STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225269	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Day Brook Village Senior Living	298 Jarvis Avenue Holyoke, MA 01040

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on record review, observations, and interviews, the facility failed to provide appropriate access to the call light for one Resident (#24) out of a total sample size of 18 residents. Specifically for Resident #24, the facility staff failed to place the Residents' call light within his/her reach placing Resident #24 at risk for unmet needs. Findings include: Review of the facility policy titled Resident's Rights Policy, revised 10/4/23, included but was not limited to: -Residents have rights and protections under Federal Law .are rendered without reprisals. < Residents have the right to reside and receive services in the facility with reasonable accommodation of needs and preferences except when to do so would endanger the health and safety of other residents. Review of the facility policy titled Call light answering, dated 5/2/05, included but was not limited to: < Prior to leaving the resident ask if there is anything else you can do for them. < Place the call light within reach of the resident. Review of the facility policy titled Initiating and Ending Clinical Nursing Procedures, dated 5/2/05, included but was not limited to: -It is the policy of this facility to follow all regulations and standards of care related to resident rights and provision of quality of care. To that end, all employees performing procedures in resident care settings will observe general practices relating to resident .dignity . and resident safety. <After performing the procedure, place call light within easy reach of the resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24 was admitted to the facility in November 2024 with diagnoses including Parkinson's Disease and Hemiplegia/Hemiparesis following cerebral infarction affecting the left side. Review of the recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #24: -has adequate hearing, clear speech, was able to be understood by others and has the ability to understand others. -has functional limitation in range of motion (ROM) to one side of the upper and lower extremity. -was receiving Hospice end of life services. Review of Resident #24's Social Service Progress Note dated 2/7/25, included but was not limited to: -Resident #24 would not answer questions for the Brief Interview for Mental Status (BIMS) assessment, but the BIMS had been attempted. Review of Resident #24's Comprehensive Person-Centered Care Plan indicated: -Problem: Resident has Hemiplegia of left side. -Interventions included: Place call light within the Residents' reach of the unaffected side and answer [call light] promptly. During an interview on 4/1/25 at 9:22 A.M., Resident #24 said that he/she wanted to tell the Nurse that it was time for his/her medication. Resident #24 said that he/she had a button to push but could not find the button. The surveyor observed that the Residents' call light [button] was located on top of the nightstand, on the left side of the Residents' bed and out of the Residents' reach. During an interview on 4/1/25 at 9:35 A.M., Certified Nurses Aide (CNA) #1 said when Resident #24 needed a drink or something else that the Resident would use the call light to call for the staff. The surveyor and CNA #1 observed Resident #24 lying in bed and the call light was located on top of the nightstand on the left side of the Residents' bed and out of reach for the Resident. CNA #1 said that she had moved the call light to the nightstand when she repositioned the Resident about an hour earlier and forgot to put the call light back within the Residents' reach but should have put the call light back. CNA #1 said that placing call lights within reach was important to Residents so that Residents can use the call light to call for staff when something is wrong or if they needed something. During an interview on 4/2/25 at 9:31 A.M., Nurse #1 said that Resident #24 had the ability to use the call light to call for staff assistance when needed. The surveyor and Nurse #1 observed that Residents #24's call light was secured/clipped to the left side of the bed below the lowest bar of the siderail and out of the Residents' reach. Nurse #1 said that the call light was not within the Residents' reach and should be within reach so that the Resident could call for assistance when needed. Nurse #1 said that the call light should have been clipped to the Residents' shirt and within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/25 at 7:45 A.M., the Director Of Nursing (DON) said that call lights should be within a residents' reach at all times so that residents could alert the staff for anything needed.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on interview, and record review, the facility failed to issue the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN: notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) for one Resident (#389) out of a total sample of 18 residents. Specifically, for Resident #389, the facility failed to issue a SNF ABN to the Resident and/ or Resident Representative when effective date of coverage for skilled services ended. Findings include: Review of the Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: ,d+[DATE], indicated the following: -The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. -The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain a copy of the ABN delivered to the beneficiary on file. -The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out representative in parentheses after his or her signature. The representative's name should be clearly legible or noted in print. -The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this, the date may be inserted by the notifier. Resident #389 was admitted to the facility in [DATE]. Review of Resident #389's clinical record indicated: -the Resident was not his/her own responsible party. -the Resident's effective date of coverage for their skilled services ended on [DATE]. -the Resident remained in the facility and did not discharge. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	-no evidence that the SNF ABN had been issued to the Resident's Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself). During an interview on [DATE] at 10:12 A.M, the Clinical Reimbursement Coordinator said that she should have issued the SNF ABN form to the Resident's Responsible party (HCP) after he/she had come off (expired) their skilled benefit but she did not issue the SNF ABN form.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on interview, and record review, the facility failed to conduct an admission assessment and document participation in the assessment to determine the necessary care and services required for one Resident (#88) out of three closed records reviewed. Specifically, for Resident #88, the facility failed to conduct direct observation and communication and complete an accurate Resident assessment upon admission, resulting in the Resident eloping from the facility. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, indicated the following relative to Cognition and Mood: -An interview is considered missed when the resident should have been interviewed, but the interview was not completed in the look back period of the assessment. -Regardless of the reason the interview was not completed -When a resident interview is missed: >C0100, is coded 1: Yes, the interview should be completed, and >The resident interview and staff assessment responses must be dashed if the interview was not completed. Resident #88 was admitted to the facility in January 2025 with diagnoses including alcohol use withdrawal, Wernicke Encephalopathy, Anxiety and Depression. Review of Resident #88's medical record indicated: -nursing admission assessment was not completed at the time of admission. -no nursing admission note with the date and time of the Resident's arrival to the facility, cognitive patterns, mood and behavior patterns, psychological well-being, and discharge planning was completed as required at the time of admission. Review of Resident #88's January 2025 medical record progress notes indicated: -1/24/25 at 12:00 P.M.: Social Services was informed that the Resident left AMA. Protective Services Referral was initiated. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/24/25 at 15:59 (3:59 P.M.): Nursing Progress Note - Nursing called the Resident's cell phone and the Resident informed nursing that he/she was home safe. The Resident was not aware that he/she needed to sign a release form. The Resident stated he/she thought he/she could just leave when he/she wanted. -1/24/25 at 9:00 P.M.: NP [Nurse Practitioner]/PA [Physician Assistant] Progress Note - Resident seen, anxious and thinking of going home, discussed importance of staying and completing rehab, risk of going AMA, declined many questions, discussed with Social Service. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #88: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15 total possible points. During an interview on 4/3/25 at 12:31 P.M., Social Worker (SW) #1 said she did not see the Resident or assess the Resident upon admission. SW #1 said she was informed by the nursing staff that Resident #88 had left the facility. During an interview on 4/3/25 at 1:38 P.M., the MDS Nurse said SW #1 was the staff member who completed the MDS Section C (Cognition) and Section D (Mood) assessments for Resident #88. During an interview on 4/3/25 at 1:41 P.M., SW #1 said she should not have documented a BIMS of 0 on Resident #88 since she never saw the Resident. SW #1 said the MDS assessment for Resident #88 was documented inaccurately. During an interview on 4/3/25 at 12:43 P.M., Nurse #8 said she saw Resident #88 between the hours of 7:00 A.M. to 9:00 A.M. on 1/24/25, and the Resident informed her that he/she wanted to leave the facility. Nurse #8 said she told the Resident to wait until he/she was seen by the Physician. Nurse #8 further said she went to the Resident's room and found the Resident's room empty at 11:30 A.M. and alerted the DON. Please Refer to F689

