STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225272	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Hill Healthcare and Rehabilitation Center	11 North Street Stoneham, MA 02180

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide quality of care in accordance with professional standards for four Residents (#154, #40, #118, and #58) out of a total sample of 31 residents. Specifically,1. For Resident #154, the facility failed to document and assess the alteration of the skin on his/her lower extremities to determine if the areas were healing or worsening and failed to report the condition of Resident 154's lower extremities to the medical provider. 2. For Resident #40, the facility failed to implement an order for a diuretic after a significant weight gain for Resident #40, who has congestive heart failure and edema.3. For Resident #118, the facility failed to label wound dressings after changing Resident #118's dressing.4. For Resident #58, the facility failed to complete weekly skin checks as ordered. Findings include:1.Resident #154 was admitted to the facility in December 2024 with diagnoses including multiple sclerosis, severe protein calorie malnutrition and chronic venous hypertension with ulcers of the right lower extremity. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/10/25, indicated Resident #154 had moderate cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible score of 15. The MDS further indicated that the Resident required substantial/maximal assistance for daily care. During an observation and interview on 1/13/26 at 9:05 A.M., Resident #154 expressed concerns regarding wounds to both of his/her lower legs. Resident #154 said that he/she felt nothing was being done to treat his/her lower extremity wounds and that the wounds seemed to not be getting better. Resident #154's legs were observed to have partial dry/crusted areas of skin that were peeling and draining fluid. There were also dried fluid stains on Resident # 154's sheets. The wounds have areas that were covered with old skin that were moist and yellow/blackish in color. Review of Resident 154's Norton Assessment (a clinical tool used to assess a resident's risk of developing pressure ulcers) dated 1/4/26, concluded that Resident #154 scored a 9 indicating he/she was at a high risk for skin breakdown. Review of Resident 154's Skin Assessment (a clinical tool used to measure moisture, color, or elasticity helping healthcare professionals monitor skin health, predict issues, and personalize care) dated 1/8/26, indicated that the Resident had multiple closed scabs to both legs. Review of Resident 154's plan of care indicated the following: -Focus: high risk for skin breakdown related to decreased functional mobility, Disease process, multiple sclerosis, severe malnutrition, adult failure to thrive, incontinent of bowel, history of vascular ulcers to BLE's, dated 12/17/24. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Intervention: assess skin condition with ADL care daily; report abnormalities. -Focus: history of actual skin breakdown related to right and left leg chronic open areas r/t Dermatitis. Recurrent occurrence. Scab now, dated 12/20/24. -Interventions: review treatments and change if not effective as needed and notify MD (medical doctor) of lack of progress in healing or deterioration. Review of Resident 154's January 2026 treatment administration record indicated that the Resident's right shin was intact with no drainage noted from dates 1/1/26 through 1/14/26. The January 2026 treatment administration record failed to indicate a wound assessment for Resident #154's left shin. Review of the medical record failed to indicate that the medical provider had been notified regarding Resident 154's change in leg wounds from dates 1/1/26 through 1/14/26. Review of Resident 154's active physician orders indicated the following: - Hibiclens External Solution 4 % (Chlorhexidine Gluconate) (an antibacterial antiseptic skin cleanser that kills germs on contact and provides sustained protection against bacteria): Apply to Bilateral legs topically every day shift every Mon, Wed, Fri for preventive Wash bilateral legs with hibiclens three times weekly, dated 1/24/25. - Right and left shin- clean with normal saline pat dry, apply moisturizer and leave open to air, every day and evening shift for dry skin, dated 11/26/25. - Wound assessment to be completed with each treatment application/dressing change. Right shin, dated 9/11/25. During an interview on 1/14/26 at 9:21 A.M., Resident #154 said that the nurse had been in before breakfast to clean both of his/her legs. Resident 154 stated that prior to this day, it had been quite some time since anyone