SBP was 74 mmHg. Metoprolol tartrate 25mg was administered.-On 11/13/25, the Resident's SBP was 79 mmHg. Metoprolol tartrate was not administered due to vital signs out of parameters.-On 11/14/25, the Resident's SBP was 88 mmHg. Metoprolol tartrate 25mg was administered.-On 11/16/25, the Resident's HR was 55 bpm (beats per minute). Metoprolol tartrate 25mg was administered. -On 11/21/25, the Resident's SBP was 88 mmHg. Metoprolol tartrate was not administered due to vital signs out of parameters. -On 12/1/25, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Resident's SBP was 81 mmHg. Metoprolol tartrate was not administered due to vital signs out of parameters. Review of Resident #12's Progress Notes failed to indicate the Resident's cardiologist was notified when his/her SBP was below 90 mmHg or HR was below 60 bpm. During an interview on 12/9/25 at 2:54 P.M., Nurse #2 said if Resident #12's vital signs were outside of the parameters given in the order (SBP below 90mmHg and HR below 60 bpm), the medication should be held and the physician notified. Nurse #2 said if the physician was notified, it should be documented in the Resident's Progress Notes. During an interview on 12/9/25 at 4:03 P.M., the ADON said Resident #12's cardiologist's office had called and recommended the Resident be started on Metoprolol and wanted the facility to monitor the Resident's blood pressure and to call their office if his/her blood pressure was low. The ADON said if the physician's order said to call the cardiologist's office for vital signs out of parameters, the cardiologist's office should have been called. During an interview on 12/10/25 at 10:51 A.M., the DON said the nurses should have been following the physician's order and calling the cardiologist when the Resident's vital signs were noted to be out of parameters.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#2) who required hemodialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to), out of a total sample of 24 residents. Specifically, the facility failed:a. to ensure nursing staff did not obtain blood pressures from the Resident's arms, where his/her AV fistulas (arteriovenous fistula, where an artery and vein connect directly, allowing blood to flow) used for hemodialysis access were located; andb. to obtain and implement physician's orders for the care and maintenance of the Resident's hemodialysis catheter (a surgically placed catheter connected to a central vein that exits the skin and attaches to the tubing on the dialysis machine) upon his/her return from the hospital; andc. to administer the Resident's phosphorus binder (a medication used to reduce the absorption of dietary phosphate) with meals per the Resident's physician's order.Findings include:Review of the facility's policy titled End-Stage Renal Disease, Care of a Resident with, revised 7/2023, indicated, but was not limited to, the following:-The facility assures that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice.-The resident's comprehensive care plan will reflect the resident's needs related to ESRD (end-stage renal disease)/dialysis care.Resident #2 was admitted to the facility in March 2025 with diagnoses including end stage renal disease.Review of Resident #2's Minimum Data Set (MDS) assessment, dated 9/5/25, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review of the MDS assessment indicated the Resident received dialysis treatment.Review of Resident #2's Physician's Orders indicated, but was not limited to, the following:-AV fistula R (right) brachial forearm check thrill and bruit each shift (order date: 3/10/25)-Central Venous Cath: IJ (internal jugular) right chest every shift for site use for dialysis, monitor site q (every) shift (order date: 3/12/25)-Dialysis center: [Dialysis Center name, address, phone] Days: Tuesdays-Thursdays and Saturdays every day shift every Tue, Thu, Sat pick up 5:45 A.M. by stretcher (order date: 3/7/25)-Monitor AV Fistula to Left arm for intactness every shift and PRN (as needed) (order date: 6/6/25)-Monitor dialysis access site dressing right chest every shift (order date: 3/7/25)-No Blood Pressure/Blood Draws to be taken in the right arm every shift (order date: 3/10/25)-Sevelamer Carbonate (a phosphorus-binding medication) Oral Tablet 800 mg (milligrams) Give 1 tablet by mouth with meals for managing high blood phosphate levels (hyperphosphatemia) Swallow whole. Do Not Chew or Crush. Take with meals (order date: 9/23/25)Review of Resident #2's Care Plan indicated, but was not limited to, the following:-Focus: NUTRITION: [Resident #2] is at high risk for malnutrition r/t (related to) hemorrhage, atrophy, T2DM (type 2 diabetes mellitus), ESRD w/ dialysis (end-stage renal disease with dialysis), palliative care, mod pro cal mal (moderate protein-calorie malnutrition), UTI (urinary tract infection), dementia, bowel regimen. Significant weight changes.Interventions: 07. Administer medications as ordered.-Focus: [Resident #2] has potential for complications r/t hemodialysis for diagnosis of End Stage Renal FailureInterventions:*Administer/monitor effectiveness of medications as ordered*Central Venous Cath: IJ Right Chest dialysis accessing, monitor site q shift*Monitor shunt site by palpating for thrill and auscultating for bruit daily. Notify physician of absence of thrill or bruit.