STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225268	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Newton	2101 Washington Street Newton, MA 02462

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a dignified experience for residents as evidenced by staff utilizing a resident bedroom for personal storage and documentation for one Resident, (#140), out of a total of 36 sampled Residents.Findings include: Review of the facility's policy titled “Dignity”, dated February 2021 indicated: Residents' private space and property are respected at all times. Resident #140 was admitted to the facility in June 2020 with diagnoses including Alzheimer's disease and heart disease. Review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #140 is severely cognitively impaired and dependent on staff for activities of daily living. On 7/16/2025 at 7:48 A.M., the surveyor observed Resident #140 asleep in bed. An iPhone was charging on his/her nightstand. On 7/16/2025 at 12:33 P.M., the surveyor observed Resident #140 asleep in bed. The iPhone was no longer on the nightstand. On 7/17/2025 at 6:55 A.M., the surveyor observed Resident #140 asleep in bed. There was an iPhone charging on his/her nightstand and a plastic bag of unknown personal items was on a chair. The phone’s alarm began sounding off and Resident #140 began adjusting in bed and raised his/her eyebrows at the noise. The alarm continued to sound for approximately five minutes before turning off. On 7/17/2025 at 7:01 A.M., the surveyor observed a Certified Nursing Assistant (CNA) exit Resident #140’s room holding the white plastic bag and leaving the unit. On 7/17/2025 at 12:09 P.M., the surveyor observed Resident #140 asleep in bed. CNA #1 was observed seated in a chair behind the door with an iPad (utilized for documentation) with his eyes closed. CNA #1 then opened his/her eyes and sat up straight and began to document on the iPad. On 7/17/2025 at 12:20 P.M., the surveyor returned to the room and observed Resident #140 asleep in bed and CNA #1 was seated behind the door holding his phone up and speaking aloud while holding the iPad. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/2025 at 6:54 A.M., the surveyor observed Resident #140 awake in bed. He/she was nonresponsive to the surveyor’s questions. A CNA was seated in a chair behind the door and documenting on her iPad. A white plastic bag of personal effects was on a chair. On 7/18/2025 at 6:59 A.M. the surveyor observed Resident #140 asleep in bed and the CNA had left the room. There was a pair of white croc shoes on the floor next to the chair the CNA was sitting on. On 7/18/2025 at 7:01 A.M., the surveyor observed the CNA ambulating into Resident #140’s room from the hallway and not wearing shoes. The CNA then exited the room wearing the white crocs and holding the white plastic bag and then left the unit. During an interview on 7/18/2025 at 10:11 A.M., Unit Manager #1 said that resident room space is private, and staff should not be keeping personal effects or making personal calls in resident rooms. Unit Manager #1 said that staff are to document at the nurses station and not in resident rooms. During an interview on 7/18/2025 at 10:18 A.M., the Assistant Director of Nursing (ADON) said that resident room space is personal and expect that staff should not store their personal effects in resident rooms, document or make personal phone calls in rooms. The Director of Nursing (DON) said that he was aware of the ongoing concerns about staff using phones on the units.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain informed consent prior to administering psychotropic medication for one Resident #129 out of a sample of 36 residents. Specifically, the facility failed to obtain legal informed consent from court prior to administering an antipsychotic medication.Findings include:A review of the facility policy titled 'Psychotropic Medication Use' with a revision date of 2/25 indicated the following:-Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: non pharmacological alternatives, the indications and rationale for the recommendation, the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings and the resident's/representative's right to accept or decline treatment.Resident #129 was admitted to the facility in May 2025 with diagnoses including schizoaffective disorder.Review of Resident #129's most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition.Review of Resident #129's July 2025 physician's orders indicated the following:-Fluphenazine (an antipsychotic medication used to treat schizophrenia and other psychotic disorders) HCl (Hydrochloride) Oral Tablet 5 milligrams (Fluphenazine HCl) Give 1 tablet by mouth in the evening for behavioral management. Start date:7/1/25-Fluphenazine HCl Oral Tablet 5 milligrams (Fluphenazine HCl) Give 2 tablets by mouth in the evening for behavioral management. Start date:7/16/25Review of Resident # 129's July 2025 Medication Administration Record (MAR) indicated that Fluphenazine was administered on 7/2/25, 7/3/25, 7/4/25, 7/5/25, 7/6/25, 7/7/25, 7/8/25, 7/9/25, 7/10/25, 7/11/25, 7/12/25, and 7/13/25.Review of the medical record indicated that Resident #129 has a court appointed Guardian. The court also authorized the treatment of Resident #129 with antipsychotic medication. A Roger's treatment plan (a court approved plan authorizing the administration of antipsychotic medication to an individual who is deemed incapacitated and unable to consent to treatment) with the medications and alternative medications Resident #129 could be administered was included.Further review of the Roger's treatment plan with an expiry date of 5/4/26 failed to indicate Fluphenazine as one the antipsychotic medications approved by the court to be used for treatment for Resident #129. The Roger's treatment plan also failed to indicate Fluphenazine as one of the alternative medications listed.During an interview and record review on 7/17/125 at 1:18 P.M., the Regional Social Worker reviewed the medical record and said Resident #129 had been administered Fluphenazine from 7/2/25-7/13/25 as ordered. The Regional Social Worker said Resident #129 should not have been administered Fluphenazine prior to getting legal consent from court.During an interview on 7/18/25 at 10:56 A.M., the Director of Nurses said he expects informed legal consent to be obtained from the responsible party prior to administering antipsychotic medication.During a telephone interview on 7/18/25 at 10:21 A.M., the court appointed Roger's Monitor, (a person appointed by the court to oversee the implementation of a court approved treatment plan for an incapacitated individual), said the [NAME] monitor role is new to him. He said he was made aware by the facility that the Resident was being administered Fluphenazine, but he was not aware that the court needed to give consent because it was not listed on the Treatment plan.