had tried to clean his/her legs. During an interview on 1/14/26 at 9:33 A.M., Nurse #1 said she washed Resident #154's legs with normal saline (a sterile, saltwater solution) then she applied cream to both legs. Nurse #1 said Resident #154's leg wounds were not open despite the dried drainage noted on the Resident's sheets and that the Resident was followed by the wound Doctor. Nurse #1 said she did not wash the Resident's legs with the skin cleanser but washed the Resident's legs with normal saline. Review of the Medication Administration Recorded dated 1/14/26 indicated that Nurse #1 documented that she had applied the hibiclens skin cleanser to both of Resident #154's legs. Review of the medical record failed to indicate that Resident #154 was being followed by the wound Doctor but had indicated that the Resident had been discharged from the wound Doctor's services on 2/25/25. During an interview on 1/14/26 at 11:46 A.M., the Nurse Practitioner (NP) said the Resident has chronic leg wounds that come and go and he/she has bad skin. The NP said the Resident is followed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by the wound Doctor. The NP said she does not always assess his/her legs and expects nursing to tell the wound Doctor and herself if the wounds are open. The NP said if there are open wounds on his/her legs nursing should reach out to the wound Doctor, then update the NP. The NP said she was not aware of any open areas within the past week. During an interview on 1/14/26 at 11:57 A.M., Unit Manager #1 said Resident 154's legs were at baseline in appearance and that there was a lot of dead skin on top of the wound. She said that if the excess skin were to be removed then the area would be open. Unit Manager #1 said that there was drainage noted and she would expect nurses to update the NP when wounds are draining so she could have the Resident referred to the wound Doctor and get treatment orders. During an interview on 1/14/26 at 1:53 P.M., the Staff Development Educator (SDC) said Resident #154's left leg was dry, but the right leg was soft and mushy and when the Resident moves around it peels off skin leaving the area with moist open skin, revealing small open areas. The SDC said she would expect the nurses to update the NP when drainage is involved and receive treatment orders. During an interview on 1/15/26 at 12:02 P.M., the Director of Nurses (DON) said nurses should be updating the NP when changes to a resident's skin is noted and request treatment orders if needed. 2. Review of the facility policy titled Heart Failure - Clinical Protocol, undated, indicated the following: The physician will identify individuals who are receiving medications, or medication combinations, associated with the treatment for HF (heart failure); for example, diuretics, ACE inhibitors, and vasodilators. The physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc.) to monitor, when to report findings to the physician, etc. The physician will address related medical issues; for example, adjust or stop medications that may be precipitating heart failure, modify doses of diuretics, determine whether oxygen is needed, etc. The physician will help monitor the progress of individuals with HF, including ongoing evaluation and documentation of signs, symptoms, and condition changes. Resident #40 was admitted in November 2025 with diagnoses including congestive heart failure. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #40 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of Resident #40's care plan indicated the following: Focus: The resident has fluid volume deficit related to diuretic use (initiated 11/19/25) Interventions: Monitor weight Q (every) week (undated) Review of the weight summary for Resident #40 indicated the following weights: 11/24/25 - 126.3 pounds (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/2/25- 133 pounds 1/14/26 - 137.6 pounds Review of the medical record failed to indicate that weights were being done weekly to monitor weight changes, per the care plan, related to Resident #40's congestive heart failure. Review of the physician note, dated 12/1/25, indicated the following decreased Lasix (a diuretic used to reduce fluid volume) to 40 mg (milligrams) in the am and 20 mg at 2pm; was taking 40 mg po twice daily: Review of the nursing progress note, dated 12/2/25, indicated Resident #40 had a 6.7 pound weight gain noted and a new order was initiated for increased Lasix, to have and extra dose of 20 mg every afternoon. Review of physician orders indicated that Resident #40 was prescribed Lasix 40 mg one time a day and 20 mg once in the afternoon. Both orders were initiated on 11/11/25. Review of the medical record failed to indicate that an additional Lasix order was initiated after Resident #40 had a 6.7 pound weight gain from 11/24/25 to 12/2/25 and that no new orders for Lasix were initiated after 11/11/25. During an interview on 1/14/26 at 3:35 P.M., the Director of Nursing said that the unit managers update the care plan and should be following the care plan regarding the weekly weights. The Director of Nursing could not speak to why the additional Lasix order never got implemented and reached out to the physician. The physician implemented new orders to increase the Lasix, ordered a chest x-ray, and implemented a new order to weigh the Resident daily. 