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on record review, and interview, the facility failed to accurately code a Minimum Data Set (MDS) Assessment for one Resident (#36) out of a total sample size of 18 residents. Specifically, for Resident #36, the facility staff failed to code the MDS accurately relative to antiplatelet (medication which prevents blood platelets from clumping together to form a clot) medication use. Findings include: Resident #36 was admitted to the facility in May 2023 with diagnoses including Aortic Valve Stenosis, Myocardial Infarction, and Hypertension. Review of Resident #36's March 2025 Physician orders included: -Enteric Coated Aspirin (antiplatelet medication) 81 mg (milligram), one tablet oral at noon for prevention of cardiac complications, effective 10/14/23. Review of the MDS assessment dated [DATE], indicated Resident #36: -was taking antianxiety, antidepressant, hypoglycemic and anticonvulsant medications. -was not coded for antiplatelet medication administration. During an interview on 4/1/25 at 10:27 A.M., MDS Nurse #1 said that the facility staff followed the Resident Assessment Instrument (RAI) Manual for guidance when completing a MDS assessment. MDS Nurse #1 said that Resident #36 was receiving an antiplatelet medication. MDS Nurse #1 said that Resident 36's MDS assessment dated [DATE], did not have an antiplatelet medication coded but should have. MDS Nurse #1 said that accurate MDS coding was important for person-centered care planning to ensure proper care and services were in place for Resident #36.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, interview, and record review, the facility failed to provide grooming assistance for one Resident (#55), out of a total sample of 18 residents. Specifically, the facility failed to ensure that Resident #55 was assisted with facial hair removal when he/she required assistance from staff with personal hygiene. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs), effective 11/14/16, indicated: -each resident will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological wellbeing, consistent with the resident's comprehensive plan of care. The ADL policy also included the following: >The facility will provide care and services for hygiene-bathing, dressing and grooming. >The care and services for ADLs will be based on the resident's ability as identified in MDS assessment, Rehab evaluation, nursing assessment and person-centered care plan. >Resident's abilities, personal choices and self-image are accounted for during ADLs. >ADLs are documented in the clinical record by staff member supporting ADLs. Resident #55 was admitted to the facility in January 2023 with diagnoses including Depression and Hyperparathyroidism. Review of a Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #55: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of eight out of a total possible score of 15. -required assistance with personal hygiene. Review of the Comprehensive Care Plan, last revised 3/20/25, indicated Resident #55: -had decreased ability to provide self-care. -decreased ability to perform ADLs. -required assistance with grooming. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/25 at 10:55 A.M., the surveyor observed Resident #55's chin to have long, thick facial hair. During an interview at the time, Resident #55 said he/she does not like to have any facial hair and that staff will help remove the facial hair when he/she remembers to ask for assistance. On 4/1/25 at 10:55 A.M., the surveyor observed that Resident #55 remained with long, thick facial hair on his/her chin. During an interview at the time, Resident #55 said he/she forgot to ask staff to remove the facial hair. During an interview on 4/1/25 at 10:51 A.M., Certified Nurses Aide (CNA) #8 said she is familiar with Resident #55 and has provided care for the Resident many times. CNA #8 said that Resident #55 needs needs assistance with all ADLs and the CNA is aware that Resident #55 prefers not to have facial hair because he/she has requested in the past that the facial hair be removed. CNA #8 said if Resident #55 did not ask to have his/her facial hair removed then CNA #8 would offer to remove the Resident's facial hair. CNA #8 said that she is not required to document removal of facial hair for Resident #55 in the clinical record. During an interview on 4/01/25 at 2:17 P.M., the Director of Nursing (DON) said that CNAs are expected to ask all residents with facial hair if they would like to have facial hair removed and the CNAs should have removed Resident #55's facial hair. The DON said that removal of facial hair should have been addressed with Resident #55's daily ADL care but that it was not addressed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on record review, observations, and interviews, the facility failed to provide treatment and services adhering to professional standards of practice related to Hospice services for one Resident (#62) out of a total sample of 18 residents. Specifically, for Resident #62, the facility failed to ensure that Hospice recommendations for comfort medication orders were implemented in a timely manner leading to a delay in medication administration for the Resident. Findings Include: Review of the facility policy titled Hospice Program, last revised 3/28/22, indicated: -when a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other comfort measures. -a member of the interdisciplinary clinical team from each facility and the hospice organization will be designated to ensure the coordination of care delivery. Resident #62 was admitted to the facility in January 2022 with diagnoses including Dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #62: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 00 out of 15. -was receiving Hospice services. -was having physical/verbal/other behaviors directed and not directed towards others. -was rejecting care. -was wandering during the seven day look back period. Review of Resident #62's clinical record indicated: -the Resident started receiving Hospice services on 1/17/25 -a Hospice Recommendation to Physicians Form dated 1/17/25 that was signed by the Resident's Physician to please add the following comfort medication orders: >Morphine Sulfate (opiate analgesic medication) 20 milligrams (mg)/milliliters (ml): give 0.25 ml (5 mg) by mouth sublingually [under the tongue] every 2 hours as needed (PRN) for pain or shortness of breath (SOB). Call if using more than 3 doses in 24 hours (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>Lorazepam (antianxiety medication) 0.5 mg tablets: give 1 tablet by mouth every 6 hours as needed (PRN) for anxiety and restlessness >Acetaminophen (pain/fever reliever medication) 650 mg suppository: insert 1 suppository (650 mg) rectally every 6 hours as needed (PRN) for mild pain or fever >Hyoscyamine (anticholinergic/ antispasmodic) 0.125 mg sublingual tablet: place 1 tablet (0.125 mg) under the tongue every 4 hours as needed for terminal secretions >Bisacodyl (laxative) 10 mg suppository: insert 1 suppository (10 mg) rectally as needed for constipation >Sennas (stimulant laxative) 8.6-50 mg: give 1 to 2 tablets by mouth 2 times daily as needed for constipation. -a Hospice Recommendation to Physician Form dated 2/27/25, signed by the Resident's Physician for the same comfort medication orders listed on 1/17/25, which further documented: *current issue: *patient on Hospice services since January 2025. *Comfort medications not yet added to the medication profile. -a Hospice Nursing Progress Note dated 3/7/25, that indicated a plan for the night Nurse to follow up that all standard Hospice comfort medications get on the patient's (medication) orders. -a Hospice Recommendation to Physician Form dated 3/13/25, that documented: *current issue: *ACTION NEEDED. *Patient admitted to Hospice services on 1/17/25, in need of comfort medication orders. This is the third recommendation submitted. -a Hospice Nursing Progress Note dated 3/13/25, that indicated recommendations left WITH URGENCY to ensure comfort medications orders are in place at extended care facility. Review of the April 2025 Physician's orders for Resident #62 indicated that the comfort medications were ordered on 3/13/25 (55 days after the initial recommendation by Hospice). During an interview on 4/3/25 at 9:01 A.M., the Director of Nursing (DON) said that Hospice recommendations should be followed up by the facility within 24 hours of the recommendation. During an interview on 4/3/25 at 11:01 A.M., the DON said that the Hospice recommendations should have been implemented when they were initially recommended, and Hospice recommendations had not been implemented.