*Protect access site from injury. Site: Right AV fistula no used for accessing dialysis [sic]*Avoid constriction on affected right arm, such as constrictive clothingNo BP on right arm with AV fistula dialysis catheter-Focus: Central Catheter: Potential for infection and/or trauma related to catheter direct access to blood.Catheter is not used by nursing staff - used for hemodialysis onlyInterventions:*Catheter is not to be accessed by nursing staff. Notify MD with any abnormal findings.*Report any abnormal findings to physician-Focus: [Resident #2] needs dialysis r/t diagnosis of End Stage Renal DiseaseInterventions:*Administer medications as ordered*Check AV fistula site for signs/symptoms of infection, pain, or bleeding daily and PRN*Do (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not draw blood or take B/P in right arm with AV fistula*Monitor/document/report PRN any signs/symptoms of infection to access site: redness, swelling, warmth or drainagea. Review of Resident #2's medical record indicated his/her right arm AV fistula was created in December 2024 and his/her left arm AV fistula was created in June 2025. Review of Resident #2's Weights and Vitals Summary indicated between 3/7/25 and 11/29/25, the Resident's blood pressure was recorded in his/her electronic medical record 43 times. Of those 43 times, 26 blood pressures were recorded as taken in the Resident's left arm, 15 blood pressures were recorded as taken in the Resident's right arm, and 2 blood pressures were recorded with no location indicated. No blood pressures were recorded as taken in the Resident's left or right leg. During an interview on 12/8/25 at 12:05 P.M., Nurse #2 said Resident #2 had an AV fistula for dialysis in his/her right arm, but it stopped working and a tunneled hemodialysis catheter and left AV fistula were put in. During an interview on 12/9/25 at 7:40 A.M., Nurse #3 said she usually takes Resident #2's blood pressure in his/her legs because he/she has dialysis fistulas in both arms.During a subsequent interview on 12/9/25 at 11:24 A.M., Nurse #2 said he usually takes Resident #2's blood pressure in his/her right wrist.During an interview on 12/9/25 at 4:02 P.M., the Assistant Director of Nursing (ADON) said Resident #2's blood pressure should be taken in his/her leg.During an interview on 12/10/25 at 10:51 A.M., the Director of Nursing (DON) said Resident #2's blood pressure should be taken in his/her leg because of the AV fistulas in his/her right and left arms.b. Review of Resident #2's Progress Notes indicated on 12/7/25 at 11:58 P.M., the Resident's dialysis catheter dressing was missing, and Nurse #4 cleaned the area and placed a new dressing. Nurse #4 also documented the Resident had scratched loose a few sutures from the line. Further review of Resident #2's Progress Notes failed to indicate the physician was notified that the Resident's dialysis catheter dressing had been removed and the Resident had scratched loose sutures from the line.Review of Resident #2's Physician's Orders failed to indicate a physician's order was obtained to cleanse and apply a new dressing to the Resident's dialysis catheter.During an interview on 12/9/25 at 4:25 P.M., Nurse #4 said when she assessed Resident #2's dialysis catheter on 12/7/25, there was no dressing and two sutures were intact. Nurse #4 said she applied a new dressing to the dialysis catheter but did not notify the physician that the dressing was off and sutures were scratched loose because the cuff (part of the catheter made of fabric or synthetic material that anchors the device and creates in infection-preventing seal by encouraging tissue growth) was not out of the skin. During an interview on 12/10/25 at 10:42 A.M., Physician #1 said he was not aware that Resident #2's dialysis catheter dressing was not in place on 12/7/25 or that Nurse #4 was concerned that the Resident had loosened his/her sutures. Physician #1 said it was his expectation that the nursing staff would call and inform the provider if the Resident's dialysis catheter dressing needed to be replaced or if there was a concern that the sutures had been loosened or removed.During an interview on 12/10/25 at 10:51 A.M., the DON said Nurse #4 should have called the physician when she became aware that Resident #2's hemodialysis catheter dressing was not in place to inform him and obtain an order to dress the hemodialysis catheter. The DON said he thought Nurse #4 may not have documented the condition of the sutures accurately and maybe it was her first time seeing the hemodialysis catheter without a dressing. The DON said he was not sure if any sutures were out/loosened by the Resident. c. Review of Resident #2's medical record indicated he/she was transported to/from dialysis by ambulance and his/her pickup time from the facility was scheduled for 5:45 A.M. Review of Resident #2's Physician's Orders indicated he/she should be taking a phosphorus-binding medication with meals. Review of Resident #2's Dialysis Communication Forms 9/30/25 through 12/9/25 