3. Review of the facility policy titled Wound Care, dated as revised January 2025, indicated the following: Documentation: The following information should be recorded in the residents' medical record: The type of wound care given. The date and time the wound care was given. The name and title of the individual performing wound care. All assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound. If the resident refused the treatment and reason why. The signature and title of the person recording the data. Resident #118 was admitted in November 2025 with diagnoses including unspecified symptoms and signs involving cognitive functions and awareness (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated 12/16/25, indicated Resident #118 scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. On 1/13/26 at 8:50 A.M., the surveyor observed Resident #118 with bandages on his/her left forehead and on his/her left hand. The bandages were undated. On 1/13/26 at 1:48 P.M., the surveyor observed Resident #118 with bandages on his/her left forehead and his/her left hand. The bandages were undated. On 1/14/26 at 7:24 A.M., the surveyor observed Resident #118 with a bandage on his/her left forehead. The bandage was undated. On 1/14/26 at 8:20 A.M., the surveyor observed Resident #118 with a bandage on his/her right hand. The bandage was undated. On 1/15/26 at 6:33 A.M., the surveyor observed Resident #118 with a bandage on his/her right and his/her left hand. The bandages were undated. Review of Resident #118's care plan for high-risk skin breakdown, revised on 1/9/26 indicated the following: Focus: readmitted on [DATE] skin tear on left anterior arm. Interventions: treatment as ordered. Review of Resident #118's active physician's orders indicated: -Left arm skin tears: wash with normal saline or wound cleanser, apply xero-form gauze and cover with dry protective dressing (DPD) daily everyday shift. Date started 1/13/26. -Left hand skin tear: wash with normal saline or wound cleanser, [NAME] xero-form and cover with DPD daily everyday shift. Date started 1/13/26. -Left should skin tear: wash with normal saline or wound cleanser, [NAME] xero-form and cover with DPD daily everyday shift. Date started 1/13/26. -Head laceration: normal saline cleanse to area daily, apply clean dry dressing. Date started 1/12/25. During an interview on 1/15/26 at 7:33 A.M., Unit Manager #3 said wound dressings should be dated when changed. During an interview on 1/15/26 at 12:00 P.M., the Director of Nursing said that dating wound dressings is the best policy and the gold standard. She said if nurses did not date their wound dressing, then it wouldn't be clear when the dressing had last been changed. 4. Review of the facility policy titled Weekly skin assessment, dated as revised 6/8/22, indicated the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All residents will have a full body assessment on day of admission and weekly thereafter. The nurse will document on weekly skin assessment in the electronic health record. Resident #58 was admitted in December 2025 with diagnoses including right knee osteoarthritis. Review of the Minimum Data Set (MDS) assessment, dated 12/22/25, indicated Resident #58 scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. Review of Resident #58's care plan for high-risk skin breakdown, revised on 12/15/25 indicated the following: Interventions: Weekly skin assessment. Review of Resident #58's active physician's orders indicated: -Weekly skin evaluation every evening shift on every Monday. Proceed to assessments and complete a skin evaluation. Date started 12/22/25. Review of Resident #58's Treatment Administration Record indicated: -Weekly skin evaluation every evening shift on every Monday. Proceed to assessment and complete a skin evaluation. Review of Resident #58's Skin evaluations scheduled for weekly on 12/1/25, 12/8/25, 12/15/25, 12/22/25, 12/29/25, 1/5/26, 1/12/26 indicated they were completed on 12/3/25 and 12/22/25. The skin evaluations for Resident #58 were completed two times out of a scheduled seven during the months of December and January. During an interview on 1/15/26 at 8:03 A.M., Unit Manager #2 said nurses know when skin checks are due by looking at their Treatment Administration Record and there is also a scheduled taped on the treatment cart. She said when a skin check is due the nurse must complete and document the skin evaluation under assessments in the electronic medical record. During an interview on 1/15/26 at 12:00 P.M., the Director of Nursing and Regional Nurse Consultant said skin evaluation should be done weekly and documented in the electronic medical record.