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to formulate Advance Directives for one Resident #129 out of a sample of 36 Residents. Specifically, the facility failed to expand a Roger's treatment plan, (a court approved plan that outlines the specific medical treatment, particularly antipsychotic medication), prior to administering antipsychotic medication.Findings include:Review of the facility policy titled 'Advance Directives' with a revision date of September 2022 indicated the following:-The resident has the right to formulate an Advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy.-Advance directive is written instruction, such as a living will or durable power of attorney for healthcare, recognized by state law (whether statutory or as recognized by the courts of the state) relating to the provisions of health care when the individual is incapacitated.-Legal representative (i.e. substitute decision maker, proxy agent- a person designated and authorized by an advance directive or state law to make treatment decisions for another person in the event the other person becomes unable to make necessary health care decisions.Resident #129 was admitted to the facility in May 2025 with diagnoses including schizoaffective disorder. Review of Resident #129's most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition.Review of Resident #129's July 2025 physician's orders indicated the following:-Fluphenazine (an antipsychotic medication primarily used to treat schizophrenia and other conditions causing psychosis) HCl (Hydrochloride) Oral Tablet 5 milligrams (Fluphenazine HCl) Give 1 tablet by mouth in the evening for behavioral management. Start date:7/1/25-Fluphenazine HCl Oral Tablet 5 milligrams (Fluphenazine HCl) Give 2 tablets by mouth in the evening for behavioral management. Start date:7/16/25Review of Resident #129's July 2025 Medication Administration Record (MAR) indicated that Fluphenazine was administered on 7/2/25, 7/3/25, 7/4/25, 7/5/25, 7/6/25, 7/7/25, 7/8/25, 7/9/25, 7/10/25, 7/11/25, 7/12/25, and 7/13/25.Review of the medical record indicated that Resident #129 has a court appointed Guardian. The court also authorized the treatment of Resident #129 with antipsychotic medication. A Roger's treatment plan with the medications and alternative medications Resident #129 could be administered was included.Further review of the Roger's treatment plan with an expiry date of 5/4/26 failed to indicate Fluphenazine as one the antipsychotic medications approved by the court to be used for treatment for Resident #129. Further review of the Roger's treatment plan failed to indicate Fluphenazine was one of the alternative medications.During an interview and record review on 7/17/125 at 1:18 P.M., the Regional Social Worker reviewed the medical record and said Resident #129 had been administered Fluphenazine from 7/2/25-7/13/25 as ordered. The Regional Social Worker said the Roger's treatment plan should have been expanded in court to include Fluphenazine prior to administering the medication to the Resident.During an interview on 7/18/25 at 10:56 A.M., the Director of Nurses said only medications in the Roger's treatment plans should be administered to residents and if new antipsychotic medications are approved by the physician, the facility should go back to court to expand the Roger's treatment plan to include the new medication.During a telephone interview on 7/18/25 at 10:21 A.M., the court appointed Roger's monitor, (a person appointed by the court to oversee the implementation of a court approved treatment plan for an incapacitated individual), said the [NAME] monitor role is new to him. He said he was made aware by the facility that the Resident was being administered Fluphenazine but he was not aware that the court would need to expand the [NAME] treatment plan to include Fluphenazine.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide initial and ongoing assessments of a wheelchair seatbelt to ensure one Resident (#24) was free from restraints out of a total sample of 36 residents. Findings include:Review of the facility policy titled, Use of Restraints, dated April 2017, indicated the following: -Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical condition and to determine if there are less restrictive interventions that may improve the symptoms. Resident #24 was admitted to the facility in June 2025 with diagnoses including dementia with behavioral disturbances, traumatic brain injury, legal blindness and unsteadiness on feet. Review of Resident #24's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident has a Brief Interview for Mental Status score of 8 out of a possible 15, which indicated the Resident has moderate cognitive impairment. The MDS also indicated Resident #24 requires substantial assistance from staff for all self-care and mobility tasks. On 7/16/2025 at 8:37 A.M., Resident #24 was observed sitting in his/her wheelchair in the unit hallway. The Resident's wheelchair had a seatbelt which was secure around the Resident's waist. When asked, Resident #24 was unable to say how long the seatbelt had been on his/her wheelchair, why it was on the wheelchair or if he/she had sustained any falls while at the facility. Review of Resident #24's physician orders failed to indicate an order for a seatbelt to be on the Resident's wheelchair. Review of Resident #24's care plans failed to indicate an intervention in any of the personalized care plans for the use of a seatbelt on the Resident's wheelchair. Review of Resident #24's medical record failed to indicate a restraint assessment had been completed to determine whether or not the seatbelt was a restraint. During an interview on 7/18/2025 at 10:15 A.M., Unit Manager #2 said Resident #24 uses a seatbelt on his/her wheelchair. Unit Manager #2 said she does not know if the facility ever did a restraint assessment for the seat belt on Resident #24's wheelchair and said she was unsure if a restraint assessment needed to be completed. During an interview on 7/17/2025 at 11:38 A.M., the Director of Nursing said Resident #24 has his/her own personal wheelchair and was admitted with that wheelchair. The Director of Nursing said the wheelchair does have a seatbelt and that the Resident is able to release the belt independently. The Director of Nursing said a formal restraint assessment should have been completed upon admission and should be completed throughout the Resident's stay to ensure the seatbelt is not a restraint. The Director of Nursing said the use of a seatbelt should also be included in Resident #24's care plans.