indicated Resident #2 ate breakfast at the facility prior to leaving for dialysis and no phosphorus-binding medications were administered within the four hours before he/she left.Review of Resident #2's Medication Administration Record (MAR) October 2025 through December 2025 indicated the Resident was scheduled to receive his/her phosphorus-binding medication at 7:15 A.M. every day. During an interview on 12/9/25 at 7:15 A.M., Nurse #3 said Resident #2 leaves the facility early for dialysis and eats breakfast before leaving at 5:45 A.M. Nurse (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#3 said she does not administer the Resident's phosphorus-binding medication when the Resident eats breakfast because the medication is scheduled to be administered at 7:15 A.M.During an interview on 12/9/25 at 7:16 A.M., Nurse #2 said Resident #2 should be taking his/her phosphorus-binding medication with all meals.During an interview on 12/10/25 at 10:42 A.M., Physician #1 said Resident #2's phosphorus-binding medication should be administered with meals.During an interview on 12/10/25 at 10:51 A.M., the DON said Resident #2's phosphorus-binding medication should be scheduled for administration when the Resident receives his/her early breakfast on Tuesday, Thursday, and Saturday before dialysis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interviews, the facility failed to ensure that all drug records were in order and an accurate account of all controlled substances (drugs or chemicals that the government regulates for its manufacture, possession, and use, that are classified into schedules based on their potential for abuse) was maintained for one Resident (#15), from a total sample of 24 residents.Findings include:Resident #15 was admitted to the facility in July 2020 and had diagnoses including dementia with behavioral disturbance, low back pain, and anxiety.Review of the Minimum Data Set (MDS) assessment, dated 11/3/25, indicated Resident #15 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15 and received Hospice services.Review of the medical record indicated Physician's Orders including but not limited to:-Lorazepam concentrate (schedule-IV controlled substance (low potential for abuse and a low risk of dependence) 2 milligrams per milliliter (mg/ML), give 0.5 mg (0.25 mL) sublingually two times a day (11/7/25)-Lorazepam oral concentrate 2 mg/ml, give 0.5 mg (0.25 mL) by mouth every 1 hour as needed (PRN) for anxiety/agitation/restlessness until 12/7/25; for 30 days started on 11/8/25Review of the November 2025 and December 2025 Medication Administration Record (MAR) and the controlled substance logbook indicated a 30 mL bottle was received from the pharmacy on 11/8/25. From 11/8/25 at 7:00 P.M. to 11/16/25 at 7:00 P.M., 15 doses of Lorazepam were documented as administered to Resident #15 for a total of 3.75 mL with 26.25 mL remaining in the bottle.The controlled substance count conducted by Nurse #7 and Nurse #1 on 11/16/25 at 3:00 P.M. indicated the status of the count was not exact.Review of a Nurse's Note written by Nurse #7, dated 11/16/25, indicated the narcotic count was off and the remaining amount of Lorazepam should be 26.25 mL. However, only 22 mL remained in the bottle (4.25 mL or 16% discrepancy). Per outgoing nurse, discrepancy to be rectified by the Director of Nursing (DON) prior to further administration.During a telephonic interview on 12/10/25 at 12:38 P.M., Nurse #7 said she identified a discrepancy with the narcotic count on 11/16/25 at 3:00 P.M. while doing count with Nurse #1. She said when the count was identified as off, Nurse #1 called the supervisor and was told the DON would rectify the discrepancy. Nurse #7 said she noted the Ativan bottle to be sealed tightly with no leakage noted in the cart.The controlled substance count conducted by Nurse #9 and Nurse #7 on 11/16/25 at 11:00 P.M., failed to indicate if the count was exact or not (blank).During a telephonic interview on 12/10/25 at 11:07 A.M., Nurse #9 said she recalls doing the narcotic count with Nurse #7 on 11/16/25 at 11:00 P.M. and there was a discrepancy with the Lorazepam. She said she should have documented no in the box indicating the count was not exact, but she did not. Nurse #9 said she observed the Ativan bottle to be sealed tightly with no leakage noted. She said she did not report the discrepancy because she was told it had already been reported earlier in the day.The controlled substance count conducted by Nurse #1 and Nurse #9 on 11/17/25 at 7:00 A.M. indicated the count was not exact.An entry in the controlled substance logbook written by Nurse #1 for Lorazepam, dated 11/17/25 at 9:30 A.M., indicated the words miss calculation (sic) and the amount of Lorazepam remaining in the bottle was 22.5 mL (previous amount remaining was 26.25 mL). This reflects a discrepancy of 3.75 mL, which equals 15 (0.25 mL doses). The entry was co-signed by the DON.Although the entry dated 11/17/25 at 9:30 A.M. adjusted the amount of Lorazepam on hand from 26.25 mL to 22.5 mL, the controlled substance count conducted by Unit Manager #1 and Nurse #1 on 11/17/25 at 3:00 P.M., was signed as not exact by Unit Manager #1 and was not