STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225283	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webster Manor Rehabilitation & Health Care Center	745 School Street Webster, MA 01570

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42761 Based on observations, interviews, and record reviews, the facility failed to provide dignified experiences on two occasions during the survey period for one Resident (#119) out of a total sample of 26 residents. Specifically, the facility failed to: -ensure that Resident #119 was clothed so that his/her arm, chest, and back were not exposed while the Resident was sitting in a common area, on two separate occasions, when the Resident was dependent upon staff for dressing. -provide Resident #119 with a dignified dining experience during one noon time meal, relative to drink preferences and assistance for eating when the Resident was dependent on staff for assistance with eating. Findings include: Review of the facility's policy titled Food and Dining Service, dated April 2015, indicated: -Table service is provided for all residents who can and will eat at the table, including wheelchair residents to help them maintain as normal a living pattern as possible. Resident #119 was admitted to the facility in March 2025 with diagnoses including bilateral conductive hearing loss, bilateral visual loss, Attention-Deficit Hyperactivity Disorder (ADHD), and Dementia. Review of Resident #119's person-centered Care Plan, initiated 3/31/25, indicated the following: -has ADL (activities of daily living) deficits and was at risk for nutritional decline relative to Dementia. -determine Resident's food/beverage preferences/eating patterns. -consistent assignments when possible. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-explain all procedures and purpose prior to performing task . Review of Resident #119's Nutrition Assessment, dated 4/1/25, indicated the Registered Dietician (RD) assessed the Resident's nutritional status through speaking with facility staff and observing the Resident after the Resident had eaten. On 4/6/25, between 11:02 A.M. and 11:13 A.M., the surveyor observed the following in the Lake Unit Dining Room: -Resident #119 was sitting in a wheelchair, his/her bottom scooted forward on the seat, and his/her back positioned away from the wheelchair backrest. -Resident #119 wore a hospital gown that was open in the back, the ties on the hospital gown were not tied and the Resident's back was exposed. -The lower front of the Resident's hospital gown was positioned on top of the Resident's lap. -The Resident's outer thighs and hips were exposed, and the Resident's incontinence brief was visible. -Four other residents were in the dining room. -No staff were present in the Dining Room at the time. -Several staff members were observed in the hallway. -Resident #119's exposed back could be seen from the hallway outside of the Lake Unit Dining Room. -At 11:13 A.M., Certified Nurses Aide (CNA) #2 entered the Lake Unit Dining Room and approached Resident #119. -CNA #2 exited the room, retrieved a blanket from the linen cart in the hallway, then returned to the Resident and placed the blanket over the Resident's lap. -CNA #2 repositioned Resident #119's hospital gown to cover his/her back but did not tie the ties. During an interview on 4/6/25 at 11:15 A.M., CNA #2 said Resident #119 had been sitting in the Lake Unit Dining Room since breakfast that morning. CNA #2 said the Resident's hospital gown was not tied in the back and his/her back was exposed. CNA #2 said that she retrieved a blanket for the Resident because the Resident was cold. On 4/7/25, between 12:16 P.M. and 1:07 P.M., the surveyor observed the following: -Two staff members assisted Resident #119 from his/her bed into his/her wheelchair. -Resident #119 wore a hospital gown that was open in the back; the ties on the hospital gown were not tied and the Resident's upper back was exposed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One staff member placed a blanket over Resident #119's lap, then transported the Resident to the Lake Unit Dining Room. -Resident #119 sat at a table with one other Resident (#76), and there were three other residents, one visitor, and three staff members in the dining room. -CNA #10 placed Resident #119's lunch meal on the table in front of the Resident. -Resident #119 did not initiate feeding him/herself and CNA #10 began to assist the Resident to eat at 12:34 P.M. -At 12:33 P.M. Nurse #7 offered coffee to Resident #76, and Resident #119 said, Coffee, yes. -Nurse #7 asked Resident #119 if he/she wanted cream and sugar in the coffee, and the Resident did not respond. -Nurse #7 said she would have to figure out how the Resident wanted his/her coffee, then exited the room. -At 12:37 P.M., Nurse #7 returned to the Dining Room with a cup of black coffee and placed it on the table in front of Resident #119, then placed some sugar packets on the table next to the coffee. At this time, Nurse #7 said, I really don't know how [Resident #119] wants [his/her] coffee to CNA #10. -At 12:53 P.M., CNA #10 stopped assisting Resident #119 to eat, stood up and said she would be right back. -At 12:56 P.M., CNA #1 sat next to Resident #119 and began assisting him/her to eat. -Resident #119's hospital gown had slipped off the Resident's right shoulder and his/her right shoulder, upper arm, and upper back were exposed. -CNA #1 continued to assist Resident #119 to eat and did not adjust the Resident's gown. -At 1:06 P.M., CNA #1 left Resident #119, who was still eating, to assist another resident in the room. -Resident #119's right upper arm and back remained exposed. -At 1:07 P.M. another staff member sat next to Resident #119 and began assisting the Resident to eat. -The Resident's right upper arm and upper back remained exposed until 1:07 P.M., when the staff member assisting him/her to eat at that time repositioned the Resident's hospital gown. -CNA #10 was observed entering and exiting resident rooms in the hallway, visible from the Dining Room, and collecting meal trays. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During the lunch mealtime, Resident #119 did not consume the coffee provided by Nurse #7. During an interview on 4/7/25 at 1:15 P.M., CNA #1 said she did not know why CNA #10 left and did not return to assist Resident #119 with his/her lunch meal. CNA #1 said that CNA #10 said she would be right back, and that CNA #10 never returned to the Dining Room. CNA #1 said she sat with Resident #119 to assist the Resident to eat because the Resident's meal had already started, and no one was assisting him/her to eat. CNA #1 said she had to assist another resident in the Dining Room, so she had to leave Resident #119 to assist the other resident. CNA #1 said when she got up to assist the other resident, another staff member sat to assist Resident #119. CNA #1 said Resident #119 should have been provided with consistent assistance of one staff member to eat during the lunch meal that day because it would have been better for the Resident. CNA #1 also said the Resident's hospital gown should have been tied in the back so that his/her body was covered properly. During an interview on 4/7/25 at 4:45 P.M., the Registered Dietician (RD) said she reviews food preferences for all new admissions, upon admission, with the residents, and with their Health Care Proxy (HCP) if the residents were unable to answer for themselves. The RD said Resident #119 was admitted to the facility in March 2025 and that she had not yet reviewed food preferences for the Resident. The RD said she thought Resident #119 communicated primarily in Spanish. During an interview on 4/8/25 at 10:56 A.M., Nurse #2 said Resident #119 was fluent in English and Spanish and that the Resident could understand both languages. Nurse #2 said the Resident had the ability to understand what was being communicated to him/her and that the Resident's ability to respond was impaired. Nurse #2 said staff were to always ask the Resident about his/her preferences, and if the Resident was unable to respond, then staff were to ask the Resident's HCP. Nurse #2 also said the Resident's HCP had not brought any clothing in for the Resident as yet and staff were dressing the Resident in a hospital gown. Nurse #2 said the Resident was dependent on staff for dressing and that staff should ensure the Resident's body was properly covered.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observations, interviews, and record reviews, the facility failed to maintain a clean and homelike environment for two Residents (#38 and #86), out of a total sample size of 26 residents, and for one Unit ([NAME] Unit), out of three units observed. Specifically, 1. For Resident #38, the facility staff failed to maintain the Resident's wheelchair in a clean and sanitary manner when the Resident was dependent on the wheelchair use for mobility and the wheelchair was visibly soiled. 2. For Resident #86, the facility staff failed to maintain the Resident's wheelchair in a clean and sanitary manner when the Resident was dependent on the wheelchair for mobility and the wheelchair was visibly soiled. 3. For the [NAME] Unit, the facility failed to ensure resident care equipment and the building were maintained in clean condition and good repair. Findings include: Review of the facility policy titled Cleaning of Wheelchairs and GeriChairs (a specialized geriatric chair), undated, included but was not limited to: -In many facilities these items (Wheelchairs/GeriChairs) are the responsibility of Nursing. If so, Environmental Services may be asked to provide cleaning chemicals or equipment. -If these items are the responsibility of Environmental Services, the first step .to arrange to get wheelchairs or Geri Chairs from the residents at a convenient time for the resident. >Materials needed: Pressure washer, Germicide, Brush/sponge, Rags, Buckets. -Steps to do job: a. Set up schedule to collect, wash, dry and return chairs. b. Arrange with nursing to get chairs from residents. c. Take chairs to an open area- basement or a shower room- use a pressure washer or scrub by hand with brush or sponge and germicide solution. d. rinse thoroughly and dry completely with rags (especially seats and wheels). -Additional information: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Proper cleaning procedures prevent the spread of infection. Review of the facility Housekeeping Cleaning Schedule, dated 6/2009 included but was not limited to the following: -Tasks: Wheelchairs. -Method: Germicidal. -Frequency: Bi-monthly. 