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to identify and assess the use of a geri-chair (a high back chair on wheels with the ability to recline) as a potential restraint for one Resident (#118) out of a total of 31 sampled Residents. Findings include: Review of the facility's Use of Restraints policy, undated, indicated the following:Restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully.Restraints shall only be used to treat the residents' medical symptoms and never for discipline or staff convenience, or for the prevention of falls.When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine underlying causes of problematic medical symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. The order shall include the following: a. The specific reason for the restraint (as it relates to the residents' medical symptoms). b. How the restraint will be used to benefit the residents' medical symptom; and c. The type of restraint, and period of time for the restraint.17. Care Plans for residents in restraints will reflect the interventions that address not only the immediate medical symptoms, but the underlying problems that may be causing the symptoms.18. Care Plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.19. Documentation regarding the use of the restraint shall include: a. Full documentation of the episode leading to the use of physical restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode. b. A description of the residents' medical symptoms that warranted the use of the restraints. c. How the restraint benefits the residents by addressing the medical symptom. d. The type of restraint used. e. The length of effectiveness of the restraint time. f. Care provided such as observation, range of motion, repositioning, and toileting. Resident #118 was admitted to the facility in November 2025 with diagnoses including unspecified symptoms and signs involving cognitive functions and awareness, depression, and sepsis. Review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #118 is severely cognitively impaired as evidenced by a score of 6 out of apossible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated that Resident #118 requires assistance with bathing, dressing and toileting. The MDS indicated that Resident #118 required partial/moderate assist for ambulation and transfers. The MDS did not indicate the use of any restraints for Resident #118. On 1/13/26 at 1:48 P.M., the surveyor observed Resident #118 behind the nursing station seated in a geri-chair in the reclined position. Resident #118 was agitated and was trying to get up by thrusting self forward and throwing his/her legs over the side of the geri-chair On 1/14/26 at 11:21 A.M., the surveyor observed Resident #118 in the hallway in front of nursing station seated in a geri-chair in the reclined position. Resident #118 was agitated and was trying to get up by throwing his/her legs over the side of the geri-chair. On 1/15/26 at 6:33 A.M., the surveyor observed Resident #118 behind the nursing station seated in a geri-chair in the reclined position. Resident #118 was agitated and was trying to get out of the geri-chair by thrusting his/her body forward and throwing his/her legs over the side of the geri-chair. On 1/15/26 at 8:48 A.M., the surveyor observed Resident #118 in his/her room in a geri-chair in the reclined position. Resident #118 was agitated and was trying out of geri-chair by thrusting his/her body forward. Review of Resident #118's active physicians' orders failed to indicate an order for a geri-chair. Review of Resident #118's fall care plan indicated: Problem start date: 12/9/25: Resident is at high risk for falls (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to: decreased mobility, history of recurrent falls, poor safety awareness, weakness, restless and agitated, constantly attempting to self-transfer, needing 1:1 attention. Interventions: geri-chair, sit at nurses' station in geri-chair. Review of Resident #118's rehab notes failed to indicate staff assessed for the use of a geri-chair. Review of Resident #118's medical record in January 2026 