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately and timely report an allegation of misappropriation to the State Agency for one Resident (#29) of 36 sampled residents. Specifically, Resident #29 alleged that a staff member stole a piece of jewelry, and the facility did not report the allegation to the State Agency. Findings include: Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated as revised September 2022, indicated: -If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immedicably to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following person or agencies. These agencies include the state licensing/certification agency responsible for the surveying /licensing the facility. Immediately is defined as within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Resident #29 was admitted to the facility in June 2025, and has diagnoses which include hypertension, diabetes, depression and anxiety. Review of Resident #29's Minimum Data Set assessment dated [DATE] indicated a Brief Interview for Mental Status examination score of 10, signifying moderate cognitive impairment. The Resident was dependent on staff for most activities of daily living. During an interview on 7/16/25 at 9:45 A.M., Resident #29 said that on 7/9/25, during the day shift, a staff member and CNA #5 entered the bedroom to give him/her a bed bath. The Resident said his/her neck chain was removed and placed on the over-bed table, placed directly in front of him/her. Resident #29 said the staff member then swept the chain into a small basin containing water and removed the basin. Resident #29 said he/she told the staff member he/she just saw her steal his/her chain. Resident #29 said the staff member denied taking the chain and told the Resident he/she did not own a chain. Resident #29 said the staff member left the bedroom but later returned and asked the Resident not to report her to management and offered to buy the chain for $50. Resident #29 said that day he/she told CNA #5 that the staff member stole his/her neck chain, and that CNA #5 confirmed to him/her he/she owned a neck chain. Resident #29 said that no one had interviewed him/her about the incident. During an interview on 7/17/25 at 8:33 A.M., CNA #5 said that on 7/16/25 Resident #29 told her that on 7/9/25 a staff member stole his/her chain necklace. CNA #5 said she had seen Resident #29's neck chain before the alleged incident. CNA #5 said she forgot to report the allegation of theft to a nurse or administration. During an interview on 7/17/25 at 9:31 A.M., the surveyor informed the Administrator that Resident #29 told the surveyor a staff member stole a chain necklace from him/her on 7/9/25, dayshift. The Administrator said he was unaware of the allegation but would immediately start an investigation and report the allegation within two hours through the Health Care Facility Reporting System to the State Agency. During an interview on 7/18/2025 at 10:34 AM, Unit Manager (UM) #3 said that she and the Administrator interviewed Resident #29 on 7/17/25. UM #3 said the Resident told them that on 7/9/25 a staff member stole his/her neck chain. UM #3 said the Resident told her he saw the staff member sweep the chain into a small water basin while washing him/her in bed. UM #3 said the Resident told her that he/she confronted the staff member about the alleged theft, and that the staff member denied that the Resident owned a neck chain. UM #3 said the Resident told her that CNA #5 was present during the incident, but that CNA #5 did not take the chain. UM #3 said that she interviewed CNA #5, and that CNA #5 told her she forgot to report the incident because it was a busy day. UM #3 said the staff members who provided bathing care to Resident #29 on 7/9/25 were arriving later this afternoon and would be interviewed for the investigation. Review of HCFRS on 7/18/25 at approximately 9:30 A.M. indicated the Facility had reported Resident #29's allegation of theft as missing personal property. The HCFRS narrative indicated: Today at 9:00am a DPH state surveyor here on annual survey asked the administrator if he was aware of a resident missing necklace. I reported i [sic] have not heard anything and went to interview the resident immediately. Resident states that on 7/9/25 he/she took the chain off and he/she saw one of the aides sweep it into a bucket. He/she cannot remember or identify who the individual was that took the item. Police came in to take a statement.During an interview on 7/18/25 at 10:01 A.M., the Administrator said Resident #29 had told him that a yet unidentified staff member stole his/her chain necklace. The Administrator said he reported the incident as missing personal property because he did not understand that allegations of theft should be reported as misappropriation. The Administrator said he would resubmit the allegation of misappropriation through HCFRS. On 7/21/25 at approximately 7:10 A.M., the surveyor

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to develop a plan of care for monitoring the effects of psychotropic medications for one Resident (#179) out of a total sample of 36 residents. Findings include:Review of the facility policy titled, Care Planning - Interdisciplinary Team, dated March 2022, indicated the following: Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team.Resident #179 was admitted to the facility in July 2025 with diagnoses including major depression and unspecified psychosis.Review of the Brief Interview for Mental Status (BIMS) completed on 7/16/25, indicated the Resident had a score of 8 out of a possible 15, which indicated the Resident has moderate cognitive impairment. Review of Resident #179's physician orders indicate the following orders for psychotropic medications:-Risperidone (an antipsychotic medication) tablet 0. 25 MG (milligrams). Give 1 tablet by mouth at bedtime for rehab.