1. Resident #38 was admitted to the facility in September 2021 with diagnoses including Osteoarthritis, muscle weakness, unsteadiness on feet, and difficulty in walking. Review of Resident #38's April 2025 Physician's orders included but was not limited to: -Health Care Proxy (HCP- appointed person who can make health care decisions for a person that was unable to do so themselves) activated, effective 9/29/21. Review of the Resident's Minimum Data Set (MDS) Assessment, dated 12/11/24, indicated Resident #38: -was unable to participate in a Brief Interview for Mental Status (BIMS) as evident by a score of 99. -was unable to walk 10 feet due to medical condition or safety concern. -used a manual wheelchair. -was dependent on another person for wheelchair mobility. Review of Resident #38's Comprehensive Person-Centered Care Plan included: -has impaired functional mobility related to disease process and required an intervention of a wheelchair for a mobility device, revised 3/25/25. On 4/6/25 at 9:08 A.M., the surveyor observed Resident #38 seated in a wheelchair in the [NAME] Unit hallway. The left-sided fabric leg rest cover on the Resident's wheelchair was stained with a dried white substance. The surveyor also observed the Resident's wheelchair seat and seat cushion had dried white and brown debris present. The surveyor observed Resident #38 seated in a wheelchair in the [NAME] Unit multipurpose room and the left-sided fabric leg rest cover on the Resident's wheelchair was stained with a dried white substance. The surveyor further observed the Resident's wheelchair seat and seat cushion had dried white and brown debris present on the following dates: -4/7/25 at 11:22 A.M. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/8/25 at 10:00 A.M. 2. Resident #86 was admitted to the facility in August 2023 with diagnoses including weakness and abnormal posture. Review of Resident #86's April 2025 Physician's orders included but was not limited to: -Guardianship (legally appointed person that was responsible for the care of someone unable to manage their own affairs), effective 1/22/25. Review of the Resident's MDS Assessment, dated 2/19/25, indicated Resident #86: -has severe cognitive impairment as evident by a BIMS score of six out of a total possible score of 15. -was unable to walk 10 feet due to medical condition or safety concern. -used a manual wheelchair. -was dependent on another person for wheelchair mobility. Review of Resident #86's comprehensive person-centered care plan included: -Resident #86 had impaired functional mobility related to disease process/condition and required intervention of a wheelchair for a mobility device, revised 10/11/23. On 4/6/25 at 5:05 P.M., the surveyor observed Resident #86 seated in a wheelchair in the [NAME] Unit hallway. The surveyor observed the Resident's right-sided wheelchair arm rest had a dried white and brown substance which continued down the length of the right-hand side of the wheelchair and onto the wheelchair seat cushion. The surveyor also observed a dried brown piece of banana on the back of the Resident's wheelchair seat. On 4/7/25 at 8:49 A.M., the surveyor observed Resident #86 seated in a wheelchair in the multipurpose room on the [NAME] Unit. The Resident's right-sided wheelchair arm rest was observed with dried white and brown substance which continued down the length of the right-hand side of the wheelchair and on the wheelchair seat cushion. The surveyor also observed a dried brown piece of banana on back of the Resident's wheelchair seat. On 4/8/25 at 11:11 A.M., the surveyor observed Resident #86 seated in a wheelchair in his/her bedroom and the right-sided wheelchair arm rest remained with dried white and brown substance which continued down the length of the right-hand side of the wheelchair and on the wheelchair seat cushion. The surveyor observed that a dried brown piece of banana also remained on the back of the Residents' wheelchair seat. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 10:42 A.M., the Housekeeping Manager said the facility did not have a resident wheelchair cleaning schedule. The Housekeeping Manager said he thought the nursing staff might be responsible for cleaning the resident's wheelchairs. The surveyor and the Housekeeping Manager observed Resident #38's and Resident #86's wheelchairs. The Housekeeping Manager said both Resident #38's and Resident #86's wheelchairs were dirty with dried spills and food debris and should have been cleaned. The Housekeeping Manager said that spills and food debris should be cleaned from the Resident wheelchairs when they occur and should not be left to be done by the housekeeping staff only. During an interview on 4/8/25 at 11:05 A.M., the Staff Development Coordinator (SDC) said that resident wheelchairs should be cleaned weekly and as needed. The SDC said the housekeeping department should be cleaning the resident's wheelchairs. The surveyor and the SDC observed the wheelchairs of Resident #36 and #86. The SDC said both Resident #36's and Resident #86's wheelchairs were very dirty with dried food debris and splatters and should be cleaned. During an interview on 4/8/25 at 11:20 A.M., the Director of Nursing (DON) said the housekeeping department was responsible to powerwash the resident's wheelchairs monthly. The DON said nursing staff should wipe spills on resident wheelchairs as they occur, but that deep cleaning should be done monthly and as needed by the housekeeping department. During a follow-up interview on 4/8/25 at 12:45 P.M., the Housekeeping Manager said housekeeping was responsible for cleaning the resident's wheelchairs. The Housekeeping Manager said all resident wheelchairs should be cleaned at least twice a month per the facility policy. The Housekeeping Manager said residents should not have to sit in dirty wheelchairs because nobody would want to sit in a dirty wheelchair. The Housekeeping Manager said the wheelchairs for Resident #38 and Resident #86 were not sanitary or homelike. The Housekeeping Manager was unable to provide evidence of when the wheelchairs for Resident #38 and Resident #86 were last cleaned. 42741 3. During the initial screening process on 4/6/25 the following was observed on the [NAME] Unit: -room [ROOM NUMBER]: significant damage to the wall was observed, including a large gouge in the lower portion of the wall and an area where baseboard wall trim had been pulled off the wall, crumbling dry wall and insulation were observed where the wall met the floor. -room [ROOM NUMBER]: Red dried substance observed on the wall near the window. The resident who resided in the room said a staff member had opened a ketchup packet last week and the ketchup squirted onto the wall by accident and no one had bothered to clean it up. On 4/7/25 from 2:40 P.M. to 3:26 P.M., the following was observed on the [NAME] Unit: -room [ROOM NUMBER]: significant damage to the wall and baseboard was still present. -room [ROOM NUMBER]: Red dried substance remained on the wall near the window. -room [ROOM NUMBER]: A bedside table with dried dark brown debris on the frame, and an area of the wall with drywall repair that was unpainted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at the time, the resident who resided in the room said someone patched the wall a few months ago but never came back to paint over the patch. The Resident Representative (RR) said he/she visited the resident often, that the resident had been at the facility for over a year, and the RR had not seen anyone wipe down the resident's bedside table where the dark brown substance on the frame was located. On 4/9/25 from 8:35 A.M. to 8:50 A.M., the surveyor and the Housekeeping Director observed the following: -room [ROOM NUMBER]: Red dried substance remained on the wall near the window. -room [ROOM NUMBER]: A Bedside table remained with dried dark brown substance on the frame. During an interview at the time, the Housekeeping Director said the wall in room [ROOM NUMBER] was dirty and needed to be wiped down and the bedside table frame in room [ROOM NUMBER] was dirty and needed to be cleaned. The Housekeeping Director said any staff in the building can let the housekeeping staff know when areas in a resident room needed to be cleaned but the housekeeping staff should also be wiping all surfaces each time they do the daily room cleaning in a room. Review of The Daily Cleaning Checklist provided by the Housekeeping Director indicated the following daily tasks were part of the cleaning routine: -Wipe clean the bedside table from top to bottom. -Wipe down walls. On 4/10/25 from 8:35 A.M. to 9:02 A.M., the surveyor and the Maintenance Director observed the following: -room [ROOM NUMBER]: significant damage remained to the wall. -room [ROOM NUMBER]: drywall repair area that remained unpainted. During an interview at the time, the Maintenance Director said the wall in room [ROOM NUMBER] was in need of repairs. The Maintenance Director said no one had made him or any maintenance staff aware that there was significant damage to the wall and any staff member could notify maintenance when a repair was needed. The Maintenance Director said room [ROOM NUMBER] had a repair done on the drywall but he was unsure how long ago the repair was completed. The Maintenance Director said he would expect maintenance staff to fix the drywall and return within a couple of days to paint the repair. The Maintenance Director said the facility did not have any specific environmental rounds to observe rooms to make sure they were in good repair and homelike, he relied on staff to let him and the maintenance staff know when repairs were needed.