failed to indicate any Restraint Assessment for the use of a geri-chair. Review of Resident #118's Nursing progress notes indicated:1/10/25: Returned from emergency room with left temporal head laceration. He/she was medicated with Ativan (anti-anxiety medication) and Zyprexa (anti-psychotic medication) prior to being sent back. Patient is a high fall risk receives 1:1 sitter at all times. The Nurse Practitioner is aware that Resident is confused, very anxious, still attempting to walk unassisted and may fall from time to time. The Nurse Practitioner ordered Trazadone (anti-depressant medication) daily and as needed.1/11/25: New geri-chair provided by physical therapy for fall prevention working positively.1/15/25: This writer (sic) was on Resident's unit and noted him/her to be sitting in a reclining chair and trying to stand/self-transfer. During an interview on 1/15/25 at 6:33 A.M., Certified Nursing Assistant (CNA) #2 said that Resident #118 used to have a standard wheelchair but has been using the geri-chair since he/she got back from the hospital. CNA #2 said that Resident #118 is a fall risk and is now in the geri-chair to prevent him/her from falling. During an interview on 1/15/25 at 6:40 A.M., Nurse #4 said she did not know how long Resident #118 had been using the geri-chair, but that he/she had been up in the geri-chair since 4:00 A.M., very agitated and trying to stand. During an interview on 1/15/25 at 7:33 A.M., Unit Manager #3 said that Resident #118 had been using the geri-chair since he/she returned from the hospital in January 2026. She said that therapy would do the assessment for the geri-chair. During an interview on 1/15/25 at 8:55 A.M. the Rehabilitation Director said Resident #118 is on caseload and he/she was assessed for a device that would provide him/her comfort in the evening hours since he/she climbs out of bed. The geri-chair was recommended for use in the evening hours since his/her last hospitalization. She said the geri-chair was not assessed as a restraint. During an interview on 1/15/25 at 12:10 P.M., the Director of Nursing (DON) said that Resident #118 was not safe in his/her standard wheelchair and was switched to the geri-chair, as recommended by therapy, for his/her comfort and to keep him/her from falling. The DON said Resident #118 is a fall risk and that the geri-chair is a fall intervention. She also said that there should be a physician's order and a consent for the use of the geri-chair. The Regional Nurse Consultant then said that there should be a restraint assessment completed before the use of the geri-chair to assess if it is a restraint.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop an activities care plan for one Resident (#40) out of a total sample of 31 residents. Findings include: Resident #40 was admitted in November 2025 with diagnoses including adjustment disorder with mixed anxiety and depressed mood. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #40 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. During an interview on 1/13/26 at 8:58 A.M., Resident #40 said that he/she would like to attend some activities but has only been to one activity since he/she's been admitted . Resident #40 said that no one comes to get him/her for activities because he/she is at the end of the hall. During an observation on 1/13/26 at 4:02 P.M., Resident #40 was sitting in his/her wheelchair in his/her room. Resident #40 said that he/she hadn't done any activities that day. Resident #40 said that he/she loves music and entertainment but can't always listen because his/her phone is not always charged. Resident #40 said that he/she also enjoys group activities. Review of the activities attendance log for January 2026 indicated that Resident #40 participated in independent activities for the entire month. Review of the care plan for Resident #40 failed to indicate that there was an individualized, person-centered activities care plan developed. During an interview on 1/14/25 at 12:51 P.M., the Activities Director said that every resident should have an activities care plan in place after admission. The Activities Director was unaware that Resident #40's care plan had not been developed.