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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. 47901 Based on record review, and interview, the facility failed to ensure the safety of one Resident (88) out of a total sample of 18 residents, who was at risk for elopement. Specifically, for Resident #88, the facility failed to assess on admission the Resident with a history of substance use disorder (SUD) for risk of elopement and initiate the elopement response when the Resident left the facility without staff being aware. Findings include: Review of the facility policy titled Elopement Prevention and Response, revised 2/24/25, indicated: -It is the policy of the facility to identify residents at risk for elopement through the completion of the Wandering/Elopement risk assessment and to provide a secure environment through the implementation of individualized care interventions. -It is the policy of the facility to ensure that residents who are at risk of elopement are escorted to and supervised during activities off unit such as rehab and outdoor activities. -Upon admission nursing will complete a wandering/elopement risk assessment. -If residents are determined to be at risk for elopement, a care plan goal and individualized approaches to ensure safety will be implemented in interdisciplinary team. -Care plan interventions will be based on assessment of risk factors for elopement including medical conditions, diagnoses including SUD (substance use disorder) history and risk for relapse and psychosocial triggers (new environment, change of routine, family dynamics). -At first notice that the resident does not seem to be in their usual/immediate living space, the resident is to be considered missing and supervisor (or highest-ranking on-site staff member) is notified. -If facility search is unsuccessful, the individual in charge will carry out the following: 1) Notify the Administrator and Director of Nursing (DON) 2) Notify the Police Department . Review of the facility policy titled Discharge Against Medical Advice (AMA), revised 2/20/19, indicated: -Ensure resident can make medical decisions. (continued on next page)

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Day Brook Village Senior Living	298 Jarvis Avenue Holyoke, MA 01040

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Encourage the resident/legal representative to consult the attending physician before leaving the facility regarding his/her choice to leave the facility. -Place the documentation of staff/resident/legal representative interactions in the clinical record. Resident #88 was admitted to the facility in January 2025 with diagnoses of alcohol use withdrawal, Wernicke Encephalopathy, Anxiety and Depression. Review of Resident #88's medical record failed to indicate: -nursing admission assessment related to wandering or elopement risk. -nursing admission note to include the date and time of the Resident's arrival to the facility, assessment of mental status upon admission, and ambulation status. Review of Resident #88's January 2025 medical record progress notes indicated: -1/24/25 at 12:00 P.M.: Social Services was informed that Resident left AMA. Protective Services Referral was initiated. -1/24/25 at 15:59 (3:59 P.M.) Nursing Progress Note - Nursing called the Resident's cell phone and the Resident informed nursing that he/she was home safe. The Resident was not aware that he/she needed to sign a release form. The Resident stated he/she thought he/she could just leave when he/she wanted. -1/24/25 at 9:00 P.M.: NP [Nurse Practitioner]/PA[Physician Assistant] Progress Note - Resident seen, anxious and thinking of going home, discussed importance of staying and completing rehab, risk of going AMA, declined many questions, discussed with Social Service. During an interview on 4/3/25 at 12:29 P.M., the Director of Nursing (DON) said Resident #88 was admitted to the facility in January 2025. The DON said there was no nursing assessment completed for the Resident by nursing upon admission to the facility. The DON said that there was no nursing assessment of the Resident's cognitive status or whether the Resident was at risk for wandering/elopement. The DON further said there was no nursing admission note that could identify the time the Resident was admitted to the facility and if there were any obvious concerns the nursing staff could have identified and documented. During an interview on 4/3/25 at 12:22 P.M., the Registered Dietician (RD) said she had seen Resident #88 when he/she arrived at facility and had sent a diet slip to the kitchen so the Resident could receive his/her evening meal. During an interview on 4/3/25 at 12:31 P.M., Social Worker (SW) #1 said she did not see the Resident or assess the Resident upon admission. SW #1 said she was informed by the nursing staff that Resident #88 had left the facility. (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 4/3/25 at 12:43 P.M., Nurse #8 said she saw Resident #88 between the hours of 7:00 A.M. to 9:00 A.M. on 1/24/25, and the Resident informed her that he/she wanted to leave the facility. Nurse #8 said she told the Resident to wait until he/she was seen by the Physician. Nurse #8 further said she went to the Resident's room and found the Resident's room empty at 11:30 A.M. and alerted the DON. During an interview on 4/3/25 at 1:19 P.M., the DON said she did not consider that Resident #88 had eloped as the facility called the Resident's home and the Resident said he/she was home safe. The DON said the Resident informed the facility staff that he/she had left the facility with an Uber driver. The DON said she sent paperwork and medications to the Resident's home and the Resident signed the AMA form. The DON said she should have initiated the facility's elopement policy, but she did not.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on record review, and interview, the facility failed to provide adequate nutritional care and services for two Residents (#54 and #35) out of a total sample of 18 residents, identified as being at risk for nutritional decline. Specifically: 1. For Resident #54, the facility failed to address significant weight loss and implement effective nutritional interventions when the Resident was identified as having greater than a 5 percent (%) weight loss in one month. 2. For Resident #35, the facility failed to provide the Resident with a diagnosis of Diabetes Mellitus (DM) the ordered glucose control nutritional supplement, when the nursing staff provided original nutritional supplements during meal times that were not ordered and MAR documentation indicated the Resident was receiving the glucose control supplement increasing the Resident's risk for inaccurate nutritional assessment and inappropriate management of blood sugar levels. Findings include: Review of the facility policy for Nutrition Management last revised 9/30/24, indicated: -Residents will receive care and services to ensure acceptable parameters of nutritional status are maintained to the extent possible as indicated by the resident's clinical condition. -Residents will receive a therapeutic diet when indicated. -Staff will consistently observe and monitor residents for changes and implement revisions to the care plan as needed. -provide a therapeutic diet that takes into account the resident's clinical condition and preferences when there is a nutritional indication. Resident #54 was admitted to the facility in May 2021 with diagnoses including Marfan Syndrome (rare genetic disorder of the connective tissue), hemiplegia and dysphagia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #54: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 00 out of 15. -was dependent on staff assistance with eating. Review of Resident #54's 2025 Weights indicated: -1/23/25: 175 pounds (lbs.) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/17/25: 169.6 lbs. -3/13/25: 156.9 lbs. (significant weight loss of 6.96% from 2/17/25 and greater than 5% in 1 month) Review of Resident #54's Progress Notes indicated: -Dietician Note dated 3/13/25, documenting question weight loss, follow with re-weigh. -Dietician Note dated 3/27/25, documenting re-weight obtained with a 12-pound weight loss in the past month. No snacks. No episodes of upset stomach or vomiting noted. (Dietician) Follow with nursing for nutritional interventions. Review of Resident #54's Nutrition Care Plan, last revised 3/27/25, indicated: -at nutritional risk due to dysphagia with history of cerebrovascular accident, right sided weakness, legally blind with resulting decreased ability to eat on own despite adaptive equipment, expressive aphasia and erosive esophagitis with occasional emesis. -notify Dietician if persistent weight loss. During an interview on 4/1/25 at 1:09 P.M., the Dietician said that she had not implemented interventions for Resident #54 after identifying his/her weight loss. The Dietician also said that she should have added a supplement, but wanted to speak with the Unit Manager (UM) first and did not have the time to do so. Review of Resident #54's clinical record failed to indicate that any intervention had been made following the Resident's weight loss until the surveyor discussion with the Dietician. 42761 2. Review of Nestle's At-a-Glance Nutritional Chart, dated 2019, indicated the following: -Boost Original is a moderate calorie, moderate protein nutritional supplement used to help fill nutritional gaps. -Boost Glucose Control was nutrition for people with Diabetes. -helps meet the unique nutritional needs of people with Diabetes as part of a comprehensive Diabetes management plan. Resident #35 was admitted from the hospital to the facility in January 2025 with diagnoses including Diabetes Mellitus. Review of Resident #35's Weights Summary indicated the following: -1/8/25: 178.3 pounds (lbs.) -2/5/25: 170.8 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/27/25: 138.4 lbs. Review of Resident #35's Diabetes Care Plan, dated 1/6/25, indicated the following: -Diet as ordered by MD (Medical Doctor). -Provide diabetic appropriate snacks. Review of the Minimum Data Set (MDS) Assessment, dated 1/9/25, indicated Resident #35: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of nine out of 15 total possible points. -required substantial assistance for eating. -had experienced weight gain, not prescribed by the Physician. Review of Resident #35's Nutrition Care Plan, most recently revised 1/9/25, indicated: -Monitor intake at all meals. -Offer alternate choices as needed. -Document intake regarding % (percent) of solids and fluids consumed. -Weight every month on facility scale. -Provide diet as ordered. -Provide supplement as ordered by MD. Review of the Nutrition Consult, dated 1/6/25, indicated Resident #35: -was not receiving nutritional supplements. -had received intravenous fluids while in the hospital. -current weight was 178.3 lbs. -usual body weight (UBW) was 164.5 lbs. -was alert, confused, and forgetful. -usual intake was 0-100%, with an average of 40%. -The Dietician recommended: - follow meal intake and assess for additional nutrition interventions. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #35's Physician order, dated 1/20/25, indicated: -controlled carbohydrates diet (restricts the intake of carbohydrates, and can be used to manage blood sugar levels). Review of Resident #35's Laboratory Blood Draw Report, dated 1/22/25, indicated the Resident's A1C (blood test used to measure the average amount of sugar in one's blood over the past three months) was 4.8 (less than 5.7 is considered in range). Review of Resident #35's clinical record indicated: -An order, dated 3/26/25, for Dietitian Consult. -Dietician Progress Note, dated 3/26/25, indicating a request for eight ounces (oz) of Boost Glucose Control drink supplement for the Resident, to be served with lunch for 21 days. -Physician order, dated 3/26/25, for one eight oz can/box Boost Glucose Control supplement drink with lunch for 21 days. Review of Resident #35's March 2025 Medication Administration Record (MAR) indicated: -The Resident received one eight oz can/box of Boost Glucose Control supplement drink with his/her lunch meal daily as ordered, on 3/27/25 through 3/31/25. -The Resident consumed 100% of the Boost Glucose Control supplement drink on 3/27/25, 3/28/25, 3/30/25, and 3/31/25. -The Resident consumed 20% of the Boost Glucose Control supplement drink on 3/29/25. Review of Resident #35's Physician Assistant (PA) Progress Note, dated 3/27/25, indicated: -Nursing reports decreased appetite. -Reported weight loss of 30 lbs. -The Resident had Hypokalemia, likely due to poor intake. -Resident does not appear to have lost that significant amount of weight on exam. -Repeat weight. -Encourage PO (by mouth) intake. -Dietician recommendations appreciated. -Dietician to follow. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #35's Dietician Progress Note, dated 3/27/25, indicated the Resident had been re-weighed and experienced apparent approximate 30 lb weight loss in the past month. Review of Resident #35's April 2025 Medication Administration Record (MAR) indicated: -The Resident received one eight oz can/box of Boost Glucose Control supplement drink with his/her lunch meal daily, as ordered, on 4/1/25 through 4/3/25. -The Resident consumed 100% of the Boost Glucose Control supplement drink on 4/1/25 and 4/3/25. -The Resident consumed 50% of the Boost Glucose Control supplement drink on 4/2/25. On 4/2/25 at 9:07 A.M., the surveyor observed the following: -Resident #35 was sitting in a wheelchair, next to his/her bed, eating breakfast. -Resident #35 had a visitor who sat on the edge of the bed, next to the Resident. -There was an empty eight oz bottle of Boost Original nutritional supplement drink on the Resident's table and the supplement drink was in a plastic cup with ice and a straw. -The nutritional supplement drink bottle did not indicate glucose control, and indicated the drink contained 37 grams (g) of total carbohydrate. -The Resident repeatedly picked up the plastic cup containing supplement drink and drank from the straw. During an interview at the time, Resident #35's visitor said he/she came to the facility to visit with Resident #35 every day at breakfast time to encourage the Resident to eat. Resident #35's visitor said that staff at the facility were very helpful and always made sure the Resident had a Boost nutritional supplement drink with breakfast because the Resident did not always eat well. On 4/3/25 at 9:10 A.M., the surveyor observed the following: -Resident #35 was sitting upright in bed, eating breakfast. -The Resident had the same visitor as the previous day, who was sitting in a chair next to the Resident's bed. -There was an empty eight oz. bottle of Boost Original nutritional supplement drink on the Resident's table and the supplement drink was in a plastic cup with ice and a straw. -The nutritional supplement drink bottle did not indicate glucose control, and indicated the drink contained 37 grams (g) of total carbohydrate and 15 g of sugar. -The Resident alternated eating the breakfast meal and drinking the supplement drink. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at this time, Resident #35's visitor said Certified Nurses Aide (CNA) #5 provided Resident #35 with the Boost Original supplement drink that morning at breakfast. Resident #35's visitor said the Resident liked the supplement drinks and that one was provided to the Resident every day with breakfast. Resident #35's visitor then said the Resident ended up drinking two of the supplement drinks the previous day (4/2/25) with breakfast. At this time, Nurse #7 entered the Resident's room holding a box of drink supplement and said she had a supplement drink for the Resident. Nurse #7 looked at the Resident's table and said, Oh, you already have one . then left the room with the additional box of drink supplement. Review of Resident #35's Meal Intake Record indicated the Resident consumed 100% of his/her breakfast meal on 4/2/25 and 4/3/25. Review of the Resident's clinical record failed to indicate any information relative to the nutritional drink supplements consumed by the Resident on 4/2/25 and 4/3/25. During an interview on 4/3/25 at 9:52 A.M., the Dietician said Resident #35 appeared to have had an approximate 30 lb weight loss over the previous month and that there may have been a problem with the accuracy of the scale. The Dietician said Resident #35 was supposed to receive one eight-ounce box of Boost Glucose Control drink supplement with lunch daily for 21 days and that staff were to monitor and record the amounts of meals and supplement drinks the Resident consumed. The Dietician said the Boost Glucose Control drink supplement was newly ordered due to the Resident's weight loss and diabetic condition. The Dietician said that Resident #35 had DM and that the Resident had always been concerned with his/her diabetic condition. The Dietician said she recommended the glucose control drink supplement for lunch time meals because lunch was when the Resident's intake appeared to be the lowest. The Dietician said for Residents with DM, it was important to consider the total carbohydrates in food and drinks when considering dietary needs. The Dietician then said the total carbohydrates in the Boost Original supplement drink that had been provided to resident #35 on 4/2/25 and 4/3/25 with breakfast contained 37 g of total carbohydrates. The Dietician said if the Resident was eating his/her meals and consuming regular drink supplements, this could impact the Resident's blood sugar and A1C levels. The Dietician also said nutritional supplements being provided to residents without an order and without her knowledge could impact her ability to accurately assess the residents' nutritional status and recommendations for nutritional interventions. The Dietician then said that she would review the Boost Glucose Control supplement drink contents for total carbohydrates and whether the Resident had any routine blood sugar monitoring in place and get back to the surveyor. During a follow-up interview on 4/3/25 at 10:08 A.M., the Dietician said the glucose control drink supplement contained 16 g of total carbohydrates compared to the Boost Original drink supplement that contained 37 g of total carbohydrates. During an interview on 4/3/25 at 10:55 A.M., CNA #5 said she gave Resident #35 a nutritional drink supplement every morning because she knew the Resident liked the drinks. CNA #5 said she would typically check with the Nurse before giving a resident a nutritional supplement drink and that she had not checked with the Nurse to see if giving the nutritional drink supplement to Resident #35 was okay. CNA #5 said she gave the Resident the nutritional drink supplement every day at breakfast because the Resident's visitor requested this and knew what the Resident liked. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At this time, CNA #5 showed the surveyor the supply closet where the nutritional drink supplements were stored on the Unit. CNA #5 unlocked the supply closet door and the surveyor observed four different types of Boost nutritional drink supplements, including Boost Original and Boost Glucose Control. When the surveyor asked CNA #5 how she knew which supplement was to be provided for the residents, CNA #5 said she just always provided the Boost Original nutritional drink supplements. CNA #5 said she never provided Boost Glucose Control nutritional drink supplements to any resident. During an interview on 4/3/25 at 11:05 A.M., Nurse #7 said she overheard the surveyor speaking with Resident #35 about the nutritional supplement that morning at breakfast and she thought the Resident was supposed to receive one and did not get it. Nurse #5 said that was why she entered the room with a nutritional drink supplement for the Resident and that she assumed since the surveyor was speaking with the Resident about the supplement that the Resident was supposed to have one. During an interview on 4/3/25 at 11:40 A.M., Unit Manager (UM) #1 said she was not aware staff on the Unit had been providing nutritional supplement drinks to Resident #35 that were not ordered by the Physician. UM #1 said nutritional supplement drinks were to be provided to residents by a Nurse, according to the Physician's order. During an interview on 4/3/25 at 12:04 P.M., the Regional Nurse said that she realizes staff care and want to help the residents and that they may not realize providing additional nutrition supplements that are not ordered could impact a resident's medical care. The Regional Nurse said education needed to be provided to staff about the risk involved when nutritional inventions were not followed as ordered by the Physician.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on record reviews, and interviews, the facility failed to accurately monitor the fluid intake for one Resident (#36) out of a total sample of 18 residents. Specifically, for Resident #36, the facility staff failed to accurately allot the daily fluid intake as ordered by the Physician and monitor the total daily fluid intake for the Resident dependent on renal dialysis, placing him/her at risk for complications related to fluid overload. Findings include: Review of the facility policy titled Dialysis Residents-Coordination of Care, revised 11/19/18, included: -The nursing facility is responsible for the overall quality of care and services the resident receives and provides the services, consistent with professional standards of practices, to residents receiving dialysis as outlined by their comprehensive person-centered plan of care. >A comprehensive person-centered plan of care . will include: -monitoring of .fluid needs and restrictions. >The facility remains responsible for the overall quality of care the resident receives including the customary standards of care provided by the facility and including the following: -monitoring fluid balance through recording and assessment of intake and output as indicated. Review of the facility policy titled Intake and Output-Monitoring of, revised 10/30/18 indicated: -Intake and output measurement is instituted based on .physician order. >Intake and output will be monitored for the following residents: -Residents receiving dialysis. >Record intake amounts in cc's (cubic centimeters) including: -PO (per os), amounts taken by mouth. >Total shift and daily intake .records. >Document: -Intake .in resident's medical record. Review of the facility policy titled Fluid Restriction, revised January 2009, included: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When a physician orders a fluid restriction due to specific clinical condition, close monitoring will be provided to maintain adequate hydration. >Verify physician order. Order must include volume or range of fluid permitted during a 24-hour period. >Notify dietary department. a. Dietary to calculate amount of fluids to be provided on meal trays. >Calculated remaining amount of fluids to be provided by nursing. a. Calculate amount allotted for each shift. >Document: a. Intake in medical record. Resident #36 was admitted to the facility in May 2023 with diagnoses including End Stage Renal Disease (ESRD) and dependence on renal dialysis. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #36: -was receiving dialysis. -was receiving a therapeutic diet. Review Resident #36's Comprehensive Person-Centered Care Plan, revised 2/2/24, included: -Problem: End Stage Renal Disease with need for Hemodialysis (HD). <Interventions included: Fluid restriction as ordered with intake monitoring (see nutritional care plan). -Problem: Nutrition/ ESRD with Hemodialysis. <Interventions included: Provide diet as ordered: 1200 ml (milliliters or cc's) Fluid Restriction. <Document intake regarding percentage of .fluids consumed. Review of Resident #36's March 2025 Physician orders included: >Hemodialysis every Tuesday, Thursday and Saturday. >Fluid Restriction 1200 ml: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Day Shift (7:00 A.M. - 3:00 P.M.) Fluid Restriction 1200 ml: Breakfast = 240 ml, Lunch = 240 ml, Nursing day = 600 ml. Add meal intake to total shift intake. -Evening Shift (3:00 P.M.-11:00 P.M.) Fluid restriction 1200 ml: Dinner =120 ml, Nursing eve (evening) = 480 ml. Add meal intake to total shift intake. -Night Shift (11:00 P.M.- 7:00 A.M.) Fluid restriction 1200 ml: Nursing night = 120 ml. During an interview on 4/1/25 at 11:38 A.M., Nurse #10 said that she was the Nurse assigned to Resident #36. Nurse #10 said that Resident #36 was prescribed a 1200 ml fluid restriction daily. Nurse #10 said that the Registered Dietitian (RD) and the Unit Manager (UM) determined how much fluid is allotted for nursing and the dietary department for a 24-hour period. Nurse #10 said that the completion and totaling of the 24-hour fluid intake for Resident #36 should be done by the 11:00 P.M.-7:00 A.M. (night shift) Nurse and was important because HD residents could have cardio-pulmonary distress if too much fluid was taken in during a 24-hour period. The surveyor and Nurse #10 reviewed Resident #36's Medication Administration Records (MARs) which indicated: -January 2025 MAR: total allotted daily intake was 1800 ml (not 1200 ml as ordered by the Physician) for 31 out of 31 days, and the total daily intake was not totaled for 12 out of 31 days. -February 2025 MAR: total allotted daily intake was 1800 ml (greater than the 1200 ml ordered by the Physician) for 28 out of 28 days, and the total daily intake was not totaled for 20 out of 28 days. -March 2025 MAR: total allotted daily intake was 1800 ml for 31 out of 31 days, and the total daily intake was not totaled for 20 out of 31 days. During an interview on 4/1/25 at 12:12 P.M., the Director of Nursing (DON) said the RD determined the fluids allotted by shift/per day for dining services and nursing. The DON said that once the RD determines the total fluid allotment, the order should be entered into the resident's electronic medical record (EMR) by the RD or unit Nurses. The DON said that accuracy of monitoring and recording of fluid restrictions was important so that residents are provided with what is ordered by the Physician. The DON said that the unit Nurses were responsible for documenting and totaling fluid intake records. During an interview on 4/1/25 at 12:55 P.M., the RD said that fluid restrictions are determined by the ordering Physician. The RD said that Nurses enter the orders for fluid restriction into the EMR as ordered by the Physician. The RD said that the 1200 ml fluid restriction allotment was a pre-set, pre-established template within the facilities computer system and therefore not determined by the RD. The RD said that she did not follow the daily fluid intakes once the order has been entered into the residents EMR. The surveyor and the RD reviewed Resident #36's MARs for January 2025, February 2025, and March 2025. The RD said that the allotted fluids template on the MARs had totaled 1800 ml and not the 1200 ml as ordered by the Physician. The RD said that the 1200 ml fluid restriction allotment in the facilities computer system was wrong and needed to be corrected. The RD said that Nurses should be totaling the daily 24-hour intake consistently but that was not done.

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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. 47901 Based on observation, record review, and interview, the facility failed to establish a system of records of receipt and disposition of controlled medications consistent with applicable state and federal requirements for two out of four medication carts on one unit (Unit One) out of two units observed to prevent loss, diversion and/or accidental exposure. Specifically, the facility failed to: -destroy controlled substance medications (including opioids, narcotics, and sedatives) that were removed from two locked medication carts on unit one and were being stored in the Administrator's office for a documented duration of greater than one year. -ensure the transfer of controlled substance medications from one page of the facility-controlled substance medication log book to another page of the log book was reconciled by the appropriate and required licensed nursing staff. Findings include: Review of the facility policy titled, Management of Controlled Substance in Skilled Nursing Facilities, revised 9/29/22, indicated: -Purpose: a) To minimize the opportunity for abuse or diversion of controlled substances. b) To promote occupational and patient safety. -To initiate a transfer page, complete transfer information at the bottom of inventory page. -Two licensed nursing staff signatures - the recording nurse and the witnessing nurse are required. -Destruction will occur when medications are discontinued, or at a minimum twice monthly. On 4/1/25 at 10:30 A.M., during a medication administration observation on unit one, the surveyor and Nurse #6 reviewed the controlled substance medication documentation labeled Book 108. The surveyor observed that narcotic medications had been removed from the controlled substance medication book and had been signed by two staff members as removed from count since 1/15/24. The surveyor observed that one Nurse had transferred pages of controlled substance medications without a second Nurse verification of transfer to other pages. The surveyor further observed that the controlled substance documentation in Book 108 failed to indicate that the controlled substance medications had been destroyed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/25 at 10:51 A.M., the surveyor and Nurse #6 reviewed the controlled substance medication documentation book labeled Book 109. Nurse #6 said the controlled substance medications had been discontinued and released to the Director of Nursing (DON) for destruction since 5/15/24. The surveyor observed that the controlled substance medications in Book 109 indicated one Nurse had transferred pages of controlled substance medications from one page to another page without a second Nurse verification. Nurse #6 said two Nurses should have verified and documented the transfer of the controlled substance medications from one page to another, but they had not. On 4/1/25 at 10:51 A.M., the surveyor and the Director of Nursing (DON) reviewed the controlled substance medication books. The DON said two Nurses were expected to verify and document the transfer of the controlled substance medication from one page to another page, but they did not. The DON further said that controlled substance medications that had been removed from the nursing medication cart on unit one was under double lock and key in the Administrator's office. During an interview on 4/1/25 at 11:07 A.M., the Administrator said controlled substance medications were expected to be destroyed monthly. During an interview at the time, the DON said the controlled substance medications had been removed from the two medication carts on unit one to be destroyed and were documented on a controlled substance disposal record but had not yet been destroyed since 1/15/24. During an observation on 4/1/25 at 11:10 A.M., the surveyor observed two cabinets in the Administrator's office, containing multiple different controlled substances medications. Review of the controlled substance medication log documented and under lock and key in the Administrator's office, indicated that the controlled substances were removed from unit one on the following dates: -1/25/24 -5/15/24 -7/15/24 -8/15/24 -10/23/24 -10/28/24 -11/16/24 -12/23/24 -1/8/25 -1/29/25 Review of the controlled substance medications located in the Administrator's office included: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-multiple cards of Tramadol (opioid pain medication) for multiple residents -multiple vials of Lorazepam (antianxiety medication) for multiple residents -multiple cards of Oxycodone (opioid pain medication) for multiple residents -multiple vials of Morphine Sulfate liquid (opiate narcotic pain medication) for multiple residents -multiple cards of Lorazepam tablets for multiple residents -multiple tablets of Hydromorphone (opioid pain medication) for multiple residents -multiple doses of Lyrica (used to treat nerve pain) for multiple residents -multiple doses of Clonazepam (antianxiety) for multiple residents -multiple doses of Ambien medication (sedative medication) for multiple residents -multiple doses of Dilaudid medications (opioid medication) for multiple residents -doses of Vimpat medication (antiseizure) for multiple residents -doses of Nayzilam medication (antiseizures) for multiple residents During a follow-up interview on 4/1/25 at 3:45 P.M., the DON said the controlled substance medications should have been destroyed but the controlled substance medications were not destroyed. The DON further said two Nurses should have documented the transfer of the controlled substance medications from one page of the controlled substance book to another page, but did not.