signed by Nurse #1.During an interview on 12/10/25 at 9:17 A.M., Nurse #1 said she did count with Nurse #9 on 11/17/25 at 7:00 A.M and signed that the count was not exact. She said she did not report the continued discrepancy because it was reported the previous day. Nurse #1 said she was the nurse that did count with Unit Manager #1 on 11/17/25 at 3:00 P.M but she forgot to sign off. She said she cannot recall if the count was exact or not that day but was asked by the DON to sign it off and date (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her signature 12/8/25.During an interview on 12/8/25 at 2:45 P.M., the surveyor reviewed the controlled substance logbook with Unit Manager #1. He confirmed that he did count with Nurse #1 on 11/17/25 at 3:00 P.M. and signed the log as not accurate. He said he did not notify a supervisor or DON of the inaccuracy.During interviews with the DON and Assistant Director of Nursing (ADON) on 12/8/25 at 2:40 P.M. and 12/9/25 at 11:20 A.M. and 1:35 P.M., the DON said he remembers hearing something about a discrepancy in the controlled substance logbook shift count but could not remember the specifics. He said the ADON was probably involved with that. The ADON said she received a call from the nursing supervisor on 11/16/25 (Sunday) and was told the count was off. She said she told the nursing supervisor to check the math and make sure it was correct. She said she did not hear anything else about it and assumed everything was okay. They said they were not made aware of any leakage with Resident #15's Ativan bottle and no one had reported any spillage. Both the DON and ADON said they were not aware of three subsequent discrepancies noted in the controlled substance logbook from 11/16/25 at 11:00 P.M. to 11/17/25 at 3:00 P.M. and did not investigate the discrepancy reported on 11/16/25 at 3:00 P.M. The DON said on 11/17/25 at 9:00 A.M., although he doesn't recall, he must have looked at the Lorazepam administration in the logbook and the numbers looked right, so he signed off on it. The surveyor reviewed Resident #15's November MAR and the controlled substance logbook with the DON. He said there are several inaccuracies in the logbook such as a blank area (Status of count: Yes/No) on 11/16/25 and a missing nurse signature on 11/17/25 in which the oncoming nurse signed the count as not exact. He said there should be no blanks areas in the logbook, and he should not have asked Nurse #1 to sign off on the 11/17/25 count when she could not recall if it was accurate or not. The DON and ADON said they have done audits of the controlled substance logbooks in the past but cannot recall the last time an audit was done and were unable to provide the survey team with any evidence that periodic audits/reconciliations had been done by the DON or ADON.Review of the medical record indicated the consultant pharmacist performed a medication regimen review (MRR) on 11/29/25 with no irregularities noted.During an interview on 12/9/25 at 11:41 A.M., the consultant Pharmacist said she has remote access to the electronic medical record and conducts her monthly MRRs off-site. She said she reviews all parts of the medical record including physician's orders, medication administration records and progress notes. She said she did not see the 11/16/25 Nurse's note in which the nurse identified that the narcotic count was off during her 11/29/25 MRR for Resident #15. She said there is an allowable discrepancy, especially with liquid medications to account for spillage, which is about 5%. I reviewed the Nurse's note and narcotic logbook documentation which indicated a 30 mL bottle was received on 11/8/25 and a 4.25 mL discrepancy identified on 11/16/25. She said that 4.25 mL is not an acceptable amount of discrepancy and if she saw the note, she would have brought it to the DON's attention for investigation. The Pharmacist said the pharmacy does periodic on-site visits for inspections that include the medication rooms and medication carts and serve as a second set of eyes for the facility. She said they make recommendations to the facility, and it is up to them to address it. The consultant Pharmacist said an on-site visit was conducted in November and a copy of the report was provided to the DON.Review of the on-site pharmacy visit report, dated 11/10/25, failed to indicate any concerns with the integrity of Resident #15's bottle of liquid Ativan stored in either the medication cart or medication room refrigerator on the B-Wing where Resident #15 resides.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure residents received food prepared by methods that conserve nutritive value, flavor and appearance as well as being palatable, attractive and at safe, appetizing temperatures for two of two test trays. Findings include:During initial screening on 12/5/25, surveyors obtained the following food concerns on the B-Wing and C-Wing units:- Food is not good and often not palatable to eat.- Food is repetitive and often cold.- The French toast is cold and soggy.- Vegetables are often cold, mushy and overcooked.- Food is cold at all mealtimes.- The temperature of the food is not good.