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure for one Resident (#145), out of a total sample of 31 residents, that services were provided to maintain his/her hearing abilities. Specifically, for Resident #145 the facility failed to assist with providing his/her's left hearing aid and ensuring it was working to support the Resident's hearing. Findings include: Review of the facility's policy, titled Hearing Aid, Care of, dated as revised February 2022 indicted the purpose of this procedure is to maintain the resident's hearing at the highest attainable level. The following information should be recorded in the resident's medical record; 1. If the resident refused the procedure, the reason(s) why and the interventions taken, Reporting, Notify the supervisor if hearing aid is damaged, Notify the supervisor if the resident complains of problems related to hearing aid and/or the hearing aid or has a wax build up in the ear.Resident #145 was readmitted to the facility in September 2024 and has diagnoses that include but are not limited to Parkinson's Disease, chronic ischemic heart disease, and unspecified dementia.Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #145 scored 3 out of 15 on the Brief Interview for Mental Status, indicating he/she has severe cognitive impairment, requires substantial/maximal assistance with upper body dressing, had highly impaired hearing, and had hearing aids or other hearing appliance is used.On 1/13/26 at 10:41 A.M., Resident #145 was in his/her room. When speaking to Resident #145 it was apparent when he/she could not respond that he/she had a hearing deficit. When Resident #145 was asked about hearing aids, Resident #145 said his/her right hearing aid recently went missing and he/she was waiting for a new right hearing aid. Resident #145 said his/her other hearing aid (left) is not working, even with the new batteries they gave him/her recently. Resident #145 said he told staff that the left hearing aid was not working.On 1/13/26 at 1:29 P.M., Resident #145 was observed in his/her room. Resident #145 did not have his/her left hearing aid in his/her ear. Resident #145 pulled a plastic container with a cover out of the top drawer of his/her bedside table, opened it, revealing one hearing aid and batteries scattered in the container. Resident #145 said the batteries did not work.On 1/13/26 at 4:31 P.M., Resident #145 was observed sitting up in his/her wheelchair. Resident #145 did not have a hearing aid in his/her left ear resulting in difficult communication.On 1/14/26 at 8:56 A.M., Resident #145 was observed in his/her room. Resident #145 did not have hearing aids in his/her ears. Resident #145 said do you have the new batteries?.Review of Resident #145's care plan dated 8/16/25 indicated Resident #145 is at risk for impaired communication due to hearing deficit, dated 8/16/22. Interventions included but not limited to place both hearing aids on in the morning and remove at bedtime.Review of Resident #145's physician's orders indicated the following:-Place bilateral hearing aids in the morning and remove at bedtime. May store at bedside. Every day and evening shift. Order date 5/24/22.-Size 13 hearing aid batteries used. Order date 5/24/22During an interview on 1/15/26 at 9:56 A.M. Social Worker (SW) #1 said Resident #145's right hearing aid was lost, found in the laundry, was out getting fixed and the Resident has not had the right hearing aid since around the end of December (2025). Social Worker #1 said at the same time she provided Resident #145 with batteries for the left hearing aid and was not aware that the Resident was not wearing the left hearing aid, nor aware that it was not working to support his/her hearing. Social Worker #1 and the surveyor went to Resident #145's room and after the SW put in one of the batteries in the container that she said she provided and placed in Resident #145's ear, Resident #145 said it was not working and he/she wanted to be able to use the hearing aid. Review of the Treatment Administration Record (TAR) dated January 2026 indicated the order to place bilateral hearing aids in the morning and remove at bedtime, may store bedside, was documented as administered 1/1/26 through 1/14/26. This documentation conflicts with the observations made and the fact supported by Social Worker #1 that Resident #145 has been without his/her right hearing aid since the end of December 2025. Review of the TAR indicated Nurse #4 documented that bilateral (continued on next page)

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	225272	A. Building B. Wing	01/15/2026