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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. 50138 Based on observations, interviews, and record reviews, the facility failed to implement a person-centered care plan relative to feeding strategies for one Resident (#98), out of a total sample size of 26 residents. Specifically, for Resident #98, the facility staff failed to provide appropriate supervision during meals placing Resident #98 at risk for aspiration (entrance of food, liquid or other substance into a person's airway and lungs instead of being swallowed into the esophagus). Findings include: Review of the facility policy titled Aspiration Precautions, dated April 2015, included but was not limited to: -Aspiration Precautions will be utilized to reduce the risk of aspiration of food or liquid into a resident's lungs. <A resident with significant risk of aspiration, which is not completely controlled by current diet modifications, will require Aspiration Precautions by the Interdisciplinary Team (IDT). <Resident's needing Aspiration Precautions will be individualized. <The resident must be assessed by the Speech Language Pathologist (SLP) for the Aspiration Precautions to be discontinued. <Develop a plan of care with feeding strategies per SLP recommendation and include on care plan as warranted. Resident #98 was admitted to the facility in March 2022 with diagnoses including Dysphagia (difficulty swallowing foods or liquids) following Cerebral Infarction (stroke) and Pneumonitis due to Inhalation of Food and Vomit. Review of the most recent Minimum Data Set (MDS) Assessment, dated 3/5/25 indicated Resident #98: -has moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 12 out of a total possible score of 15. -required supervision or touching assistance for eating. -received a mechanically altered diet. Review of Resident #98's April 2025 Physician's orders included but was not limited to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Regular Diet: puree consistency, dysphagia level 1 texture (all foods must be pureed or blended to a smooth, homogenous consistency like pudding), honey thick liquids consistency, no straws, continual supervision 1:8 (one staff member to eight residents) ratio, effective 1/31/25. -Maintain Aspiration Precautions: 1:8 supervised PO (Per Os-by mouth) intake, no straws, every shift, effective 2/5/25. -May crush all appropriate medications according to guidelines, effective 3/1/22. -Give medications by mouth one at a time with pudding every shift, effective 9/9/22. Review of the Resident's Care Card, revision date 10/11/24, included but was not limited to: <Supervised dining. <During meals and after each meal observe for signs and symptoms of aspiration: coughing, tearing, runny nose, wet vocal tone, difficulty breathing, pocketing food. Review of the Comprehensive Person-Centered Care Plan indicated Resident #98: -has swallowing difficulty related to abnormal swallow study, coughing, drooling, respiratory failure, and aspiration pneumonia with interventions including supervised dining, last revised 2/12/25. -has an Activity of Daily Living (ADL) deficit with interventions including supervised eating, last revised 10/30/23. On 4/6/25 at 9:36 A.M., the surveyor observed that the privacy curtain to Resident #98's bed was pulled closed to the foot of the bed and the bed was out of view from the hallway. The surveyor entered the room and observed from the foot of the bed that Resident #98 was reclining in his/her bed behind the closed privacy curtain and the head of the bed was raised. Resident #98 was observed to be eating bites of oatmeal at the time. The surveyor did not observe any staff present in the Resident's room while the breakfast meal was being consumed. During an interview on 4/7/25 at 9:02 A.M., Nurse #5 said she was the Nurse caring for Resident #98. Nurse #5 said Resident #98 had a Physician's ordered diet of Level 1 dysphagia diet, puree consistency with honey thick liquids with a 1:8 ratio for staff supervision. Nurse #5 said Resident #98 was supposed to be out of bed and supervised by staff for meals while eating but sometimes the Resident refused to get out of bed. Nurse #5 said Resident #98 needed to be supervised by staff when eating because the Resident was at risk for aspiration. The surveyor and Nurse #5 observed that Resident #98 was behind a closed privacy curtain, out of view from the hallway, and in bed eating breakfast without a staff member present. Nurse #5 said that the staff member who delivered the Resident's meal tray should not have left the meal tray alone with the Resident. Nurse #5 said she was unable to identify which staff member had delivered the meal tray to Resident #98. Nurse #5 said that staff should be following Resident #98's Physician's orders and care plan for supervision at meals. During an interview on 4/8/25 10:37 A.M., the Speech Therapist (ST) said she provided the recommendations for supervision for meal intake for Resident #98 due to the Resident's aspiration risk. The ST said the Resident should be supervised by staff with all food intake due to aspiration risk. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webster Manor Rehabilitation & Health Care Center	745 School Street Webster, MA 01570

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 9:48 A.M., the surveyor observed the Resident lying upright in bed behind a closed privacy curtain and out of view from the hallway. The Resident had a meal tray containing pudding and oatmeal and was observed to be taking bites of oatmeal from a spoon. The surveyor did not observe a staff member present in the Resident's room while he/she was eating. During an interview on 4/9/25 at 9:49 A.M., Certified Nurses Aide (CNA) #6 said she had delivered the breakfast tray to the Resident. CNA #6 said the Resident required a puree diet with thickened liquids due to aspiration precautions and that the Resident should not be left unattended with food or fluids. CNA #6 said she had supervised the Resident at breakfast time, and the Resident had refused for CNA #6 to remove the breakfast tray when it was time for her to leave. CNA #6 said the meal tray should not have been left with the Resident. CNA #6 further said that the Nurse should have been told when the Resident refused to allow the tray to be removed because the Resident could choke. During an interview on 4/9/25 at 9:51 A.M., Nurse #5 said she was the Nurse for Resident #98. Nurse #5 said CNA #6 should have told the Nurse when the Resident refused to have his/her meal tray collected. Nurse #5 said Resident #98 should not be left unattended with food due to a risk of aspiration.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47901 Based on observations, interviews, and record reviews, the facility failed to provide treatment in accordance with professional standards of practice relative to an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body) for one Resident (#3) out of a total sample of 26 residents. Specifically, the facility failed to: -obtain a Physician order that included the accurate size indwelling urinary catheter required for the Resident, when the ordered and inserted catheter sized were different. -ensure the Resident had a leg bag to promote mobility and dignity/privacy when the Resident was out of bed. -provide Enhanced Barrier Precaution (EBP) during ADL (activities of daily living - washing, bathing, grooming) care of the Resident. Findings include: Review of the facility's policy titled, Urinary Leg Bag, dated April 2015, indicated: -The use of the leg bag for urinary catheter drainage is permitted whenever necessary to promote mobility, ease of ambulation, and resident/patient dignity and self-esteem. -Urinary catheter bags should be kept in privacy bags to maintain resident's dignity/privacy. Review of the facility's policy titled, Urinary Catheter Insertion (Indwelling), dated April 2015, indicated that an indwelling urinary catheter will be inserted when the resident/patient clinical condition demonstrates necessity by a licensed nurse, as ordered by the Physician. Review of the Centers for Disease Control and Prevention (CDC) guidelines for Proper Techniques for Urinary Catheter Maintenance, reviewed at https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html, indicated the following: -Use Standard Precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system. -Maintain a closed drainage system. Review of the CDC guidelines for Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs). Retrieved from: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, revised, 7/12/2022. indicated the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. >Enhanced Barrier Precautions included the following: -Providers and Staff must wear gloves and a gown for the following High-Contact Resident Care Activities: -Dressing -Bathing/Showering -Transferring -Changing Linens -Providing Hygiene -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care. Resident #3 was admitted to the facility in December 2024 with diagnoses including Chronic Systolic Heart Failure, Rhabdomyolysis, Altered Mental Status, Acute Kidney Failure and Neuromuscular Dysfunction of Bladder. Review of Resident #3's Hospital Discharge Summary, dated 3/30/25, indicated: -discharge diagnoses included Urinary Tract Infection (UTI), Urinary Retention, Stroke with Expressive Aphasia and Urethral Catheter 16 French (Fr). -urinary culture contained greater than >100,000 CFU/ML (significant urinary tract infection) of Pseudomonas Aeruginosa (a bacterial infection). -continue on Levaquin (antibiotic) for 5 days relative to Urinary Tract Infection treatment. Review of Resident #3's clinical record indicated the following active Physician orders: -Indwelling Foley (urinary) catheter size 16 Fr, 10 ml (milliliter) balloon (bulb - a fluid filled balloon at the end of the indwelling urinary catheter that is inflated to prevent the indwelling urinary catheter from dislodging) every shift for retention, dated 3/31/25. -Foley catheter care every shift, dated 3/31/25. -Enhanced Barrier Precaution related to Foley catheter every shift, dated 4/4/25. Review of Resident #3's Foley Catheter Care Plan, revised 4/1/25, indicated: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-has a Foley catheter related to neurogenic bladder. -catheter care every shift. -Leg bag when out of bed. Review of Resident #3's Nursing Progress Note dated 4/2/25 at 2:08 P.M., indicated: -Foley catheter was removed and the Resident could not void. -Nurse inserted a Foley catheter 16 Fr, 10 ml balloon. Review of the Minimum Data Set (MDS) Assessment, dated 1/2/25, indicated Resident #3: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of eight out of 15 total possible points. -has an indwelling urinary catheter. -was dependent on staff for toilet hygiene. On 4/6/25 at 8:15 A.M., the surveyor observed Resident #3 lying in bed in his/her room. The surveyor observed clear catheter tubing, extending out from under the bed covers, was connected to a urinary drainage bag. The surveyor observed that the tubing was draining clear light-yellow urine and there was no signage indicating the Resident was on EBP. The surveyor further observed that there was no Personal Protective Equipment (PPE) near or around the Resident's care area. On 4/6/25 at 8:20 A.M., the surveyor observed the Infection Preventionist (IP) and Unit Manager (UM) #1 walk around the unit placing EBP signs at residents' doors. During an interview at the time, the IP said she was walking around to place EBP signs at the residents' doors to alert the nursing staff to wear gowns and gloves for residents that needed high contact care. The IP said all residents who have a central line, urinary catheter, feeding tube, tracheostomy, and required wound care would need to be on EBP. During an interview on 4/6/25 at 9:00 A.M., the IP said Resident #3 should have been on EBP since his/her re-admission from the hospital but he/she was not on EBP. On 4/6/25 at 9:16 A.M., the surveyor observed CNA #4 perform ADL care for Resident #3, without donning (putting on) a gown. During an interview on 4/6/25 at 9:25 A.M., CNA #4 said she did not know that Resident #3 was on EBP. CNA #4 said she should have had a gown on, but she did not. On 4/7/25 at 10:08 A.M., the surveyor observed Resident #3 seated in a wheelchair in the dining area. The Resident's Foley catheter tubing was visible and observed with light yellow urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 8:53 A.M., the surveyor observed Resident #3 seated in the dining area having breakfast. The Resident's Foley catheter tubing was hanging underneath his/her wheelchair with light yellow urine visible in the tubing. On 4/8/25 at 9:04 A.M., the surveyor and Nurse #3 observed Resident #3's Foley catheter. Nurse #3 said Resident #3 should have been provided a leg bag for urinary drainage, for privacy and dignity, but he/she was not provided a leg bag. Nurse #3 further said Resident #3's current Foley catheter size was 16 Fr with 5 ml balloon. Nurse #3 said Resident #3's Physician's order indicated 16 Fr with 10 ml balloon and that the order and the actual catheter size the Resident had inserted did not match.