- Toast is always soggy. On 12/9/25 at 11:30 A.M., the surveyor requested a test tray to the C-Wing unit and made the following observations:- At 11:47 A.M., the food truck containing the test tray leaves the kitchen for the C-Wing unit.- At 11:50 A.M., the food truck arrives on the C-Wing unit and staff begin passing trays.- At 11:58 A.M., the last tray is delivered to a resident from the food truck. On 12/9/25 at 12:00 P.M., the surveyor and the Food Service Director (FSD) completed the test tray together and the food temperatures were as follows:- Soup: 106 F (Fahrenheit); cold to taste- Riced Cauliflower: 118 F; cold to taste, no seasoning/flavor- Egg Noodles: 112 F: cold to taste, no seasoning/flavor- Beef Stroganoff: 104 F; flavorful but meat is cold to taste During an interview on 12/9/25 at 12:04 P.M., the FSD said the hot food items were too cold and she would expect them to be hotter and closer to 130 F. On 12/10/25 at 7:32 A.M., the surveyor requested a second test tray to the B-Wing unit and made the following observations:- At 7:58 A.M., the food truck containing the test tray leaves the kitchen for th e B-Wing unit.- At 7:59 A.M., the food truck arrives on the B-Wing unit and staff begin passing trays.- At 8:09 A.M., the last tray is delivered to a resident from the food truck. On 12/10/25 at 8:10 A.M., the surveyor and Nurse #1 completed the test tray together and the food temperatures were as follows:- Hot Cereal: 120 F; lukewarm temperature, bland flavoring- Eggs: 117 F; cold to taste; bland flavoring- Toast: 100 F; lukewarm temperature, soggy During an interview on 12/10/25 at 9:00 A.M., the FSD and surveyor reviewed the second test tray results from the B-Wing unit. The FSD said she would expect temperatures to be hotter. The FSD said food temperatures should be closer to 130 F when served to residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to:1. Ensure food items were properly dated and stored in the main kitchen and equipment was maintained in a sanitary manner;2. Ensure the ice machine in the main kitchen was maintained in a clean, sanitary condition; and3. 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). Findings include:Review of the 2022 Food Code by the Food and Drug Administration (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.- 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location.- 4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues.- 6-501.12 (A) Physical facilities shall be cleaned as often as necessary to keep them clean. Review of the facility's policy titled Food and Supply Storage, dated last revised 6/2018, indicated but was not limited to the following:- Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by dates.- Follow recommendations from the manufacturer when indicated on the product for storage time and storage location. Review of the facility's policy titled Ice Production and Handling, revised 6/2018, indicated but was not limited to:- Keep equipment clean, including draining, cleaning, and sanitizing internal components of the ice machine as needed and according to the manufacturer's specifications, cleaning schedules and preventative maintenance schedules. 1. On 12/5/25 at 7:45 A.M., the surveyor made the following observations in the main kitchen:- One container of scrambled eggs on the second shelf in the walk-in refrigerator was not labeled/dated.- One Imperial Thickened Dairy Drink (Mildly Thick Nectar Consistency) was opened in the reach-in refrigerator by the service line and did not have an open date. The manufacturer's label indicated to discard seven days after opening.- One Ocean Spray 100% Apple Juice (60 fluid ounces) Bottle was opened and not dated in the reach-in refrigerator.- One clear pitcher with a milk-like substance was not labeled or dated.- One 2-Liter (L) Coca Cola Bottle was located on the bottom shelf of reach-in refrigerator, it was opened and not dated.- The microwave located on a table behind the service food line had dark, black burn-like stains noted to top inside. On 12/9/25 at 11:00 A.M., the surveyor made the following observations in the main kitchen:- Two Imperial Thickened Dairy Drinks (Mildly Thick Nectar Consistency) were opened in the reach-in refrigerator by the service line and did not have an open date. The manufacturer's label indicated to discard seven days after opening.- One clear pitcher with a milk-like substance was not labeled or dated.- The microwave located on a table behind the service food line had dark, black burn-like stains noted to top inside. During an interview on 12/10/25 at 9:00 A.M., the surveyor and the Food Service Director (FSD) toured the kitchen. The FSD said the microwave was used to reheat resident food when a unit calls down after meal service for additional items to ensure the food is hot. The FSD said the microwave is cleaned daily. The FSD said the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	microwave should not have any burn-like residue/stains and needed to be replaced. The FSD said all opened drink items in the reach-in refrigerator should be labeled with an open date and use by date. The FSD said the pitcher contained a milk substance and should have been labeled. 