-Trazodone (a mood stabilizing medication) Oral Tablet 50 MG. Give 1 tablet by mouth every 24 hours as needed for insomnia until 7/26/2025.The physician orders failed to indicate an order to ensure monitoring of the medications for side effects.Review of Resident #179's individualized care plans failed to indicate a care plan was developed for the use of psychotropic medications.During an interview on 7/18/2025 at 8:04 A.M., Nurse #8 said she is not sure who develops resident care plans at the facility as she has never written one. During an interview on 7/18/2025 at 10:15 A.M., Unit Manager #2 said the admitting nurse creates the baseline care plans and then the interdisciplinary team edits and creates all other needed care plans to address all needs of the residents. Unit Manager #2 said residents who are receiving psychotropic medications should have a care plan created to monitor the side effects of these types of medications. Unit Manager #2 reviewed Resident #179's care plans and said Resident #179 should have had a psychotropic medication care plan developed and didn't. Unit Manager #2 said there should also be an order to monitor the side effects of psychotropic medications and this was not done.During an interview on 7/18/2025 at 10:57 A.M., the Assistant Director of Nursing said all residents who are receiving psychotropic medications should be monitored for potential side effects. The Assistant Director of Nursing said this monitoring is ensured by either having an order to monitor or having a care plan for monitoring in place. The Assistant Director of Nursing reviews Resident #179's medical record with the surveyor and said the Resident was missing psychotropic care plans and an order to monitor potential side effects of these medications.During an interview on 7/18/25 at 12:14 P.M., the Director of Nursing said any resident receiving psychotropic medications should have a care plan addressing the use of these medications and the need to monitor for potential side effects of these medications.

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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 observation, record review and interview the facility failed to provide quality standards of professional practice for 3 residents (# 11 , #15 and #21), out of a total sample of 36 residents. Specifically:1.For Resident #11, the facility failed to implement physician's orders by administering liquid consistency as ordered.2. For Resident #15, the facility failed to implement the use of a Prevlon Boot (a specialty device utilized to prevent pressure on the heel) as ordered by the physician.3. For Resident #21 the facility failed to adhere to professional standards of nursing practice, when Nurse #2 left medications with Resident #21, who was not assessed as being able to self-administer medications. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #11 was admitted to the facility in February 2025 with diagnoses including dysphagia. Review of Resident #11's most recent Minimum Data Set (MDS) dated [DATE] did not indicate a Brief Interview for Mental Status (BIMS) score because the resident is rarely/never understood. Review of Resident #11’s July 2025 physician’s orders indicated the following: -Regular diet, pureed (PU4) texture, moderately thick (MO3) consistency. Start date:5/30/25. [sic] -Aspiration precaution every shift. Start date: 5/19/25. -Aspirin EC (enteric coated) Tablet Delayed Release 325 milligrams-Give 1 tablet by mouth in the morning for ppx (prophylaxis), take with a full glass of water, do not crush. Give with food to minimize GI (gastrointestinal) irritation. Start date: 6/4/25. Review of Resident #11’s most recent speech therapy treatment encounter notes dated 6/17/25 indicated the following: Precautions-PEG (Percutaneous Endoscopic Gastronomy) continuous nocturnal feeds starting at 7 PM, pureed solids, moderately thick, (honey), liquids. Feeding assistance, Aspiration precautions. During an interview on 7/18/25 at 7:57 A.M., Nurse #6 said she had just administered Aspirin to Resident #11. She said she let the Aspirin dissolve in apple sauce (a puree of stewed apples) prior to administering it to the Resident. Nurse #6 said after Resident #11 took the dissolved Aspirin in apple sauce, she administered Apple juice (a drink made by pressing and processing apples) because Resident #11 does not like water. Nurse #6 said she did not add any thickening agent to the Apple juice. Review of the July 2025 Medication Administration Record (MAR) indicated Aspirin had been administered as ordered. The MAR further indicated Nurse #6 had administered Aspirin to Resident #11 on the following days, 7/11/25, 7/12/25, 7/15/25, 7/16/25 and 7/18/25. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/25 at 8:42 A.M., the Speech Therapist said Resident #11 should only ingest moderately thick liquids. The Speech Therapist said Nurse #6 should have thickened the Apple juice prior to administering it to the Resident. During an interview on 7/18/25 at 10:59 A.M., the Director of Nurses said Nurses should implement physician’s orders. The DON said Resident #11 should not be administered thin liquids. The DON said the Nurses should thicken liquids prior to administering the liquids to Resident #11. 2. Resident #15 was admitted to the facility in February 2024 with diagnoses including peripheral vascular disease and type 2 diabetes. Review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #15 is severely cognitively impaired and is dependent on staff for assistance with bathing, dressing and eating. Resident #15 was unable to participate in the interview process due to his/her cognitive status. Review of the clinical record indicated a physician’s order: Prevalon boot to RLE (right lower extremity) at all times as tolerated. May remove for care and to assess for skin integrity, every shift, 5/9/24. On 7/16/2025 at 7:56 A.M., the surveyor observed a Prevalon boot on Resident #15’s bedside table. Resident #15 was asleep in his/her wheelchair not wearing the Prevalon Boot. On 7/16/2025 at 12:54 P.M., the surveyor observed Resident #15 eating lunch in the dining room. He/she was not wearing the Prevalon boot. On 7/17/2025 at 8:14 A.M., the surveyor observed Resident #15 seated in his/her wheelchair watching TV in his/her room. He/she was not wearing the Prevalon boot. On 7/17/2025 at 9:08A.M. the surveyor observed Resident #15 in the dining room eating breakfast. He/she was not wearing the Prevalon boot. On 7/17/2025 at 10:40 A.M., the surveyor observed Resident #15 in an activity. He/she was not wearing the Prevalon