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observations, interviews, and record reviews, the facility failed to provide respiratory care and services consistent with professional standards of practice for three Residents (#123, #69, and #35) out of a total sample of 26 residents. Specifically, 1. For Resident #123, the facility failed to: -ensure that the oxygen concentrator was set at two (2) liters per minute (LPM) as ordered by the Physician. -ensure there was an indication for the use of oxygen. -ensure the staff provided a new nasal cannula to the Resident after his/her previous nasal cannula was contaminated after laying on the Resident's bedroom floor. 2. For Resident #69, to ensure a clean and sanitary oxygen concentrator (a device used to deliver supplemental oxygen) gross particle air intake filter in accordance with manufacturers guidelines placing the Resident at risk for impaired oxygen supply delivery and contamination. 3. For Resident #35, ensure Physician's orders were in place for the care and services of a Continuous Positive Airway Pressure (CPAP) machine and that proper infection control practices were maintained for the Resident's CPAP to reduce contamination and risk of respiratory infection. Findings include: 1. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for oxygen therapy. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease (COPD) that oxygen administration may lead to an increase in PaCO2. -Equipment, maintenance and supervision: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>All oxygen delivery equipment should be checked at least once daily . >Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. Review of facility policy titled Oxygen Administration, revised April 2015, indicated: -deliver low flow oxygen rates and concentration, per the Physician's order. -set oxygen flow rate to the prescribed liters flow per minute. -verify oxygen is flowing through the tips of the cannula. -replace and date cannula and tubing weekly or when visibly soiled or damaged. Resident #123 was admitted to the facility in December 2024 with diagnoses including Dementia with Psychotic Disturbance, anxiety, legal blindness, weakness and Alzheimer's Disease. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #123: -was severely cognitively impaired as evidence by a Brief Interview for Mental Status (BIMS) score of one out of 15 possible points. -was receiving oxygen therapy. -was dependent on staff for activities of daily living (ADL - washing, bathing, grooming) care. Review of Resident #123's April 2025 Physician's orders indicated: -Oxygen continuously via nasal cannula at 2 liters per minute (LPM) every day shift, started on 2/13/25 Review of Resident #123's Person-Centered Care Plan failed to indicate any evidence that included oxygen use and/or corresponding diagnosis for use. On 4/6/25 at 11:50 A.M., the surveyor observed that Resident #123 was seated in a wheelchair in the dining room. The Resident was observed with a nasal cannula in his/her nostrils that was connected to a portable oxygen concentrator which was attached to the Resident's wheelchair. The surveyor observed that the dial flow to the oxygen concentrator was set at zero. During an interview at the time, Unit Manager (UM) #1 said that the oxygen concentrator should be set at 2 LPM. On 4/6/25 at 12:15 P.M., the surveyor observed there was a stationary oxygen concentrator in Resident #123's bedroom with a nasal cannula connected to the oxygen concentrator. The surveyor observed that the nasal cannula was dated 3/31/25, and laying directly on the bedroom floor. On 4/6/25 at 1:45 P.M., the surveyor observed Resident #123 lying in bed. The surveyor observed that the Resident was receiving oxygen flow via nasal cannula set at 2 LPM, with the soiled nasal cannula tubing that was previously laying on the floor and dated 3/31/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/6/25 at 2:34 P.M., Certified Nurses Aide (CNA) #5 said she had picked up the oxygen tubing with the nasal cannula laying on the floor and placed the nasal cannula in Resident #123's nostrils. During an interview at the time, the Infection Preventionist (IP) said CNA #5 should have thrown away the used nasal cannula tubing and applied a new nasal cannula tubing for the Resident. During an interview on 4/8/25 at 8:10 A.M., the Assistant Director of Nursing (ADON) said Resident #123 was admitted to the hospital in February for Shortness of Breath (SOB) and Pneumonia. The ADON said the facility staff should have obtained the diagnosis for the use of Resident #123's oxygen but they had not. The ADON said the Interdisciplinary Team (IDT) should have developed a care plan for the use of oxygen, but they had not. 50138 2. Review of the facility policy titled Oxygen Concentrators, undated, included the following: -Objective: To provide the patient and facility with cost effective alternative to high pressure cylinders and or liquid oxygen vessel. <Never obstruct the inlet filter's flow of air from the room. <The inlet should be wiped clean of dust, minimally once a week, or more often, if needed. Review of the New Life Elite oxygen concentrator user manual, dated 8/2012, included but was not limited to: -The air intake gross particle filter prevents dust and other airborne particles from entering the oxygen concentrator unit. -Cleaning, Care and Proper Maintenance: <Do not operate the unit without the air intake gross particle filter in place. <At least one time each week, wash the air intake gross particle filter, which is located in the back of the unit. Follow these steps to properly clean the air intake filter: 1. Remove the filter and wash it in a warm solution of soap and water. 2. Rinse filter thoroughly, and remove excess water with a soft, absorbent towel. Ensure the filter is dry before replacing it. 3. Replace the dry filter to the back of the unit. Resident #69 was admitted to the facility in May 2023, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Respiratory Failure. Review of the Minimum Data Set (MDS) Assessment, dated 2/25/25, indicated that Resident #69: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was cognitively intact as indicated by a Brief Interview for Mental Status (BIMS) score of 13 out of a total possible score of 15. -was receiving oxygen therapy. Review of Resident #69's April 2025 Physician's orders included but was not limited to: -oxygen via nasal cannula to maintain SpO2 (measure of oxygen in the blood as a percentage of the maximum oxygen the blood could carry) greater than 92%. Call Provider if oxygen above 4 liters per minute (LPM) to maintain SpO2 as needed, effective 6/19/24. -change oxygen tubing every Sunday on (11:00 P.M.- 7:00 A.M.) every night shift, effective 2/27/24. Review of Resident #69's Comprehensive Person-Centered Care Plan included but was not limited to: -The Resident had a diagnosis of Respiratory Failure with interventions including administration of oxygen, initiated 8/14/24. The surveyor observed Resident #69 seated in a wheelchair at the bedside with oxygen flowing at 2 LPM via nasal cannula from an AirSep New Life Elite oxygen concentrator and the oxygen concentrator was observed to have a thick coating of dark gray dust on the air intake gross particle filter on the following: -4/6/25 at 8:03 A.M. -4/6/25 at 3:46 P.M. -4/7/25 at 8:39 A.M. During an interview on 4/7/25 at 10:30 A.M., Nurse #5 said she was the Nurse providing care for Resident #69. Nurse #5 said oxygen tubing should be changed, and the oxygen concentrator wiped clean on the night shift (11:00 P.M.-7:00 A.M.) every Sunday for all residents that received oxygen therapy. The surveyor and Nurse #5 observed Resident #69's air intake gross particle filter on the oxygen concentrator. Nurse #5 said the Resident's air intake gross particle filter on the oxygen concentrator was coated in dust and should be cleaned. Nurse #5 said she did not know the process for cleaning the filter because cleaning should be done on the night shift. During an interview on 4/7/25 at 11:00 A.M., the Regional Infection Preventionist (IP) said oxygen concentrator filters should be cleaned by the nursing department weekly per the manufacturers guidelines to prevent equipment malfunction. 42741 3. Review of the facility policy titled CPAP/BiPAP Management, revised 4/25, indicated the following: -CPAP or BiPap System/Machine Cleaning (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>Wipe machine off twice monthly with damp cloth. >Replace disposable filters per manufacturer guidelines. >Clean non-disposable filters weekly and replace when needed. >Use warm soapy water and let air dry before inserting back into machine. -Headgear >Wash as needed. -Mask and Nasal Pillows >Wash daily with mild detergent (rinse thoroughly with warm water to remove all detergent and residue, air dry). -Tubing >Wash bi-monthly with mild detergent or white vinegar solution, rinse with warm water and air dry between uses. -Humidifier: >Change distilled water daily right before bed . >Clean chamber weekly and let air dry. Documentation -Document on the individual's treatment sheet or nursing progress note his/her response to CPAP . -Add the wearing and cleaning routine of equipment to the Treatment Administration Record (TAR) Storage -When .CPAP not in use, mask will be stored in a bag at resident bedside. Resident #35 was admitted to the facility in April 2022 with diagnoses including Obstructive Sleep Apnea (OSA). Review of the most recent comprehensive Minimum Data Set (MDS) Assessment, dated 4/18/24, indicated Resident #35 scored a 14 out of 15 on the Brief Interview of Mental Status (BIMS) indicating he/she was cognitively intact. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/6/25 at 8:26 A.M., the surveyor observed a CPAP machine on Resident #35's nightstand and the CPAP mask laying on the nightstand, not in a bag, and with dried debris all over the mask. The surveyor further observed that the CPAP humidifier chamber had dried white material all along the edges, brown stains on the bottom of the chamber, and white debris floating in the water. During an interview at the time, Resident #35 said he/she wore his/her CPAP every night. Resident #35 further said staff did not clean his/her CPAP equipment regularly and he/she could not recall the last time that staff had cleaned or changed out his/her CPAP equipment. Review of Resident #35 April 2025 Physician's orders indicated the following order: -CPAP to be worn daily at bedtime, remove in the AM (morning) with a start date of 11/2/22. Review of Resident #35's March 2025 Treatment Administration Record (TAR) indicated Resident #35 wore his/her CPAP daily as ordered in the month of March 2025. Review of Resident #35's April 2025 TAR indicated Resident #35 wore his/her CPAP daily from 4/1/25 through 4/6/25. During an interview on 4/7/25 at 8:23 A.M., Nurse #3 said Resident #35 wore his/her CPAP every night. The surveyor and Nurse #3 reviewed Resident #35's April 2025 TAR and Nurse #3 said nursing staff was documenting daily that the Resident wore his/her CPAP to bed and that it was removed in the morning when the Resident got up for the day. Nurse #3 said when a Resident has a CPAP, Physician's orders should be in place for the care and services of the CPAP equipment such as daily changing of the water, regular cleaning of the CPAP mask and hose, and when the CPAP equipment needed to be replaced. Nurse #3 reviewed Resident #35's Physician's orders and said there were no orders in place for the care and services of Resident #35's CPAP so she could not be sure when the Resident's CPAP equipment had last been cleaned. On 4/7/25 at 8:30 P.M., the surveyor and Nurse #3 observed Resident #35's CPAP equipment and the following was observed: -CPAP mask was laying directly on the nightstand and had dried debris all over the mask. -The humidifier chamber had large white dried particles of debris in the water chamber area, significant buildup of debris along the edges of the water chamber, and brown stains on the bottom of the water chamber. During an interview at the time, Nurse #3 said it did not appear Resident #35's CPAP had been cleaned in some time, and been cleaned regularly due to the amount of buildup and debris in the water chamber and mask. Nurse #3 said the CPAP mask should be stored in a bag when not in use and not laying directly in contact with the Resident's nightstand. Nurse #3 said not properly cleaning a Resident's CPAP equipment could put the Resident at risk for an increased chance of acquiring a respiratory infection.