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47901 Based on observation, and interview, the facility failed to provide resident choices for beverage and meal preferences, on one unit (Unit Two) out of two units observed. Specifically, the facility failed to ensure that fluids and meal preferences were honored when the meals tickets identified residents' choices of fluids and meals. Findings include: Review of the facility policy titled Nutrition Management, revised 9/30/24, indicated: -Residents will receive care and services to ensure acceptable parameters of nutritional status are maintained to the extent possible as indicated by the resident's clinical condition. -Purpose is to provide nutritional care and services to each resident, consistent with the resident's comprehensive assessment. -To recognize, evaluate, and address the nutritional needs of every resident, including, but not limited to, the resident at risk or currently experiencing impaired nutrition. -To provide a therapeutic diet that considers the resident's clinical condition and preferences, when there is a nutritional indication. -Sufficient fluid intake is offered to maintain proper hydration and health. -Is offered a therapeutic diet when there is a nutritional problem, and the health care provider orders a therapeutic diet. On 4/1/25 at 8:16 A.M., the surveyor observed the following during the breakfast meal activity on the Unit Two dining area: -Dietary Aide #1 serving meals in styrofoam plates accompanied by plastic eating utensils. -All the meals that were to be served were placed in a large cart. -Three Certified Nurses Aides (CNA's) brought the large cart out of the dining room and walked from resident room to resident room and distributed the meals to the residents in the rooms and in the hallways. -One staff member was observed with a cart that contained pitchers of orange juice and cranberry juice. -The staff members walked from resident room to resident room and served the Residents with either orange juice or cranberry juice. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/25 at 8:48 A.M., the surveyor reviewed the meal tickets for the residents on Unit Two. The surveyor observed that the residents' meals tickets included oatmeal, whole milk, hot beverage of choice, Lactaid milk, and/or fortified cream of wheat. The surveyor observed that none of the item choices listed on the meal tickets were offered to the unit residents. The surveyor also observed that one resident received orange juice with his/her meal, and his/her meal ticket indicated no orange juice, only Lactaid milk. During an interview on 4/1/25 at 9:10 A.M., the Food Service Director (FSD) said the meal tickets were based on resident needs and preferences and were evaluated by the Registered Dietitian (RD). During an interview on 4/1/25 at 9:24 A.M., with the Unit Two staff, CNA #2 said all the CNAs knew the residents likes and dislikes and the CNAs did not follow the information on the meal tickets. During an interview on 4/1/25 at 9:26 A.M., CNA #3 said the facility staff knew the residents' likes and dislikes and only offered beverages that the residents would like. During an interview on 4/1/25 at 9:31 A.M., CNA #4 said the facility staff had been working in the facility for a long period of time and knew what the residents' preferences were. CNA #4 said the staff did not follow what the meal tickets indicated. During an interview on 4/1/25 at 9:33 A.M., Nurse # 3 said the CNAs were very familiar with the residents' likes and dislikes and would only provide what the CNAs think the residents would prefer. During an interview on 4/1/25 at 9:40 A.M., Nurse #2 said he was an Agency Nurse and that the CNAs knew the residents and were aware of the residents' preferences. Nurse #2 said he depended on the CNAs to provide what the residents needed related to food and fluid preferences. On 4/1/25 at 12:15 P.M., the surveyor observed one staff member going from resident room to resident room and serving the residents with either orange juice or cranberry juice. During an interview on 4/1/25 at 1:23 P.M., the RD said the menu and the meal tickets had been new six months ago. The RD said the CNAs were very familiar with the residents on Unit Two. The RD said that she was not aware the residents' meal tickets for preferences were not being followed but would review and get back to the surveyor. During an interview on 4/1/25 at 3:53 P.M., the Director of Nursing Services (DNS) said she would expect the CNAs to follow the meal tickets based on the residents dietary and fluid preferences. During a follow-up interview on 4/1/25 at 4:37 P.M., the RD said the CNAs needed to follow the meal tickets for residents' diet, choices, and fluid needs. The RD further said the resident given orange juice should not have been given orange juice when the meal ticket said no orange juice. On 4/2/25 at 8:38 A.M., the surveyor and the RD reviewed the meal ticket for a resident that had been served his/her breakfast meal. The RD said the resident should have received fortified cream of wheat as indicated on the meal ticket, but he/she did not receive the fortified cream of wheat. The RD said the fortified cream of wheat had been ordered for the resident due to weight loss and the resident should have received the fortified cream of wheat as ordered. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/25 at 8:02 A.M., the surveyor observed the breakfast meal being set up in the Unit Two dining room. The surveyor observed the FSD read the meal tickets, and the Dietary Aide would serve the meals on the styrofoam plates. The surveyor observed other staff members were receiving the plated resident meals and setting up the meals to be distributed to the residents who were in their rooms or seated in the hallways. On 4/3/25 at 9:02 A.M., the surveyor and the FSD reviewed the meal tickets. The meal tickets indicated fruited yogurt, corned beef hash, and fresh melon fruit cup. During an interview at the time, the FSD said the fruited yogurt, the corned beef hash and the fresh melon fruit cup were not provided to the residents as indicated on the residents meal tickets. The FSD said that they should have reviewed the meal tickets and honored the preferences on the tickets, but they did not. The surveyor and the FSD reviewed one resident's meal ticket which indicated pancake with syrup and saw that the resident received dried toasted bread. The FSD was observed asking the Dietary Aide why the resident received dried toast and the Dietary Aide said she gave the resident dried toast because she knew what the resident liked. On 4/3/25 at 9:07 A.M., when the surveyor asked to interview the Dietary Aide, the Dietary Aide said she would not respond to the surveyor. The Dietary Aide would not provide her name when the surveyor requested. During an interview on 4/3/25 at 12:18 P.M., the RD said the facility had fresh melon fruit in stock and that the staff should have provided the fresh melon fruit to the residents as indicated on the residents meal tickets. The RD said the fruited yogurt was available as indicated on the residents dietary slips. The RD further said the corned beef hash was put on the meal tickets by the dietary staff in error as they did not have corned beef hash on the menu.

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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. 45429 Based on observation, and interview, the facility failed to adhere to safe food practices to prevent contamination of food and beverage items intended for resident consumption in the facility's main kitchen. Specifically, the facility failed to implement safe food practices in the main kitchen relative to labeling, dating and storage guidelines. Findings include: Review of the facility policy titled Dietary: Sanitary Conditions, last revised 9/21/22, indicated: -store, prepare, distribute and serve food under sanitary conditions. -follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the presentation of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes. -when food is purchased by the nursing home, inspection for safe transport and quality upon receipt and proper storage helps ensure its safety. Keeping track of when to discard perishable foods and covering, labeling and dating all foods stored in the refrigerator or freezer is indicated. -Dry food storage - desirable practices include managing the receipt of dry food, removing foods not safe for consumption, keeping dry foods in closed containers and rotating supplies. During an initial walk-through of the facility's main kitchen on 3/31/25 at 7:13 A.M., the surveyor observed the following: >the walk-in Refrigerator: -3 unlabeled and undated large pitchers of juice >the walk-in Freezer: -one unlabeled and undated box of 40 powdered donuts -one opened, resealed, unlabeled and undated clear bag of waffles -one opened, resealed, unlabeled and undated clear bag of onion rings -one opened, resealed, unlabeled and undated clear bag of French fries -two opened, resealed, unlabeled and undated clear bags of cookie dough (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one opened resealed, unlabeled and undated clear bag of bag of spring rolls -one open to air, unlabeled and undated, box of lemon bars >dry storage area: -one opened, resealed, undated bag of spaghetti -one opened, resealed, undated bag of pudding mix -one opened, resealed, undated bag of muffin mix -one opened, resealed, undated box of lasagna -one open to air, undated box of lasagna -one opened, resealed, undated bag of oatmeal During an interview on 3/31/25 at 7:24 A.M., Dietary Staff #4 said that the food items in the walk-in refrigerator and walk-in freezer should have been labeled and dated, and they were not. Dietary Staff #4 also said that many of the staff in the main kitchen were new. During an interview on 3/31/25 at 7:27 A.M., Dietary Staff #3 said that the items opened in the dry storage area probably should have been labeled and dated. During an interview on 3/31/25 at 11:40 A.M., the Food Service Director (FSD) said that all unlabeled and undated items should have been labeled and dated after the items were opened. The FSD also said that the items should have indicated when they should be thrown away by the dietary staff.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42761 Based on interview, and records reviewed, the facility failed to ensure all required members of the QAPI Committee participated in quarterly QAPI meetings. Specifically, the facility failed to ensure the Infection Preventionist (IP) attended and participated in one of four consecutive quarterly QAPI meetings reviewed. Findings include: Review of the facility's four most recent quarterly QAPI meeting attendance sheets provided by the facility indicated the following: -All required members were present for the meeting held on 1/28/25. -All required members were present for the meeting held on 10/17/24. -All required members were present for the meeting held on 7/17/24. -The Administrator, Director of Nursing (DON), and Medical Director were present for the meeting held on 2/8/24. -The IP was not present for the meeting held on 2/8/24. During an interview on 4/3/25 at 1:45 P.M., the Administrator said that the facility did not have an IP when the quarterly QAPI meeting was held on 2/8/24.