boot. Review of the Resident #15’s care plans failed to indicate Resident #15 had behaviors of refusing care. Review of the nurse progress notes failed to indicate Resident #15 had refused wearing the Prevlon boot on 7/16/25 and 7/17/25. Review of the July 2025 Treatment Administration Record (TAR) indicated Resident #15 had been wearing his/her Prevlon boot during the 7:00 A.M., – 3:00 P.M. shift; contrary to the surveyor's observations. During an interview on 7/17/2025 at 10:42 A.M., Certified Nursing Assistant (CNA) #1 said that Resident #15 is easy going and never refuses care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 7/17/25 at 12:18 P.M., and 7/17/25 at 1:57 P.M., Nurse #1 said that the Resident does not refuse care or treatments. Nurse #1 said that CNAs are responsible for donning Prevlon boots on residents and the nurses verify they are put on. Nurse #1 said she thought Resident #15’s Prevlon boot was put on him/her around breakfast time and was not aware that he/she had not been wearing it. During an interview on 7/18/2025 at 10:18 A.M., the Assistant Director 0f Nursing (ADON) said that physician's orders should be implemented as ordered. The Director of Nursing (DON) said that CNAs should be donning Prevlon boots and nurses are expected to verify and document that residents are wearing the boots as ordered. 3. Resident #21 was admitted to the facility in August 2019 with diagnoses that include but are not limited to end stage renal disease, dependence on renal dialysis, unspecified protein-calorie malnutrition, major depressive disorder, and adult failure to thrive. Review of the facility’s policy, titled Administering Medications dated with a revision date April 2019, indicated the following: Medications are administered in a safe and timely manner and as prescribed. 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Review of the comprehensive Minimum Data Set assessment dated [DATE] indicated Resident #21 scored 15 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as cognitively intact, and requires supervision or touching assistance with daily care activities including toileting, dressing and transfers. During an interview on 7/16/25 at 8:04 A.M., Resident #21 was sitting in his/her wheelchair. A medication cup with pills in a substance and a spoon was on the overbed tray table. Resident #21 picked up the medication cup and moved the spoon around revealing partially disintegrated pills. Resident #21 said he/she did not know what the pills were and that the nurse left them because he/she was getting dressed this morning. Review of Resident #21’s medical record failed to reveal a physician order, a self-administration of medication assessment, or care plan indicating medication could be left with Resident #21 for self-administration. During an interview on 7/16/2025 at 8:26 A.M., Nurse #2 said a nurse’s duty is to make sure residents take their medication as ordered and to stay with the resident when they take their medication, or document if they refuse to take the medication. Nurse #2 said that medication should not be left with a resident. Nurse #2 said Resident #21 is independent and knows his/her medications. Nurse #2 and the surveyor went to Resident #21’s room and the medication cup with pills inside the cup was on the overbed tray. Nurse #2 said he gave Resident #21 the medications whole in apple sauce. Nurse #2 said it may be protonix (a medication used to treat acid reflux), and lamictal (a mood stabilizer). Nurse #2 said the medication should not have been left in Resident #21’s room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/2025 at 10:37 A.M., Nurse #5 said when a nurse administers medication it is the nurse’s duty to stay with the resident while they take their medication and that medication in a medication cup is not left with a resident. Nurse #5 said Resident #21 accepts his/her medications and the medication in a cup should not have been left in the room with the Resident. During an interview on 7/18/2025 at 10:48 A.M., Unit Manager #3 said the nurse administering medication stays with a resident to ensure the medication is taken and does not leave medication in a resident’s room unless they have a physician’s order for self-administration. During an interview on 7/18/2025 at 11:06 A.M., the Director of Nursing (DON) said unless a resident has an order and care plan for self-administration of medication the nurse is to stay with the resident to ensure the medication was taken and the medication cup containing medication should not be left with the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure the residents of the facility were free from accidents. Specifically, the facility failed to:1.) Ensure a wander guard was in place and ensure the resident was not moved to a less secure unit, resulting in the elopement of one Resident, (#62), out of a total of 36 sampled Residents.2.) Respond appropriately to an open flame fire during breakfast service in the kitchen. Findings include: 1. Resident #62 was admitted to the facility in May 2025 with diagnoses including altered mental status and mild neurocognitive disorder due to physiological condition with behavioral disturbance. Review of Resident #62’s most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status score of 7 out of a possible 15, which indicated the Resident has severe cognitive impairment. The MDS also indicated Resident #62 requires supervision for all self-care and mobility tasks. During an interview on 7/16/25 at 9:15 A.M., Resident #62 was observed walking in his/her room independently. Resident #62 was unable to provide any history into his/her stay at the facility. During survey, the surveyor attempted to contact Resident #62’s guardian and did not receive a return call. Review of the incident report dated 6/21/25 indicated Resident #62 had eloped from the facility and had been missing for 4 hours before being found by the police. Review of Resident #62’s initial skilled nursing assessment dated [DATE] failed to complete the section addressing the Resident’s wandering status. Review of the nursing note dated 5/16/25 indicated: -“Resident noted to be pleasantly confused and goal driven to go to the bank. Resident ambulating independently with no assistive device. Allotment assessment initiated. Care plan updated. NP (Nurse Practitioner) aware. Room change to secure unit completed.” On 5/16/25, Resident #62 was transferred to a secure, code locked unit. Review of Resident #62’s elopement/wandering