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Webster Manor Rehabilitation & Health Care Center	745 School Street Webster, MA 01570

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42761 Based on observations, interviews, and record reviews, the facility failed to provide sufficient nursing staff on two resident Units (Lake Unit and Tapestry Unit) out of three resident units, to attain/maintain the highest physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to: -Provide sufficient nursing staff to ensure all residents on the Lake Unit, including Resident #119, were provided with timely morning activity of daily living (ADL) care. -Provide sufficient nursing staff to ensure all residents on the Lake and Tapestry Units were provided timely medication administration. Findings include: Review of the Facility Assessment, last reviewed 3/26/25, indicated the following: -The facility's capacity was 135 with an average daily census of 124.87 residents. -For bathing, the facility had an average of 79 residents requiring assistance of one to two staff and an average of 35 residents who were dependent on staff. -For dressing, the facility had an average of 86 residents requiring assistance of one to two staff and an average of 24 residents who were dependent on staff. -For transfers, the facility had an average of 84 residents requiring assistance of one to two staff and an average of 14 residents who were dependent on staff. -For toileting, the facility had an average of 74 residents requiring assistance of one to two staff and an average of 29 residents who were dependent on staff. -ADL care included: bathing/showers, mouth care, dressing, eating . -Mobility care included: transfers, ambulation . -Mental health and behavior care included: .identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, . -Medication care included: administration of medications that residents need. -The facility utilized a staffing calculator based on daily census to provide safe staffing ratios. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-For staffing, the facility would take into consideration resident acuity and need to the extent possible. Review of the facility's Lake Unit Midnight Census Report, dated 4/6/25 (indicating the census for 4/7/25) indicated there were 42 residents actively residing on the Lake Unit. Review of the facility's Nursing Staff Schedule for 4/7/25 indicated the following: -The total required number of Certified Nurse Aides (CNAs) for the day (7:00 A.M.-3:00 P.M.) shift =14.0. -The total number of assigned CNAs for the day shift =11.1. -Three CNAs were assigned to work on the Lake Unit for the day shift. -The total required number of Licensed Nurses for the day shift = 6.0. -The total number of assigned Licensed Nurses for the day shift = 6.0 (two Nurses were assigned to the Lake Unit). -The total number of Resident Care Assistants required for 8:00 A.M. through 4:00 P.M. = 1.0. -The total number of Resident Care Assistants assigned for 8:00 A.M. through 4:00 P.M. = 0.0. 1. Resident #119 was admitted to the facility in March 2025 with diagnoses including history of Traumatic Brain Injury (TBI), Dementia, Dysphagia, and weakness. On 4/7/25, between 8:40 A.M. and 9:33 A.M., surveyor #2 observed the following from outside of Resident #119's room: -Resident #119 was lying in bed with the head of the bed slightly elevated and his/her eyes closed. -At 8:54 A.M., a CNA entered Resident #119's room with the Resident's breakfast tray. -The CNA placed the breakfast tray on a table at the foot of the bed, stated the Resident's name, then entered the bathroom to wash her hands and exited the room. -A different CNA (#1) entered the Resident #119's room at 9:26 A.M. (32 minutes after the Resident's breakfast tray was delivered to the Resident's room) at which time CNA #1 woke and repositioned the Resident, then began assisting the Resident to eat. -CNA #1 exited the room at 9:33 A.M. (seven minutes after initiating feeding assistance for Resident #119) carrying the Resident's breakfast tray. -The Resident remained in bed with his/her head elevated and was observed to be chewing the food that was in his/her mouth. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at the time, CNA #1 said that Resident #119 had eaten his/her oatmeal and consumed approximately half of his/her milk, and did not consume any of the main breakfast entree. During an interview on 4/7/25 at 10:12 A.M., with surveyor #2 and Nurse #2, Nurse #2 said the day shift began with two CNAs to care for 45 residents (45 was the Unit's capacity; census on the Unit was 42) and that the third CNA assigned for the day shift did not start working on the Unit until about 7:30 A.M. Nurse #2 said she felt bad that the CNAs did not have enough time to feed the Residents. Nurse #2 said Resident #119 was a slow eater but always ate all of his/her meals. Nurse #2 said if the staff had enough time, Resident #119 would have eaten all of his/her breakfast. During an interview on 4/7/25 at 10:21 A.M., with surveyor #2 and CNA #1, CNA #1 said there were three CNAs scheduled to work on the Lake Unit. CNA #1 further said at this time she still had five residents to provide morning ADL care to and two residents to provide showers for. On 4/7/25 at 12:04 P.M., surveyor #1 observed Resident #119 lying in bed with the head of the bed elevated and the Resident's eyes were open. During an interview on 4/7/25 at 12:15 P.M., with surveyor #1 and Nurse #7, Nurse #7 said that she was the supervisor on the Lake Unit. Nurse #7 said some residents were still in bed and that staff were running a bit behind. Nurse #7 said it was a busy day, and she did not know if any staff had called out of work that day. On 4/7/25, between 12:16 P.M. and 1:14 P.M., surveyor #1 observed the following from outside of Resident #119's room: -Two staff members entered Resident #119's room and closed the door. -Staff opened the Resident's door at 12:19 P.M. and the surveyor observed that Resident #119 was sitting up in his/her wheelchair. -The Resident was wearing a hospital gown with ties in the back that were not tied. -The back of the Resident's hospital gown was open, and the Resident's upper back was exposed. -One staff member assisted Resident #119 down the hallway toward the Dining Room. -The Resident was served his/her lunch meal at 12:31 P.M. and CNA #10 began assisting Resident #119 to eat at 12:34 P.M. -At 12:53 P.M., while Resident #119 was still eating, CNA #10 stood up and said she would be right back. -CNA #10 proceeded to leave the Dining Room. -At 12:56 P.M., CNA #1 sat next to Resident #119 and assisted the Resident with eating. CNA #10 had not returned. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The surveyor observed CNA #10 entering and exiting resident rooms in the hallway closest to the Dining room, carrying resident meal trays and placing them back into the meal cart. -At 1:06 P.M., CNA #1 stopped assisting Resident #119 to eat and attended to another resident in the Dining room. -At 1:07 P.M. another staff member sat next to Resident #119 and assisted the Resident with eating. -The Resident finished eating at 1:14 P.M. During an interview on 4/7/25 at 1:15 P.M., with surveyor #1 and CNA #1, CNA #1 said there were three CNAs working on the Lake Unit that day on the 7:00 A.M. through 3:00 P.M. (day) shift. CNA #1 said they were supposed to be staffed with four CNAs for the day shift on the Unit and that when they were staffed with three CNAs, the CNAs were unable to complete resident morning ADL care timely. CNA #1 said there were several residents who required assistance of two staff for transfers and several residents who required assistance for bathing and dressing. CNA #1 said if there had been another CNA on the Unit, all morning ADL care would have been provided for the residents by 11:00 A.M., and the residents would have been out of bed before lunch. CNA #1 said she still had one resident remaining to assist with showering. CNA #1 said she normally would have completed the shower for the resident before lunch, and that because only three CNAs were working, she was not able to provide the resident's shower in the morning. CNA #1 said all ended up working out because the resident who still needed a shower did not feel well in the morning, and he/she was agreeable to shower later in the day. CNA #1 said the CNAs on the Lake Unit also had responsibilities for answering the call lights timely, providing drinks, snacks, and toileting assistance for residents as well as assisting residents who smoke to the smoking area. CNA #1 said that late morning care provided to residents, including Resident #119, was not due to preferences of the residents and that it was due to having three CNAs to care for 42 residents. During an interview on 4/10/25 at 9:33 A.M.,with surveyor #1 and the Scheduler, the Scheduler said that the facility uses a staffing calculator to determine nursing staff levels and that resident acuity is not cnsidered when determining staffing needs. The Scheduler said the numbers on the schedule indicated as required were for the whole facility and not separated by unit. The Scheduler said it was the facility's responsibility to determine how to distribute the staff within the facility. The Scheduler said there were CNA callouts for the day shift on 4/7/25, and that one of the callouts came in the evening before (4/6/25). When surveyor #1 asked how the facility attempted to fill the CNA callout spots, the Scheduler said she messaged two CNAs in the morning on 4/7/25 and she thought the supervising Nurse who worked the prior evening had made some calls. The Scheduler said she did not have time to contact any other staff in the morning on 4/7/25 because she was pulled to work as a CNA on the Tapestry Unit from 8:00 A.M. until 9:00 A.M. The Scheduler said she would need to contact the supervising Nurse who took the CNA callout on 4/6/25 for the 4/7/25 day shift to see whether the Nurse made attempts to contact other staff to come in and work. The Scheduler also said the three CNAs assigned to work on the Lake