2. The surveyor, with the FSD present, made the following observations of the ice machine in the main kitchen:- 12/5/25 at 7:45 A.M.: Orange stains/spots to the white plastic portion of the upper inside of the ice machine and black/orange stains to the back portion of the machine; Vendor sticker indicated 8/11/25.- 12/9/25 at 11:00 A.M.: Orange stains/spots to the white plastic portion of the upper inside of the ice machine and black/orange stains to the back portion of the machine; Vendor sticked indicated 8/11/25. During an interview on 12/10/25 at 9:00 A.M., the FSD said the ice machines are cleaned quarterly by an outside vendor and cleaned monthly by the facility. The FSD said there should be no residue in the ice machine, and they needed to be cleaned. 3. On 12/9/25 at 11:10 A.M., the surveyor made the following observations during the lunch line service:- At 11:12 A.M., Dietary Staff #2 began taking temperatures of all the food items on the service line.- At 11:14 A.M., Dietary Staff #2 walked from the food service line to the trash can, used an alcohol wipe to clean the thermometer, touch the top of the trash can with both hands and returned to the food service line to take the temperature of the next food item.- At 11:15 A.M., Dietary Staff #2 walked from the food service line to the trash can, used an alcohol wipe to clean the thermometer, touch the top of the trash can with both hands and return to the food service line to take the temperature of the next food item.- At 11:17 A.M., Dietary Staff #2 walked from the food service line to the trash can, used an alcohol wipe to clean the thermometer, touch the top of the trash can with both hands and return to the food service line to take the temperature of the next food item.- At 11:19 A.M., Dietary Staff #2 walked from the food service line to the trash can, used an alcohol wipe to clean the thermometer, touch the top of the trash can with both hands and return to the food service line to take the temperature of the next food item.- At 11:21 A.M., Dietary Staff #2 walked from the food service line to the trash can, used an alcohol wipe to clean the thermometer, touch the top of the trash can with both hands and return to the food service line to take the temperature of the next food item. During an interview on 12/10/25 at 9:05 A.M., the FSD and the surveyor reviewed the observations made during the food line service. The FSD said hand hygiene should have been completed prior to returning to the food service line to take food temperatures.

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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 observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed:1. For Resident #2, to implement Enhanced Barrier Precautions; and2. For Resident #77, to perform hand hygiene during medication administration.Findings include: Review of the facility's policy titled Infection Control Guidelines for Nursing Procedures, revised 7/2024, indicated, but was not limited to, the following: -Enhance Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) -EBP is indicated for nursing home residents with: *Infection or colonization with an MDRO when Contact Precautions don't otherwise apply *Chronic wounds *Indwelling medical devices -PPE: Use of gown and gloves during high-contact resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing -In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub: *Before preparing or handing medications Review of the Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, indicated, but was not limited to, the following:- Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)- Enhanced Barrier Precautions are recommended for residents with any of the following: 1) infection or colonization with a MDRO or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. Review of the CDC Enhanced Barrier Precautions sign indicated:-Everyone must clean their hands, including before entering and when leaving the room-Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care (any skin opening requiring a dressing). 1. Resident #2 was admitted to the facility in March 2025 with diagnoses including end stage renal disease. Review of Resident #2's Minimum Data Set (MDS) assessment, dated 9/5/25, indicated Resident #2 (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #2's medical record indicated the Resident had bilateral arteriovenous fistulas and a tunneled hemodialysis catheter in his/her right chest. Further review indicated the Resident returned from the hospital in November 2025 with a surgical wound on his/her right hip. Review of Resident #2's Care Plan failed to indicate the Resident required Enhanced Barrier Precautions. Review of Resident #2's Physician's Orders failed to include orders for Enhanced Barrier Precautions. On 12/8/25 at 7:57 A.M., the surveyor observed a CDC Enhanced Barrier Precautions sign posted outside of the Resident's room and a cart with personal protective equipment (PPE) was located beneath the sign. On 12/9/25 at 11:24 A.M., the surveyor observed Nurse #2 applying a dressing over Resident #2's right hip surgical incisions. CNA #1 was present and assisting in positioning the