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hearing aids were documented as placed per physician order on 1/13/25 and 1/14/25.Review of the progress notes in Resident #145's medical record from 1/1/26 through 1/14/26 failed to indicate the Resident refused to have the left hearing aid placed.During an interview on 1/15/26 at 10:30 A.M., Nurse #4 said Resident #145's right hearing aid is not available. Nurse #4 said the order is for nursing to place the hearing aids in the Resident's ear. Nurse #4 said the Resident did tell him that the batteries were not working for the left hearing aid.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to ensure physicians orders for the care of pressure ulcers were implemented for one Resident (#86) out of a total sample of 31 residents. Specifically, for Resident #86, the facility failed to ensure that the wound physician's recommendations for treatment to Resident #86's sacrum were followed. Findings include: Review of the facility policy titled Prevention of Pressure Ulcers, undated, indicated the following: It is the policy to prevent pressure ulcers unless clinically unavoidable and to provide care and services to promote the prevention of pressure ulcer development, the healing of pressure ulcers that are present (including of infection to the extent possible) and prevent development of additional pressure ulcers. Resident #86 was admitted to the facility in December 2025 with diagnoses including peripheral vascular disease, unstageable pressure ulcers of sacral region (base of the spine), left heel, left ankle and acquired absence of right leg below knee. Review of Resident #86's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of four out of a possible 15, which indicated Resident #86 had severely impaired cognition. This MDS also indicated that Resident #86 required dependence for mobility and that he/she was admitted with three unstageable (full thickness tissue loss where the wound bed is obscured by dead tissue) pressure ulcers. Review of Resident #86's most recent Norton risk Assessment, dated 12/31/25, indicated the Resident was at high risk for skin breakdown. Review of Resident #86's pressure ulcer care plan dated 12/3/25, indicated:-Unstageable sacrum.-Provide treatment as ordered.-Low air loss mattress set at 80-120.-Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, sign and symptoms of infection, maceration, etc. to MD. Review of Resident #86's weekly wound assessment tool, dated 1/12/26, indicated sacrum Length 4.0 cm, Width 0.5cm. Review of Resident #86's active physician orders indicated the following:-Wound assessment to be completed with each treatment application/dressing change every day shift. Start date 12/4/25.-Weekly Skin Evaluation every night shifts every Thursday for monitoring. Start date 12/3/25.-Sacrum: cleanse with normal saline, pat dry, and apply calcium alginate (highly absorbent material) and cover with bordered foam every day shift. Start date 12/5/25. Review of the wound physician's note dated 1/12/26, indicated Resident #86's wound to the sacrum demonstrates an open wound with a mixture of granulation (new, healthy) tissue and slough obscuring the extent of the wound bed, consistent with an unstageable pressure-related injury. Review of the wound physician's recommendations dated 1/12/26, indicated for Resident #86:-Sacrum: cleanse with wound cleanser, apply santyl and calcium alginate to base of wound, secure with dressing, change daily and as needed. Review of the Nurse Practitioner #2 progress note dated 1/14/26 did not indicate that she was aware of the 1/12/26 wound physician recommendation to change treatment order to Resident #86's sacrum wound. Review of Resident #86's medical record failed to indicate new treatment orders were implemented to the sacrum wound as recommended by the wound physician on 1/12/26. On 1/15/25 at 7:10 A.M., Nurse #2 and surveyor observed Resident #86's sacrum wound. During observation of the sacrum there were two new open areas noted under Resident's scrotum. Nurse #2 said she had done Resident's treatments the day before and those open areas were not there. The sacrum/scrotal wounds were covered in slough. During an interview on 1/15/25 at 7:32 A.M., Unit Manager #3 said she had done rounds with the wound physician on 1/12/25 and the open areas under Resident's scrotum were not there. She said that recommendations that are made by the wound physician need to be approved by the Nurse Practitioner but that they are usually put into place the same day. She said the recommendation to add santyl to Resident #86's sacrum treatment must have been overlooked but she would have expected it to have been initiated the same day. During a phone interview on 1/15/25 at 12:00 P.M., Nurse Practitioner #2 said that she would expect any recommendations by the wound physician to be put in place since they are the experts. On 1/15/26 at (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:01P.M., the Director of Nurses (DON) said the Unit Manager had been on a cart on 1/12/26 and that must be why the recommendations got missed, but they should have been put in place.