Unit had punched in on time, so she did not understand why the Lake Unit would only have had two CNAs working at the start of the day shift on 4/7/25. At the time, surveyor #1 and the Scheduler reviewed the daily nursing staff schedule for 4/7/25 as follows: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNAs required: 14.0 -CNAs assigned: 11.1. During a follow-up interview on 4/10/25 at 10:48 A.M., with surveyor #1 and the Scheduler, the Scheduler said that the supervising Nurse did not attempt to contact any staff to fill the CNA callout received for the 4/7/25 day shift. The Scheduler also said she found out that CNA #1, who was assigned to work on the Lake Unit for the day shift on 4/7/25, punched in on time that day but did not arrive on the Lake Unit until about 7:20 A.M. which was why the Lake Unit only had two CNAs at the start of the day shift on 4/7/25. During an interview on 4/10/25 at 11:09 A.M., with surveyor #1 and the Director of Nursing (DON), the DON said that the Lake Unit was very busy. The DON said the Lake Unit was usually staffed with three CNAs on the day shift and if there was a need, a fourth CNA would be assigned by pulling a CNA from another Unit. The DON said she had not heard of any issues that indicated nursing staff were not able to get their work done timely on the Lake Unit when staffed with three CNAs. The DON said the facility had a large per diem CNA pool and that the Scheduler would have been responsible to place calls on 4/7/25 in an attempt to get staff to come in and fill the spots where CNAs had called out. The DON said there was a Resident Care Assistant (RCCA) assigned to work the day shift on the Lake Unit, but the RCCA was also out. The DON said she was not aware the RCCA was not working on 4/7/25 until about 11:00 A.M. The DON said acuity of the residents is considered when determining where to place assigned staff and if staff on the Lake Unit had communicated they were having difficulty getting their work done on 4/7/25, this would have been addressed so that the residents' needs could be met. 47901 2. On 4/7/25 at 10:12 A.M., during a medication administration observation of Nurse #2 on the Lake Unit, surveyor #2 observed the following: -Nurse #2 stopped the medication administration process and toileted residents. -Nurse #2 stopped the medication administration (twice), answered resident call lights, and provided care as needed. During an interview at the time, surveyor #2 asked Nurse #2 why most of the residents medication administration screens were Red and Nurse #2 said that she was very late with the resident medication administration. Nurse #2 said she had to stop the medication administration to deliver breakfast trays, assist with feeding the residents, assist the CNAs to answer call lights, and toilet the residents as needed. Nurse #2 said they had started the shift with two CNAs for 45 Residents on the Lake Unit (capacity of the Unit was 45, census on the Unit was 42, with mixed rehab and long-term care residents). Nurse #2 said the third CNA assigned to work the day shift did not show up on the Unit until about 7:30 A.M. Nurse #2 said she still had five residents who had morning medications to be administered and they were all late. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/25 at 10:48 A.M., during a medication administration observation of Nurse #4 on the Tapestry Unit Side One by surveyor #2, Nurse #4 said that she was very late with the medication administration. Nurse #4 said the Tapestry Unit had been very busy with delivering breakfast trays, assisting residents to eat, and constantly redirecting wandering residents to ensure the residents' safety. Nurse #4 said there were two Nurses on the Tapestry Unit with four CNAs, but the intermittent redirection of residents caused a delay in the medication administration. Nurse #4 said she had eight residents waiting to receive their morning medications that were due at 9:00 A.M. On 4/7/25 at 11:09 A.M., during a medication administration observation of Nurse #3 on the Tapestry Unit, Side Two by surveyor #2, Nurse #3 said that she had two residents waiting to receive their 9:00 A.M. medications. Nurse #3 said it was very difficult to complete medication administration timely due to the required, frequent redirection of residents. Nurse #3 said the Nurses had to stop medication administration to assist with feeding residents. Nurse #3 said one Nurse and two CNAs had to stay in the dining room to monitor breakfast safety while the other Nurse and two CNAs remained on the floor to assist the other residents who were eating in their bedrooms and redirect wandering residents for safety. During an interview on 4/7/25 at 2:05 P.M., with surveyor #2 and the Director of Nursing (DON), the DON said that she was aware that sometimes the residents' behaviors could cause a delay in the medication administration and that the Corporation was auditing the medication administration to liberalize the times of the medication administration. The DON said nursing department staffing is based on the residents' ratios and the facility Scheduler managed the staffing ratios. The DON further said she knew two CNAs had called out for the morning shift on the Tapestry Unit but was unaware if attempts had been made to replace the two CNA call outs. During an interview on 4/7/25 at 3:11 P.M., the Scheduler said she worked as CNA sometimes when there was a need to do so. The Scheduler said two CNAs had called out for the morning shift on the Tapestry Unit, and that she needed to assist on the Tapestry Unit as a fourth CNA for one hour until one CNA arrived on the Tapestry Unit at 8:00 A.M. The Scheduler said she did not have time to call other staff members to see if they could come in and work. The Scheduler said she was unaware that the third CNA assigned to the Lake Unit did not arrive on the Lake Unit until 7:30 A.M.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 42761 Based on observations, interviews, and record reviews, the facility failed to provide appropriate treatment and services for one Resident (#79), out of a total sample of 26 residents, who was diagnosed with Dementia, to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Specifically, the facility failed to provide diversional interventions for Resident #79, according to the Resident's interests, when the Resident repeatedly paced the hallways of the Lake Unit and repeatedly vocalized, he/she did not know what to do. Findings include: Resident #79 was admitted to the facility in February 2025 with diagnoses including Dementia. Review of Resident #79's Care Plan indicated the following: -Resident is at risk to try to leave the nursing Unit, attempting to leave the facility, pacing, roaming/wandering in/out of peer rooms, initiated 2/5/25 and revised 2/17/25. -Encourage participation in positive meaningful activity programs of choice (2/5/25). -Establish and maintain daily routine to meet physical needs (2/5/25). -Ambulates with continual supervision (2/6/25). -The Resident had behavior problems related to diagnosis of Dementia, wandering, refusing care, and cursing (initiated 2/17/25). -Address wandering behavior by walking with or attempt to redirect from inappropriate area, engage in divisional [sic] activity (2/17/25). -Anticipate care needs and provide them before the Resident becomes overly stressed. -Offer materials of interest for independent leisure activity (2/18/25). -Offer to go with Resident just to take a look (2/18/25). Review of Resident #79's Minimum Data Set (MDS) Assessment, dated 2/11/25, indicated the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of four out of 15 total possible points. Review of Resident #79's Admission Recreation Assessment, dated 2/8/25 and completed 2/18/25, indicated the Resident had current interests in the following areas: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Games/cards. -Arts/crafts. -Exercise. -Music -Watching television/movies. -Talking/conversing. -Social events. -Observing nature. Further review of the Admission Recreation Assessment indicated the Resident's decision-making ability was severely impaired and that the Resident's short and long term memory were poor. On 4/6/25, between 8:15 A.M. and 8:40 A.M., the surveyor observed Resident #79 repeatedly pace up and down the hall on the Lake Unit and repeatedly verbalize that he/she did not know what to do. During this time, the surveyor observed three different staff members direct the Resident to sit in a chair in the hallway on three different occasions. No diversional activity was offered to the Resident. Each time the Resident sat down, staff walked away and the Resident stood back up, paced the hallway, and verbalized that he/she did not know what to do. On 4/6/25, between 9:30 A.M. and 10:00 A.M., the surveyor observed Resident #79 repeatedly pace up and down the hall on the Lake Unit and repeatedly verbalize that he/she did not know what to do. During this time, the surveyor observed two different staff members direct the Resident to sit in a chair in the hallway. No diversional activity was offered to the Resident. Each time the Resident sat down, staff walked away, and the Resident stood back up, paced the hallway, and verbalized that he/she did not know what to do. The surveyor observed the Resident begin to pace more quickly and rub his/her face with his/her hands. On 4/7/25 at 12:10 P.M., the surveyor observed Resident #79 repeatedly pace up and down the hall on the Lake Unit. The Resident made vocalizations as follows: - I don't know what to do. - I don't know where to go. - Jesus Christ, I'm just going to throw everybody out of this place (in a louder voice with a furrowed brow). During this time, the surveyor observed the Resident use his/her hands to rub his/her face. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 2:11 P.M., the surveyor observed Resident #79 pacing back and forth in the hallway on the Lake Unit. As Resident #79 passed by another resident, the other resident yelled out loudly. The surveyor then observed Resident #79 move away from the resident who yelled out. Resident #79 furrowed his/her brow and said, These people scare me. I can't be near them. The surveyor then observed Resident #79 to continue pacing the hall. On 4/7/25 at 2:14 P.M., the surveyor observed the following: -Resident #79 pacing in the hall on the Lake Unit. -Resident #79 spoke to staff and residents as he/she paced. -Resident #79 stopped next to another resident in the hall and began talking to the resident and asked the resident where he/she should go. -The other resident shook his/her head and used his/her right hand to make a waving motion toward Resident #79. -Nurse #2 was in the hallway at this time, standing at the med cart, in close proximity to and with her back toward Resident #79. -CNA staff were observed entering and exiting resident rooms in the same area where Resident #79 was. -No staff were observed interacting with Resident #79 during this time and no staff offered any diversional activity. -Resident #79 then stepped away from the resident who waved his/her hand and entered another resident's room and sat on the bed. On 4/8/25 at 11:45 A.M., the surveyor observed Resident #79 pacing in the hallway on the Lake Unit. At this time, the surveyor said hello to Resident #79. Resident #79 then looked at the surveyor and said, I'm just not sure where I am supposed to be. I'm just walking here. The Resident then shook his/her head while waving his/her hands in the air and continued to pace up and down the hallway. During an interview on 4/8/25 at 4:10 P.M., Nurse #2 said Resident #79 has Dementia and that the Resident paced and wandered on the Unit. Nurse #2 said Resident #79 did attend activities when they were scheduled, and that the Resident did not always stay at the activities due to his/her attention span being short and needing to stay busy. Nurse #2 said it was important to provide Resident #79 with redirection and diversional activities when the Resident paced and wandered. Nurse #2 said she knew the Resident would engage in tasks including folding towels/face cloths and word searches as the Resident had demonstrated this activity interest since being at the facility. Nurse #2 said that just instructing the Resident to sit was not an effective diversional activity. Nurse #2 said staff on the Unit should have attempted to provide diversional activities of interest to meet the needs of the Resident when the Resident paced the hall and inquired about what to do.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation, interviews, and record reviews, the facility failed to serve food that was palatable, and at a safe and appetizing temperature on one Unit ([NAME] Unit) out of three units observed. Findings include: During the initial screening process on 4/6/25 the following comments were made by Residents relative to the food served at the facility: -Hot food is always cold. Staff do not offer to reheat the food. -Hot food is never hot, it is always cold. Staff do offer to warm it up in microwave but then everything is over cooked. -Hot food is cold by the time it is served to him/her in his/her room. -Hot food comes lukewarm at times but is most often cold. -Never get hot meals. -Food comes lukewarm. During the Resident Council meeting held on 4/7/25 from 11:00 A.M. to 11:50 A.M., 12 of the 24 Resident's in attendance said the hot food served at the facility is often served cold. Review of the 1/28/25 Resident Council Meeting minutes indicated the Residents expressed food was cold. Review of the Resident Council Concern Follow-Up, dated 2/28/25, indicated the Food Services Directors' (FSD) response to the 1/28/25 concern of the food being cold: Cooks temp food before we start serving. On 4/8/25 at 9:18 A.M., the surveyor completed a test tray during the breakfast meal on the [NAME] Unit with the Regional FSD and the following temperatures and palatability was observed: -French toast 96.2 degrees Fahrenheit (F), cold to taste -Scrambled eggs 95.1 F, cold to taste -Sausage link 97.6 F, cold to taste -Ground sausage 94 F, cold to taste -Puree sausage 97.7 F, cold to taste (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview following the test tray observation, the Regional FSD said food should be palatable and at an appetizing temperature when it is served. The Regional FSD said he would expect hot food temperatures to be higher than what they were served at today. During an interview on 4/8/25 at 9:27 A.M., Nurse #1 said many residents in the facility complain regularly that the hot food is served cold and often times staff have to reheat the food in the unit microwave. During an interview on 4/8/25 at 1:17 P.M., the FSD said she was aware there have been concerns from the Residents in the past relative to cold food and she had done test trays but would need to look for the documentation. The FSD said food should be served a palatable temperature, hot food should be hot and cold food should be cold. The FSD said hot food does not leave the kitchen under 165 Fahrenheit (F) and the temperature should not fall significantly by the time the food reaches the units. During a follow-up interview on 4/8/25 at 2:22 P.M., the FSD provided documentation from one test tray completed for each meal on the Tapestry Unit on 8/6/24 and two test trays completed for the breakfast meal on the Tapestry Unit on 1/22/25. The FSD was unable to provide any documentation to show test trays had been done on the [NAME] Unit or that any test trays had been done after the Resident Council had voiced concerns about cold food during the 1/28/25 Resident Council Meeting. The FSD said one day of test trays in August 2024 and one day of test trays in January 2025 was not sufficient and test trays should have been on going to assess the reasons why food was being delivered cold to the units.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observations, interviews, and record reviews, the facility failed to provide preferred food items for one Resident (#60) out of a total sample of 26 residents. Specifically, the facility failed to provide the Resident's preferred food items for two consecutive meals when the preferred food items were to be provided, as indicated on the Resident's meal tray card. Findings include: Review of the facility's policy titled Food and Dining Service, dated April 2015, indicated the following: -In regard to likes and dislikes, whenever a resident expresses these, the nurse makes out a change in dietary needs form indicating the resident's feelings and this is forwarded to the Dining Services Department. -These preferences are recorded. Resident #60 was admitted to the facility in December 2023 with diagnoses including Diabetes and Protein-Calorie Malnutrition. Review of Resident #60's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. Review of Resident #60's Physician order, dated 4/2/25, indicated: -Magic Cup, two times a day for significant weight loss (wild berry). During an interview on 4/6/25 at 10:51 A.M., Resident #60 said he/she did not like the eggs served for breakfast at the facility and that he/she was supposed to get cottage cheese instead of the eggs. Resident #60 said the cottage cheese was not always provided. On 4/9/25 at 9:15 A.M., the surveyor reviewed Resident #60's meal tray card which indicated the following items were to be provided with the Resident's breakfast meal: -Fruit cup. -Cereal. -Cottage Cheese. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At this time, the surveyor observed the following on Resident #60's breakfast meal tray while the Resident was eating: -Two slices of raisin toast. -One muffin. -Eggs. The fruit cup, cereal, and cottage cheese were not present on the Resident's breakfast tray. During an interview at the time, Resident #60 said he/she had not been consistently getting preferred items on his/her meal trays, and he/she did not know why. On 4/9/25 at 12:55 P.M., the surveyor reviewed Resident #60's meal tray card which indicated the following items were to be provided with the Resident's lunch meal: -Fruit cup. -Cottage Cheese. -Magic Cup (berry flavor). At this time, the surveyor observed the following on Resident #60's lunch meal tray while the Resident was eating: -Chicken breast. -Rice. -Mashed potatoes with gravy on the side. -Jello. -Magic Cup (chocolate flavor). The meal tray did not include a fruit cup, cottage cheese and the preferred flavor Magic Cup. During an interview at the time, Resident #60 said he/she did not get the preferred items of a fruit cup and cottage cheese. Resident #60 said he/she was a picky eater and would not eat the chocolate flavored Magic Cup because the chocolate taste was fake. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/25 at 3:52 P.M., the Food Service Director (FSD) said Residents were supposed to receive the food items indicated on their meal tray tickets. The FSD said there were difficulties with ordering specific food items at times and that if the food items could not be obtained, the items would be substituted according to the resident's dietary needs and preferences. The FSD said she did not realize until that morning, after the breakfast tray line started, that the facility did not have cottage cheese. The FSD said she contacted the facility next door, and the facility next door provided cottage cheese before the breakfast tray line was completed. The FSD further said she does not know why the Resident did not receive cottage cheese since it had been obtained from another facility. The FSD also said that the facility had not been able to obtain berry flavored Magic Cups recently, so chocolate was being provided which is why Resident #60 received a chocolate flavored Magic Cup instead of berry flavored with lunch on 4/9/25. The FSD said she had not spoken with the Dietician relative to a substitute for the berry flavored Magic Cup or with the Resident relative to a possible other flavor preference. The FSD also said the facility did have fruit cups available for both the breakfast and lunch meals on 4/9/25, so the Resident should have received a fruit cup at both meals, as indicated on the Resident's meal tray card.