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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. 50138 Based on record review, observation, and interview the facility failed to adhere to infection control standards of practice for one Resident (#44) out of a total sample of 18 residents, and maintain sanitary medication storage for a medication administration cart on one unit (Unit Two) out of two units. Specifically, 1. For Resident #44, the facility staff failed to follow Physician orders for Enhanced Barrier Precautions (EBP's-the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), while providing high contact wound care for the Resident. 2. the facility failed to maintain a clean medication administration cart during a medication administration observation on Unit Two putting the unit residents at risk for medication contamination. Findings include: 1. Review of the facility policy titled Enhanced Barrier Precautions, dated 1/10/23 included but was not limited to: -EBP's will be used in these conditions . <All residents on the unit with any wounds. -EBP's require gowns and gloves for all high contact care including . <Wound care, any skin opening requiring a dressing. Resident #44 was admitted to the facility in November 2024 with diagnoses including Pressure Ulcer (localized damage to the skin and/or underlying tissue that occurs as a result of long-term pressure) of the right heel area. Review of Resident #44's Comprehensive Person-Centered Care Plan indicated: -Problem: Pressure ulcer to right heel, effective 2/11/25. <Interventions: Treatment to area per Physician order. -Problem: EBP, last revised 2/25/25. <Interventions: EBP signage to residents' room and to utilize Personal Protective Equipment (PPE- special protective barriers like gloves, gowns, masks and/or goggles worn to create a barrier between a person and germs) per policy for high contact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's March 2025 Physician's orders indicated: -Right heel, day shift (7:00 A.M.-3:00 P.M.) apply collagen Puracol [brand] sheet, covered by foam and change daily. -Enhanced Barrier Precautions every shift. EBP signs posted on the resident's door with proper PPE. On 4/2/25 at 9:04 A.M., the surveyor observed Resident #44 seated in a wheelchair in his/her bedroom. The surveyor observed signage on the Resident's doorway which included: -ENHANCED BARRIER PRECAUTIONS. EVERYONE MUST: <Clean their hands, including before entering and when leaving the room. -PROVIDERS AND STAFF MUST ALSO: <Wear gloves and gowns for the following High-Contact Resident Care Activities: >Wound care: any skin opening requiring a dressing. On 4/2/25 at 11:02 A.M., the surveyor observed the following wound care provided to Resident #44: -Nurse #8 and Unit Manager (UM) #2 cleansed their hands with hand sanitizer, donned (put on) clean gloves and entered the Resident's room. -Nurse #8 and UM #2 were not observed to don gowns prior to entering the Resident's room. -Nurse #8 cleaned the work surface with a disinfectant wipe, allowed it to dry and then placed a clean towel on top of the disinfected work surface. -Nurse #8 discarded her gloves into a clear plastic trash bag being held by UM #2. Nurse #8 cleansed her hands with hand sanitizer and donned clean gloves. -Nurse #8 was then observed to set up dressing supplies on the clean work surface. -Nurse #8 doffed (removed) her gloves, discarded them into a clear trash bag being held by UM #2. Nurse #8 then cleansed her hands with hand sanitizer and donned clean gloves. -Nurse #8 removed the Resident's sock and shoe from the right foot followed by the old dressing that was in place on the Resident's right heel. -The old dressing was observed to contain a small amount of ensanguines (bloody) drainage and Nurse #8 discarded the old dressing into the clear plastic trash bag held by UM #2. -Nurse #8 then placed a clean dry towel under the Resident's right heel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #8 doffed her gloves, discharged her gloves into the clear plastic trash bag being held by UM #2. Nurse #8 then cleansed her hands with hand sanitizer and donned clean gloves. -Nurse #8 cleansed the Resident's right heel wound with 4-inch x 4-inch gauze and normal saline solution. -Nurse #8 doffed her gloves and discarded them into the clear plastic trash bag held by UM #2, cleansed her hands with hand sanitizer and don new gloves. -Nurse #8 applied a 2-inch x 2-inch square of collagen Puracol dressing to the wound bed followed by a foam dressing. -Nurse #8 re-applied the Resident's sock and shoe. -UM #2 removed the residual dressing supplies from work surface and discarded them into the clear plastic trash bag. -UM #2 and Nurse #8 were observed to doff their gloves, discard the gloves into the clear plastic trash bag and cleanse their hands with hand sanitizer before exiting the Resident's room. The surveyor, Nurse #8, and UM #2, observed the EBP signage hanging on Resident #44's doorway. Nurse #8 said that the signage was for Resident #44 because the Resident required EBP. UM #2 said that the EBP signage was posted for Resident #44 because of the need for wound care. UM #2 said that all residents with wounds require EBP. Nurse #8 said that EBP prevents the residents from getting an infection from the staff. UM #2 said that she and Nurse #8 should have had gowns on when providing Resident #44's wound care but did not have gowns on. During an interview on 4/3/25 at 11:04 A.M., the Infection Preventionist (IP) said that all residents with wounds should be placed on EBP and that the nursing staff had been educated on the importance of EBP about a month ago. The IP said that EBP was needed to prevent residents from being exposed to germs by facility staff and that staff should be wearing gowns when providing wound care. 47901 2. Review of the facility policy titled General Cleaning and Maintenance of Equipment, revised 6/28/16, indicated: -Resident care equipment will be cleaned and decontaminated after use and will be prepared for reuse. -Equipment and supplies will be cleaned and decontaminated as soon as practical after use. (continued on next page)

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	225269	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Day Brook Village Senior Living	298 Jarvis Avenue Holyoke, MA 01040

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 9:34 A.M., the surveyor observed Nurse #5 during the medication administration pass on Unit Two. The surveyor and Nurse #5 observed the medication administration cart to have a dried spilled liquid in the drawers and particles of medication pills left in the medication cart drawers, along with an old rusted scissors in a drawer. The surveyor further observed that the medication cart also contained stained dried dark particles in the corners of the drawers. During an interview at the time, Nurse #5 said she was an Agency Nurse and that this was her first time being on the medication cart. Nurse #5 said the medication cart could harbor bacteria which could lead to the spread of infections. On 4/2/25 at 9:37 A.M., the surveyor, Nurse #5, and Director of Nursing (DON) observed the same medication cart on Unit Two. The DON said the medication cart was dirty and needed to be cleaned. The DON said there was a cleaning schedule but was unsure when the medication cart was last cleaned and/or disinfected.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interviews, and records reviewed, the facility failed to administer Pneumococcal Vaccinations for two Residents (#36 and #81) of five applicable residents, out of a total sample of 18 residents, increasing the Residents' risk for acquiring Pneumococcal illnesses. Specifically, the facility failed to administer Pneumococcal Vaccines for Residents #36 and #81, when the Residents were eligible to receive, and consented to, the Pneumococcal immunization. Findings include: Review of the facility's policy titled Resident Pneumococcal Immunization, dated September 2011 and revised 9/1/23, indicated the following: -Residents will be offered immunizations to protect them against Pneumococcal disease unless the vaccine is medically contraindicated, or the resident has already been immunized. -Pneumococcal immunizations will be provided as recommended by the CDC (Centers for Disease Control and Prevention) Advisory Committee for Immunization Practices (APIC) recommendations. -Standing orders signed by the Medical Director for Pneumococcal immunization will be utilized. -Individual orders from each attending physician are not required. -It is best to use the PneumoRecs VaxAdvisor app or website. -The PneumoRecs VaxAdvisor app helps vaccination providers quickly and easily determine which Pneumococcal Vaccines a patient needs and when. Review of the CDC guidance titled Pneumococcal Vaccine Recommendations, dated 10/26/24, indicated the following for individuals [AGE] years of age and older: -Administer PCV (Pneumococcal Conjugate Vaccine) 15 (Pneumococcal immunization that protects against 15 types of Pneumococcal disease), PCV20 (Pneumococcal immunization that protects against 20 types of Pneumococcal disease), or PCV21 (Pneumococcal immunization that protects against 21 types of Pneumococcal disease), for all adults [AGE] years or older: -Who have never received any Pneumococcal Conjugate Vaccine. -Whose previous vaccination history is unknown. -If PCV15 is used, administer a dose of PPSV23 at least one year later. -The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If PCV20 or PCV21 is used, a dose of PPSV23 is not indicated. 