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately document in the electronic medical record for two Residents (#12 and #84), out of a total sample of 31 residents. Specifically, 1. For Resident #12, nursing staff documented a right arm sling as being provided when it was not. 2. For Resident #84, the facility failed to accurately record the Resident's oxygen saturation percentages in the medication administration record. Findings include: 1.Resident #12 was admitted to the facility in October 2025 with diagnoses that included but not limited to Alzheimer's Disease and a displaced fracture of the upper end of the right humerus. Review of the most recent Minimum Data Set assessment, dated 10/24/25, indicated Resident #12 scored 6 out of 15 on the Brief Interview for Mental Status exam, indicating he/she had severely impaired cognition, had an upper extremity impairment on one side, and was dependent on staff for upper and lower body dressing. On 1/13/26 at 8:30 A.M., Resident #12 was observed in a recliner near the nursing desk. Resident #12 could not be interviewed. Review of Resident #12's physician's orders indicated the following: R (Right) Arm: Ensure sling in place at all times. Monitor CSM (circulation, sensation and movement). May remove for hygiene, adl (activities of daily living) and skin assessment every shift, active date 10/20/25. On 1/13/26 at 2:14 P.M., Resident #12 was observed in a geri-recliner and being wheeled by a nurse and placed near the front of the nursing desk. Resident #12's right arm was held to his/her side and not in a right arm sling. On 1/14/26 at 4:17 P.M., Resident #12 was observed in a geri-recliner in front of the nursing desk. Resident #12's right arm was not in a sling. On 1/15/25 at 10:10 A.M., Resident #12 was observed in a geri-recliner, and his/her right arm was not in a sling. Review of the Treatment Administration Record (TAR) dated 1/2026 indicated the right arm sling was administered 1/1/26 through 1/14/25. On 1/15/26 at 10:14 A.M., Nurse #4 said Resident #12 used to have a sling and now that the pain has receded, he/she is not using the sling. Nurse #4 said he/she has not put on the sling for a while now. Nurse #4 reviewed the orders and said the order was still in place. Nurse #4 said if there is an order it should be followed unless it is discontinued. Nurse #4 went to Resident #12's room and found a sling in the bottom drawer. During an interview on 1/15/26 at 10:18 A.M., Unit Manager #4 said she has been employed at the facility for one month, and that she had not seen Resident #12 wearing a right arm sling recently. Unit Manager #4 said the Resident may have had the sling when he/she first came up to the unit, and that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she believed the order for Resident #12's right sling may have been discontinued. Unit Manger #4 reviewed the orders and said the order for the sling was in place and that the nurses should not be documenting on the TAR that the right arm sling was provided when it was not. 2. Resident #84 was admitted in October 2024 with diagnoses including dementia and hypertension. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #84 scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of the MDS indicated Resident #84 does receive oxygen therapy. Review of the current physician's orders for Resident #84 indicate an order to provide 2 L (liters) of oxygen when the Resident's oxygen saturation is less than 92%. Review of the oxygen saturation vitals for Resident #84 indicated the following oxygen saturation percentages: 1/13/26: 18% 11/26/25: 7% Review of the progress notes failed to indicate any follow up or review of the vitals that were out of the oxygen saturation parameters, per the physician orders. During an interview on 1/14/26 at 3:54 P.M., the Director of Nursing said that staff should be entering vitals correctly and it is an issue she has identified and is working on.

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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. Based on record review and interviews, the facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) (a form issued by SNFs to notify Medicare beneficiaries of potential financial liability for certain services) for 2 applicable residents, out of a sample of 3 residents. Specifically, the facility failed to issue SNF ABN notices after skilled services ended. Findings include: A review of two Notices of Medicare Non-coverage issued for the two residents who remained in the facility after skilled services ended on 11/28/25 and 1/9/26 respectively, failed to indicate that SNF ABN notices were issued. During an interview on 1/14/26 at 10:04 A.M., Social Worker #1 said that the expectation for residents who remain in the facility after skilled services ending is to get a SNF ABN notice informing them of potential financial liability for certain services.