Resident. Nurse #2 and CNA #1 were not wearing a gown as indicated. The CDC Enhanced Barrier Precautions sign was posted outside of the Resident's room and PPE was located in a cart beneath the sign. During an interview on 12/9/25 at 11:29 A.M., Nurse #2 said Resident #2 required Enhanced Barrier Precautions and he should have been wearing a gown when performing wound care. During an interview on 12/9/25 at 3:30 P.M., the Assistant Director of Nursing (ADON) said Resident #2 required Enhanced Barrier Precautions due to his/her hemodialysis catheter and right hip wound. The ADON said Nurse #2 should have worn a gown when performing Resident #2's wound care. During an interview on 12/10/25 at 10:51 A.M., the Director of Nursing (DON) said Nurse #2 should have been implementing Enhanced Barrier Precautions and wearing a gown when performing Resident #2's wound care. 2. Review of the facility's policy titled Administering Medications, dated as revised 9/2024 indicated but was not limited to: - Staff follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. On 12/9/25 at 5:00 P.M., the surveyor observed Nurse #8 prepare and administer medication to Resident #77. The surveyor observed: -Nurse #8 prepare the Resident #77's medication without performing hand hygiene prior to initiating medication preparation -At 5:05 P.M., Nurse #8 entered Resident #77's room. The surveyor observed an EBP sign at the door which indicated EBP were required for Resident #77. Nurse #8 entered the room and did not perform hand hygiene. -At 5:10 P.M., Nurse #8 exited Resident #77's room, and did not perform hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225267	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 5:13 P.M., Nurse #8 returned to Resident #77s room and re-entered the room without performing hand hygiene. Nurse #8 continued with administering medications to Resident #77. -At 5:18 P.M., Nurse #8 exited Resident #77's room and returned to the medication cart. Nurse #8 did not perform hand hygiene upon completion of medication administration or when exiting Resident #77's room. During an interview on 12/9/25 at 5:30 P.M., Nurse #8 said she did not perform hand hygiene when preparing and administering Resident #77's medications, and thereafter. During an interview on 12/10/25 at 9:13 A.M., Unit Manager #2 said Nurse #8 should have performed hand hygiene. She said the nurse is familiar with the facility policy and did not follow it during her medication pass. During an interview on 12/10/25 at 12:40 P.M., the ADON said the nurse should have performed hand hygiene. She said when a room has a sign indicating EBP was required the precautions should be followed. She said the nurse did not follow the policy as required.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to ensure two Residents (#8 and #9), out of a total sample of five residents reviewed for immunizations, were screened for eligibility to receive the recommended influenza and pneumococcal vaccinations, residents/residents' representatives were educated on the benefits and potential side effects of the vaccines, and were offered and administered (if applicable) the vaccines in a timely manner. Specifically, the facility failed:1. For Resident #8, to ensure influenza and pneumococcal vaccines were administered after the Resident had consented to receive the vaccines; and 2. For Resident #9, to ensure the Resident's medical record included documentation that indicated the Resident's Representative was provided education regarding the benefits and potential side effects of influenza vaccination and either consented to receive or refused vaccine administration. Findings include:Review of the facility's policy titled Influenza Vaccine, revised 11/2020, indicated, but was not limited to, the following:-All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.-Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents unless the vaccine is medically contraindicated, or the resident has already been immunized.-Residents admitted to the facility between October 1st and March 31st shall be offered the vaccine.-Prior to vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine.-A resident's refusal of vaccine shall be documented. -Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.1. Resident #8 was admitted to the facility in September 2025 with diagnoses including heart failure.Review of Resident #8's Immunization Consent indicated that the Resident had consented to annual influenza vaccine administration but declined pneumococcal vaccination on 9/24/25. On 10/16/25, Resident #8 signed a new Immunization Consent and consented to annual administration of influenza vaccine and consented to the recommended schedule of administration of pneumococcal vaccination. Review of Resident #8's medical record failed to indicate the Resident had received the 2025-2026 influenza vaccine or pneumococcal conjugate vaccine after he/she had consented to their administration.During an interview on 12/10/25 at 9:34 A.M., Unit Manager #2 said Resident #8 had initially refused all vaccines, but a new consent was completed when the Resident returned from a hospitalization and the Resident had consented to administration of all vaccines. 