1. Resident #36 was admitted to the facility in May 2023 with diagnoses including Diabetes Mellitus (DM) and End Stage Renal Disease (ESRD). Review of Resident #36's Immunization Record indicated the Resident received a dose of PPSV23 Vaccine on 1/17/19. Review of Resident #36's clinical record indicated the following: -The Resident was greater than [AGE] years of age. -No evidence the Resident had received any Pneumococcal immunizations since the dose of PPSV23 on 1/17/19. -Consent for administration of Pneumococcal immunization, dated 4/12/24. Review of the CDC PneumoRecs VaxAdvisor online calculator indicated the following recommendation for Resident #36: -Give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23. 2. Resident #81 was admitted to the facility in June 2024 with diagnoses including Hypertension, DM, and Chronic Kidney Disease (CKD). Review of Resident #81's clinical record indicated the following: -The Resident was greater than [AGE] years of age. -The Resident consented to receive the Pneumococcal immunization on 10/21/24. -No evidence the Resident had ever received a Pneumococcal Vaccine. Review of the CDC PneumoRecs VaxAdvisor online calculator indicated the following recommendation for Resident #81: -Give one dose of PCV15, PCV20, or PCV21. -If PCV20 or PCV21 is used, their Pneumococcal vaccinations are complete. -If PCV15 is used, follow with one dose of PPSV23 to complete their Pneumococcal vaccinations. During an interview on 4/1/25 4:30 P.M., the Regional Infection Preventionist (IP) said that Resident's #36 and #81 were not up-to-date with their Pneumococcal immunizations and that providing the Pneumococcal immunizations to both Residents had been missed by the facility. The Regional IP said that neither Resident #36 nor Resident #81 had any medical contraindications for the Pneumococcal immunizations being administered.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observations, interviews, and records reviewed, the facility failed to maintain an effective pest control program to ensure that the facility was free of pests on one Resident Unit (Unit Two) of two Resident Units. Specifically, the facility staff failed to implement measures to eradicate and contain fruit flies located in the Unit Two Pantry, Unit Two hallways, and two Resident's rooms (#35 and #24), increasing the risk for rapid multiplicity of fruit flies and contamination. Findings include: Review of the facility's policy titled Pest Control, dated 2001 and updated 7/9/24, indicated the following: -The facility shall maintain an effective pest control program. -The facility maintain an on-going pest control program to ensure that the building is kept free of insects and rodents. -Maintenance services assist, when appropriate and necessary, in providing pest control services. Review of the Cleveland Clinic's guidance titled How To Get Rid of Fruit Flies for Good at https://health.clevelandclinic.org/how-to-get-rid-of-fruit-flies, dated 10/30/24, indicated the following: -Fruit flies are a nuisance. -Clean up any food spills and crumbs quickly. -Fruit flies have fondness for moist foods and humid climates. Review of the facility's Pest Control Service Inspection Report from the facility's contracted pest control company, dated 1/3/25, indicated the following: -Roach/Rodent/Fruit Fly service was provided. -An open condition for a large hole in the wall around the pipes in the cabinet under the Second Floor Pantry sink. -The hole in the wall could allow insects/rodents to enter. -The facility was responsible to fix the hole in the wall. -Action required for fixing the hole in the wall was first reported to the facility on [DATE]. Further review of the facility's Pest Control Service Inspection Reports indicated the following: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pest control inspection services were provided at the facility on: 1/7/25, 1/17/25, 2/7/25, 2/21/25, 3/7/25, 3/20/25, and 4/1/25. -The Pest control company's recommendation for the facility to fix the hole in the wall around the pipes in the cabinet under the Second Floor Pantry sink continued to display on all of stated pest control visits. During an interview on 3/31/25 at 9:25 A.M., Resident #35's visitor said that he/she observed fruit flies in Resident #35's room when he/she visited the Resident at meal times. On 3/31/25 at 3:21 P.M., the surveyor observed two fruit flies flying outside of Resident #24's room and landed on the surveyor's computer. On 4/2/25 at 7:57 A.M., the surveyor observed a fruit fly flying in the hallway, outside of the Pantry and near the surveyor's head, on Unit Two. During an interview on 4/2/25 at 8:00 A.M., Certified Nurses Aide (CNA) #3 said she has been seeing a few fruit flies throughout the Sunrise hallway on Unit Two. CNA #3 said she could not say whether fruit flies were present on the Memory Lane hallway of Unit Two because she did not work on that hallway of the Unit. During an interview on 4/2/25 at 8:09 A.M., CNA #6 said she had been seeing fruit flies a lot in the Memory Lane hallway on Unit Two. CNA #6 said she had not communicated her observations of the fruit flies to the facility because there were only a few flies. CNA #6 said she would let her Nurse know if she saw more fruit flies than usual and if she saw fruit flies in the residents rooms. On 4/2/25 at 9:07 A.M., the surveyor observed a fruit fly on the wall behind Resident #35's head while the Resident was eating in his/her room. During an interview at the time, Resident #35's visitor, who was also in the room, said he/she visited the Resident daily during breakfast and that he/she often saw a couple of fruit flies in the room when the Resident was eating. Resident #35's visitor said he/she often had to swat the fruit flies away from the Resident when the Resident was eating breakfast. Resident #35's visitor said he/she was not sure if the facility administration was aware of the fruit flies in the Resident's room. The surveyor observed the fruit fly on the wall behind Resident #35's head fly off of the wall and into the air. During an interview on 4/2/25 at 9:12 A.M., Nurse #1 said she noticed more fruit flies in the hallways on Unit Two. Nurse #1 said she assumed maintenance knew and was working on a solution. On 4/2/25 at 10:03 A.M., the surveyor observed two fruit flies in Resident #24's room, on the Resident's overbed table. During an interview on 4/2/25 at 10:05 A.M., the Maintenance Director said fruit flies had been an on-going issue in the facility. The Maintenance Director said nursing staff reported increased fruit fly activity on Unit Two a few weeks prior and that pest control services had been in to inspect the facility. On 4/2/25 at 11:09 A.M., the surveyor observed the following in the Unit Two Pantry: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The top of the sink was sealed off with plastic wrap and blue tape. -A large hole in the wall around the pipes in the Unit Two Pantry cabinet under the sink. -Brown-colored water stains on the floor of the cabinet. -Evidence of rodent droppings on the floor of the cabinet. -One fruit fly in the cabinet which flew out of the cabinet after the surveyor opened the cabinet door. -One plate containing partially wet yellow egg yolk and a covered cereal bowl was on the counter near the sink. -The cover on the cereal bowl indicated: 4/2, 0700. -Dried yellow substance on the counter next to the plate. -Two fruit flies were flying around in the food service area of the Pantry. During an interview at the time, Dietary Aide (DA) #2 said the sink was not in use and the Pantry needed to be cleaned. During an interview on 4/2/25 at 1:12 P.M., the Maintenance Director said there was no hole in the cabinet under the sink in the Unit Two Pantry. The surveyor and the Maintenance Director observed the inside of the cabinet under the sink in the Unit Two Pantry where there was a large hole around the pipes. The Maintenance Director said that he did not see why this would be a problem since the hole in the wall never came up as an issue with the pest control company. The Maintenance Director said he has been the Maintenance Director at the facility for about two and a half years. The Maintenance Director said he was responsible to retrieve the pest control reports from an online portal and that pest control recommendations would be completed. The surveyor and the Maintenance Director reviewed the pest control company reports which indicated the need for the facility to fix the hole in the cabinet around the pipes under the Unit Two Pantry sink. The surveyor and the Maintenance Director further reviewed that this recommendation was first made on 7/5/19 and on all pest control reports reviewed by the surveyor from 1/3/25 through 4/1/25. During an interview on 4/2/25 at 2:10 P.M., the Administrator said fruit flies had been a problem for the facility in the past and that he thought the presence of fruit flies on Unit Two had just occurred, over the last couple of days. The Administrator said the facility had enhanced its pest control services with the pest control company and that the Maintenance Director was responsible to implement the recommendations made by the pest control company. On 4/2/25 at 2:22 P.M., the surveyor placed a call to the facility's contracted pest control company and left a message with reception. A representative from the pest control company did not return the surveyor's call by the end of the survey period on 4/3/25.