care plan initiated on 5/16/25, had a goal that the Resident would not leave the facility unattended and indicated the following interventions: -Room change to secure unit. -Engage resident in purposeful activity. -Identify triggers for wandering/elopement. -Identify if there is a certain time of day wandering/elopement attempts occur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skilled nursing assessments after Resident #62’s display of wandering behaviors indicated the following: -assessment dated [DATE] indicated Resident #62 wanders at night, however, failed to complete the other wandering sections or initiate a care plan intervention for the wandering behavior. -assessment dated [DATE] failed to complete any sections focused on wandering behaviors. -assessment dated [DATE] indicated Resident #62 wanders at night, however, failed to complete the other wandering sections or initiate a care plan intervention for the wandering behavior. --assessment dated [DATE] failed to complete any sections focused on wandering behaviors. Review of Resident #62’s elopement assessment dated [DATE] indicated the Resident had verbally expressed the desire to go home, packed belongings to go home or stayed by the exit door, had wandered on the unit, had a wandering behavior pattern that was goal directed, and has recently been admitted to the facility and is not accepting the situation. Review of the nursing note dated 5/22/25 indicated Resident #62 was at high risk of elopement and included the following: -“Resident is alert verbal and pleasantly confused able to make (his/her) needs known. Assist with ADL's (activities of daily living) cooperative. Out of bed and ambulates in unit using RW (rolling walker) gait is slow and steady. High risks for elopement wander in and out of (his/her) room. Socializing with another resident. From time to time will ask how to get home. Wants staff to call Uber for (him/her). Verbally redirect with good effects.” Review of the nursing note dated 5/26/25 indicated Resident #62 was at high risk of elopement and included the following: -“High risks for elopement wander in and out of (his/her) room. Socializing with another resident. From time to time will ask how to get home. Asking for (his/her) fiancé.” Review of the nursing note dated 6/11/25 indicated Resident #62 was at high risk of elopement and included the following: -“Resident is alert verbal and pleasantly confused able to make (his/her) needs known. Assist with ADL's cooperative. Out of bed and ambulates in unit gait is slow and steady. High risks for elopement wander in and out of (his/her) room. Belonging pack and asking about (his/her) car. Verbally redirect with poor effects. From time to time will ask how to get home. Family in to visit. Verbally redirect with good effects. ” Review of the nursing note dated 6/17/25 indicated the following: -“Patient moved to [NAME] unit room [ROOM NUMBER]D with meds and belongings on 6/17/25. Nursing report was given to receiving nurse and stated understanding. Guardian was notified and agreed to room change.” (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders indicated that on the same day Resident #62 was transferred off the secured, locked unit, the physician prescribed a wander guard (a device that would alarm if the Resident were to leave the new unit). Review of Resident #62’s elopement assessment dated [DATE], (the day after he/she was transferred off the secured code locked unit,) indicated the Resident had previous attempts at elopement in the facility, had verbally expressed the desire to go home, packed belongings to go home or stayed by the exit door, had wandered on the unit, had a wandering behavior pattern that was goal directed, and has recently been admitted to the facility and is not accepting the situation. Review of the Treatment Administration Record for June 2025 indicated that the wander guard was not in place on 6/18/25, 6/19/25, 6/20/25 or 6/21/25. The nursing notes failed to indicate that the clinical team was made aware of the missing wander guard. Review of the nursing note dated 6/21/25 indicated the following: -“Resident noted missing from the unit at around 4:40 PM. Code Gray activated. Staff responded. Unable to locate resident in the unit. Unable to locate the resident in the building nor facility grounds. Resident is care planned for 15 minute checks period last seen in the unit at around 4:30 PM walking in the hallway. MD and responsible party notified of the event. Local Police Department called to report a missing person. At approximately 8:00 PM police notified facility that BPD was able to locate the Resident at (his/her) home address. MD and responsible party updated. Residents sent to ER on section 12 for further evaluation. ” During an interview on 7/18/2025 at 10:15 A.M., Unit Manager #2 said Resident #62 was moved off the secured, code locked unit secondary to him/her “doing better” and wanting to participate in more activities. Unit Manager #2 said she is unaware of the circumstances that led to Resident #62’s elopement from the facility. During an interview on 7/18/2025 at 10:57 A.M., the Assistant Director of Nursing said Resident #62 was transferred off the secured, code locked unit because the clinical team felt he/she had settled in and was needing to participate in activities more. The Assistant Director of Nursing said she was unaware of the nursing notes indicating the Resident had increased wandering behaviors and was a “high risk of elopement”. The Assistant Director of Nursing said that when Resident #62 was moved off of the unit, he/she was given a wander guard as an intervention to prevent elopement because it would alarm if the Resident went onto the elevator. The Assistant Director of Nursing reviewed the TAR from June 2025 with the surveyor and said the Resident did not have the wander guard in place at the time of elopement or for the couple days prior and she does not remember any of the nursing staff reporting the wander guard missing to the clinical team. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/2025 at 12:14 P.M., the Director of Nursing said Resident #62 was moved off the secured, code locked unit so that he/she could be closer to activities. The Director of Nursing said that at the time of the move, the facility was aware the Resident was a risk for elopement, and a wander guard was provided to him/her. The Director of Nursing said that if he was aware the Resident was displaying increased behaviors of elopement as the nursing notes indicated, he would not have agreed to the Resident being moved to a different unit. The surveyor and Director of Nursing reviewed the nursing notes that indicated the Resident was at high risk of elopement and was having increased behaviors and he said he was not aware of this. The Director of Nursing said that at the time of Resident #62’s elopement, Resident #62 was not wearing the wander guard as ordered and, after reviewing the TAR, said the nursing staff must have been aware of this and should have notified him. 2. Review of the facility policy titled “Fire Safety and Prevention”, dated as revised July 2024, indicated: fire prevention is the responsibility of all personnel residents’ visitors and the public. Review of the conveyor toaster user manual indicated the following: 12. Oversized bread, metal foil packages or utensils must not be inserted in a toaster as they may involve a risk of fire or electrical shock. 13. Do not attempt to dislodge food when toaster is plugged into electrical outlet. 14. To avoid possibility of fire, do not leave unattended during use. 23. Some exterior surfaces on the unit will get hot. Use caution when touching these areas to avoid injury. On 7/18/25 between 7:42 A.M. and 8:20 A.M., the surveyor made the following observations while watching the breakfast line: -At 7:42 A.M., and 7:55 A.M., The surveyor observed an open flame inside of the toaster on the conveyor belt. There was smoke coming from the toaster. The Dietary Aid walked away from the toaster leaving the open flame with burning toast on the conveyor belt unattended. Dietary Aid #2 walked over to the conveyor toaster picked up the metal tongs and removed the piece of bread that was on fire. The Dietary Aid did not unplug the toaster or notify anyone of the fire. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 8:05 A.M., The surveyor observed Dietary Aid #2 place English muffins on to the conveyor toaster belt, then walked away from the conveyor toaster leaving kitchen area leaving the English muffins on the conveyor belt unattended. At 8:07 A.M., the surveyor observed an open flame inside of the toaster on the conveyor belt. There was smoke coming from the toaster. The English muffins began to smoke and fire with large growing open flames continued to grow, consuming the English muffin. The surveyor notified the Food Service Director (FSD) and Dietary Aid who were present in the kitchen yet did not notice the large fire inside of the toaster. Dietary Aid #1 was observed picking up metal tongs and placed them into the electric toaster attempting to remove the English muffin that was on fire inside of the toaster. The FSD was heard telling the dietary aid to “don’t stick metal into the toaster you need to unplug it first!” The open flame continued to burn, and fire was observed on the conveyor belt as smoke continued to come out of the toaster. The toaster had a tray place on top containing several plastic bags containing sliced bread and English muffins. The surveyor intervened and informed staff to remove the tray from the top of the conveyor toaster to avoid a potential second fire. During an interview on 7/18/25 at 10:45 A.M., Dietary Aid #1 said the toaster should not be left unattended and said he would use the fire extinguisher if the fire got any bigger to stop it from spreading. Dietary Aid #1 said this has happened before, but they are able to put out the fire by tapping the bread inside with a spoon or tongs. During an interview on 7/18/25 at 10:47 A.M., Dietary Aid #2 said he was not sure what to do because the toaster has never caught fire before. During an interview on 7/18/25 at 10:49 A.M., the FSD said staff should never leave the toaster unattended and said staff should unplug the unit and notify other staff if a fire has occurred. The FSD said he should have been notified when the first fire started and said the unit could have been inspected for food stuck on the belt and for proper management to prevent any additional fires. The FSD said metal tongs should never be placed inside the unit and said items should not be stored on top of a hot conveyor toaster because they could catch fire.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation and interview, the facility failed to ensure staff followed proper sanitation and food handling during meal service to prevent the potential outbreak of foodborne illness.Findings includeReview of the facility polity titled, Food: Preparation and Service, undated, indicated the following:-Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices.-Cross-contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. Cross- contamination can also occur when raw food touches or drips onto cooked or ready-to-eat foods.-Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.On 7/18/25 from approximately 7:40 A.M. to 8:10 A.M., the following was observed in the facility kitchen during the breakfast meal line:-The Food Service Director (FSD) had on a pair of gloves and picked up a lid off the steam table, potentially contaminating his gloves. He then used the same gloved hand and picked up an English muffin and placed it on a plate to be served. He then used the same gloved hand to move a rolling food cart, grasping the handle and then picked up a breakfast sandwich and re-arranged it on a serving plate. The FSD then picked up a metal scoop to lift off the lid to the pureed food located on the steam table. He used the same potentially contaminated scoop to serve food to be placed on serving plates. He then picked up tongs with his gloved hands and then touched slices of cheese to be placed on the breakfast sandwiches. He then picked up the sandwiches with his potentially contaminated gloved hand. The FSD picked up eggs with his gloved hands and placed them on plates. He proceeded to touch plates, serving utensils, trays, and bowls, with his gloved hands. The FSD touched toast, English muffins, fried eggs, and placed items on a plate to be served to residents. The FSD did not remove his gloves or perform hand hygiene throughout this observation. -Dietary Aid #1 had one glove on his left hand and was observed moving a food cart across the kitchen placing his gloved hand on the food cart handles. He then used his potentially contaminated gloved hand to pick up clean serving plates placing his gloved fingers on the inside of the dishes. He then used his potentially contaminated gloved hand to pick up a toasted English muffin and place