2. Resident #9 was admitted to the facility in November 2025 with diagnoses including dementia and diabetes.Review of Resident #9's medical record indicated a guardian (someone appointed by the court responsible for making decisions for another person) had been appointed on 6/6/21.Review of Resident #9's medical record failed to include documentation that indicated the Resident's guardian was provided education regarding the benefits and potential side effects of influenza vaccination and either consented to receive or refused vaccination.During an interview on 12/9/25 at 3:30 P.M., the Assistant Director of Nursing (ADON) said the facility offers influenza vaccination to all eligible residents and all residents who consent to vaccination should receive the vaccine as soon as possible. The ADON said vaccine consent and administration is recorded in the electronic medical record. During an interview on 12/10/25 at 10:24 A.M., Unit Manager #2 said the nurse assigned to a resident would complete the Immunization Consent form with the resident when they are first admitted to the facility. Unit Manager #2 said she would check the Immunization Consent form the next day and that the Medical Records Coordinator would also check the Immunization Consent form to ensure it is completed. Unit Manager #2 said if a resident consented to vaccine administration, any nurse could input the order for the vaccine in the electronic medical record for administration.During an interview on 12/10/25 at 10:51 A.M., the Director of Nursing (DON) said he is responsible for tracking and reporting resident vaccine administration. The DON said if a resident consents to influenza vaccination, the vaccine should be administered as soon as possible.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to ensure two Residents (#8 and #9), out of a total sample of five residents reviewed for immunizations, were screened for eligibility to receive the recommended COVID-19 vaccination, residents/residents' representatives were educated on the benefits and potential side effects of the vaccine, and were offered and administered (if applicable) the vaccine in a timely manner. Specifically, the facility failed:1. For Resident #8, to ensure COVID-19 vaccine was administered after the Resident had consented to receive the vaccine; and 2. For Resident #9, to ensure the Resident's medical record included documentation that indicated the Resident's Representative was provided education regarding the benefits and potential side effects of COVID-19 vaccination and either consented to receive or refused vaccine administration. Findings include:Findings include:1. Resident #8 was admitted to the facility in September 2025 with diagnoses including heart failure.Review of Resident #8's Immunization Consent indicated that the Resident had declined COVID-19 vaccination on 9/24/25. On 10/16/25, Resident #8 signed a new Immunization Consent and consented to administration of COVID-19 vaccine/booster. Review of Resident #8's medical record failed to indicate the Resident had received the 2025-2026 COVID-19 vaccine after he/she had consented to its administration.During an interview on 12/10/25 at 9:34 A.M., Unit Manager #2 said Resident #8 had initially refused all vaccines, but a new consent was completed when the Resident returned from a hospitalization and the Resident had consented to administration of all vaccines. 2. Resident #9 was admitted to the facility in November 2025 with diagnoses including dementia and diabetes.Review of Resident #9's medical record indicated a guardian (someone appointed by the court responsible for making decisions for another person) had been appointed on 6/6/21.Review of Resident #9's medical record failed to include documentation that indicated the Resident's guardian was provided education regarding the benefits and potential side effects of COVID-19 vaccination and either consented to receive or refused vaccination.During an interview on 12/9/25 at 3:30 P.M., the Assistant Director of Nursing (ADON) said the facility offers COVID-19 vaccination to all eligible residents and all residents who consent to vaccination should receive the vaccine as soon as possible. The ADON said vaccine consent and administration is recorded in the electronic medical record. During an interview on 12/10/25 at 10:24 A.M., Unit Manager #2 said the nurse assigned to a resident would complete the Immunization Consent form with the resident when they are first admitted to the facility. Unit Manager #2 said she would check the Immunization Consent form the next day and that the Medical Records Coordinator would also check the Immunization Consent form to ensure it is completed. Unit Manager #2 said if a resident consented to vaccine administration, any nurse could input the order for the vaccine in the electronic medical record for administration.During an interview on 12/10/25 at 10:51 A.M., the Director of Nursing (DON) said he is responsible for tracking and reporting resident vaccine administration. The DON said if a resident consents to COVID-19 vaccination, the vaccine should be administered as soon as possible.