it on to a serving plate. Dietary Aid #1 was observed removing his contaminated glove and put on a new glove, (without performing hand hygiene). He was then observed picking up metal tongs with his gloved hand and then using the same gloved hand to remove bread from the conveyor toaster. He then removed his contaminated glove from this hand and did not perform hand hygiene. He then used his bare hands to move a breakfast cart and picked up bags of sliced bread with his bare hand. Dietary Aid #1 did not perform hand hygiene throughout the observation. -Dietary Aid #2 was observed picking up a white rag with his gloved hands to clean off the table by the conveyor toaster. He then used his contaminated gloved hand to pick up slices of bread to place them into the conveyor toaster. He then used his contaminated gloved hands to move a rolling food cart by touching the handles and then picked up the toasted English muffins with his potentially contaminated gloved hands. Dietary Aid #2 did not remove his gloves or perform hand hygiene throughout this observation. -Dietary Aid #3 had on a pair of gloves and picked up a knife by the handle and proceeded to cut English muffins. She then picked up a pair of tongs with her gloved hands and then picked up English muffins with her potentially contaminated gloved hands to be placed on a serving plate. Dietary Aid #3 did not remove her gloves or perform hand hygiene throughout this observation. During an interview on 7/18/25 at 10:44 A.M., Dietary Aid #1 said staff must wash their hands before and after glove use and said he should not be handling or touching food items with a contaminated glove. During an interview on 7/18/25 at 11:04 A.M., Dietary Aid #3 said she should not have touched food items with her gloves after touching equipment.During an interview on 7/18/23 at 10:50 A.M., the Food Service Director (FSD), said staff need to wash their hands prior to putting on gloves and then if gloves become contaminated by touching items other than food, the gloves must be changed, and hands should be washed again.

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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 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 record 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 transmission of communicable diseases and infections. Specifically, the facility failed to implement occupational health policies prohibiting contact with residents or their food, evidenced by observations of Dietary Aide #1 working in the facility kitchen while having a skin injury on his hand which prevented him from being able to perform hand hygiene. Findings include:Review of the facility policy titled Employee Health Program, dated September 2022, indicated the following:Our facilities employee health program strives to promote the health safety and well-being of our personnel and prevent the spread of communicable diseases among staff and residents.-Providing employee screening for communicable diseases and infections-Employment physical examinations and testing shall focus on occupational health and remain relevant to job requirements in the workplace for example the nature and scope of an employee's physical limitations of endurance or strength is relevant only if his or her job responsibilities require physical endurance and or strength.-Employment examination shall also be used to screen employees for signs symptoms and or risk factors for communicable diseases.On 7/18/25 from approximately 8:10 A.M., the following was observed in the facility kitchen during the breakfast meal line:-Dietary Aid #1 had one glove on his left hand and was observed moving a food cart across the kitchen placing his gloved hand on the food cart handles. He then used his potentially contaminated gloved hand to pick up clean serving plates placing his gloved fingers on the inside of the dishes. He then used his potentially contaminated gloved hand to pick up a toasted English muffin and place it on to a serving plate. Dietary Aid #1 was observed removing his contaminated glove and put on a new glove. He did not perform hand hygiene.-Dietary Aid #1 was observed picking up metal tongs with his gloved hand and then using the same gloved hand to remove bread from the conveyor toaster. He then removed his contaminated glove from this hand and did not perform hand hygiene. He then used his bare hands to move a breakfast cart and picked up bags of sliced bread with his bare hand.The surveyor observed blue stitching located on Dietary Aid #1's left index finger. There was a laceration with stitches exposed on the outside of the finger and it was not covered.During an interview on 7/18/25 at 10:45 A.M. Dietary Aid #1 said he was injured about a week and a half ago at home requiring 10 stitches to his left index finger and said he cannot get the area wet and wears gloves to protect the stitches. Dietary Aid #1 said he told the Food Service Director (FSD) about his injury and said he wears a glove because he can't perform hand washing or use alcohol because of the open cut and stitches.During an interview on 7/18/25 at 10:53 A.M., the FSD said he did not know about the stitches and said he thought it was just a bad cut because he saw Dietary Aid #1 with a finger condom on it the other day. The FSD said the area should be covered with a bandage and not exposed to food. The FSD said he did not notify anyone about the open area to the finger. During an interview on 7/18/25 at 11:24 A.M., the Human Resource Director said she was not made aware of the employees' injury and said she should have been notified because the dietary aid needs to be cleared for work following stitches to his hands and said staff cannot work if they cannot wash their hands and perform work duties. During an interview on 7/18/25 at 11:46 A.M. the Director of Nurses (DON) said if staff report an illness or injury, we need to know to track it for infection control reasons to determine next steps. The DON said staff cannot work with open wounds and said standard infection control practices are facility wide and said he expects staff to follow hand washing guidelines and not report to work if open skin lesions are unable to be covered or contained. During an interview on 7/18/25 at 12:06 P.M., the Administer said the staff member should not have been working until he was cleared to do so and said staff should not be working with open wounds or stitches and said staff must be able to wash their hands appropriately.