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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. 42761 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the facility failed to: -Maintain meal carts and coffee carts in a sanitary manner for meal service for residents. -Maintain the plate warmer in a clean and sanitary manner prior to housing plates in the plate warmer for meal service to residents. -Prepare coffee for residents in a sanitary manner. -Maintain the stand-up refrigerator and stand-up freezer in a clean and sanitary manner for food storage. Findings include: Review of the facility's Dietary Department Guidelines, dated January 2014, indicated the following: -The facility must store, prepare, and distribute food under sanitary conditions. -The Dietary Department will be maintained in a clean and sanitary manner to prevent food borne illness. -All areas of the Dietary Department will be cleaned on a regular schedule. -Logs/schedules will be kept of cleaning tasks as they are completed. On 4/6/25 between 7:20 A.M. and 8:00 A.M., the surveyor observed the following in the facility's Main Kitchen: -The meal carts were lined up with their doors open in the food service area. -The meal carts contained resident trays for breakfast including the residents' meal cards, napkins, and silverware. -The inside and outside walls and the floor of each meal cart had spattered, dried, white and brown debris. -Dietary Staff #1 filled two large, insulated, spouted beverage containers with coffee from the countertop coffee maker while the large, insulated, spotted beverage containers were on the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at the time, Dietary Aide #1 said he was filling the coffee containers for the residents' breakfast. -Two stacked milk crates covered with spattered, dried white, tan, and brown debris were positioned on the floor between the two large, insulated, spouted beverage containers while the container was being filled with coffee. -The openings of the spouts were positioned just above the floor. -A rolling two-shelf cart containing one crumpled surgical mask, one foam cup with a cover and straw that contained some liquid, and a meal tray containing partially eaten food items was next to the coffee station. -The plate warmer was on and held two separate stacks of plates in the food preparation area. -The top of the plate warmer had several areas white, tan, and brown debris. Some of the debris resembled food crumbs. -The stand-up refrigerator and stand-up freezer contained items for resident consumption and had spattered white and brown debris on the floors, inside walls, and outside doors. -The tray line began. On 4/6/25 at 8:09 A.M., the surveyor observed the first breakfast meal cart and three-shelf coffee cart on the Lake Unit as follows: -The breakfast meal cart contained resident meal trays. -The inside and outside walls and the floor of the meal cart had spattered, dried, white and brown debris. -The coffee cart held one large, insulated, spouted beverage container of coffee, a tray of coffee mugs, a container of hot water, packets of creamer, and packets of sugar. -The shelves and handle of the coffee cart had spattered, dripped, dried white and brown debris. -Staff served the residents their meals and hot drinks from the lunch meal cart and coffee cart. On 4/7/25 at 12:03 P.M., the surveyor observed the first lunch meal cart and a three-shelf coffee cart delivered to the Lake Unit from the facility Main Kitchen as follows: -The lunch meal cart contained resident meal trays. -The inside and outside walls and the floor of the meal cart still had spattered, dried, white and brown debris. -The coffee cart held one large, insulated, spouted beverage container of coffee, a tray of coffee mugs, a container of hot water, packets of creamer, and packets of sugar. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The shelves and handle of the coffee cart had spattered, dripped, dried white and brown debris. -Staff served the residents their meals and hot drinks from the lunch meal cart and coffee cart. On 4/7/25 at 12:24 P.M., the surveyor observed the second lunch meal cart on the Lake Unit, outside of the Lake Unit Dining Room. The Resident meal trays were being passed, and the meal cart was observed to have spattered, dried, white and brown debris on the inside walls, floor, and outside walls of the cart. During an interview on 4/7/25 at 3:00 P.M., with the Food Service Director (FSD) and Regional FSD, the FSD said there was no established cleaning schedule for items in the Main Kitchen and there were no logs maintained to indicate when cleaning in the Main Kitchen occurred. The FSD said the meal carts were supposed to be cleaned between meal services and as needed and that resident meals should not be stored in and served from meal carts that are not clean. The FSD said the stand-up refrigerator and freezer should not have spattered debris inside of them, where resident food is stored. The FSD also said the two-shelf cart containing a meal tray from a previous meal, surgical mask and foam cup should not have been in the Main Kitchen where the coffee was being made and that the cart should have been brought directly into the Dish Room. The FSD also said the plate warmer should not have had dried debris and crumbs on it while storing clean plates for resident use. The FSD said the two stacked milk crates in the coffee making area were there for dietary staff to place the two large, insulated, spouted beverage containers on while transferring coffee from the coffee maker into the container. The FSD said the purpose of the milk crates was to keep the beverage containers off the floor. The FSD said there was no evidence relative to when food storage and distribution items in the Main Kitchen were last cleaned and the Regional FSD said a cleaning schedule would need to be developed.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 42741 Based on observations, interviews, and record reviews, the facility failed to have an effective policy which addressed the reheating of residents' food brought into the facility in accordance with professional standards to ensure food safety. Specifically, the facility failed to provide a working thermometer and adequate reheating instructions to reheat residents' food brought into the facility by family to an internal temperature of 165 degrees Fahrenheit (F) to prevent potential foodborne illnesses. Findings include: Review of the facility policy titled Personal Food Policy, dated November 2016, indicated the following: -Facility staff will assist residents with accessing the nourishment kitchens, and with accessing and proper heating any personal food. -Staff will refer to the Reheating Chart (included with this policy) for specific reheating instructions. -Staff will use a thermometer to ensure the food is reheated adequately . -In order to assist family and visitors to understand safe food handling practice for microwave usage refer to the United States Department of Agriculture (USDA) Cooking Safely in the Microwave Oven (included). -Any questions regarding safe food handling should be directed to the nursing supervisor or food and nutrition supervisor. Review of the Reheating Chart included in the policy indicated the following: -Beverages >1 serving (1 cup) at room temperature - reheat 30-45 seconds -Note: Serving temperatures at point of service is 165 F Review of the USDA Cooking Safely in the Microwave Oven included in the policy failed to indicate specific instructions for the reheating of beverages. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 9:07 A.M., on the Tapestry Unit, the surveyor observed the Activities Director (AD) reheating a large paper cup with coffee in the kitchenette microwave. When the AD was done reheating the coffee she exited the kitchenette, started to walk to the unit dining room. The surveyor intervened and asked the AD about reheating the beverage. The AD said she had reheated the cup of coffee for a resident, that the resident's family member had brought in. The AD said she did not take the temperature of the coffee after she reheated it and was unsure what temperature a reheated beverage should be. The AD said if the beverage was too hot, it risked the Resident accidentally being burned. The surveyor and the AD to the kitchenette and located a thermometer on top of the microwave. The AD cleaned the thermometer and attempted to take the temperature of the coffee but the thermometer only read LL. The AD said she would need to speak with the kitchen staff to find out what temperature a reheated beverage should be and left the unit to go to the kitchen. During an interview on 4/7/25 at 9:18 A.M., the AD returned to the unit kitchenette with a new thermometer. The AD said Certified Nurses Aide (CNA) #5 told her reheated beverages should be between 160-180 F. The surveyor and the AD observed a sign posted on the unit kitchenette door which indicated the following: >Reheating Food in Microwave -Place food in microwave save plate/container. -Heat food item for 1 minute on high heat. -Use caution when handling plate/container. -Once heated place thermometer in the center of the food item. -The temperature should read 150-165 Fahrenheit .[sic] The AD said she was unsure if the sign was the proper instructions and temperature for reheating beverages and she had reheated the beverage to 99 F, which she showed the surveyor on the new thermometer she brought up from the kitchen. During an interview on 4/7/25 at 9:33 A.M., with the FSD and the Regional FSD, the Regional FSD said a Reheating Chart should be posted in the unit kitchenette and it was not. The FSD said the sign on the unit kitchenette door should indicate it was also for reheating beverages and it should be updated so staff was aware that it was correct instructions and temperature for reheating food and liquid. The FSD observed the thermometer that was initially in the unit kitchenette and the thermometer read LL and the FSD said the thermometer was in need of new batteries. The FSD said there was no regular process in the facility for staff to check if the thermometers on the units were in working order and someone should be checking to make sure they worked. Both the FSD and the Regional FSD said they were unaware of what training non-dietary staff are provided in regards to the reheating of food brought in by families. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 10:48 A.M., the Staff Development Coordinator (SDC) said during orientation the reheating of food brought in by families should be reviewed. The education should include proper reheating directions, temperature taking, and where to find the thermometer and instructions in the unit kitchenettes. The surveyor asked to be provided with documentation to show the AD and CNA #5 had education regarding the safe and proper reheating of food and the SDC said she would see if she could find documentation. During a follow-up interview on 4/8/25 at 3:53 P.M., the SDC said she was unable to provide any documentation to show the AD and CNA #5 had received any form of education regarding the safe and proper reheating of food brought in by families.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on record reviews, and interviews, the facility failed to ensure that Pneumococcal immunizations were offered and administered for two Residents (#12 and #20) of five applicable residents, out of a total sample of 26 residents. Specifically, the facility failed to: 1. Offer Pneumococcal immunization for Resident #12 when the Resident had been previously immunized and was not up-to-date with Pneumococcal immunization, which increased the Resident's risk for Pneumococcal disease. 2. Administer Pneumococcal immunization for Resident #20 when the Resident had been previously immunized, was not up-to-date with the Pneumococcal immunization, and consented to Pneumococcal immunization, which increased the Resident's risk for Pneumococcal disease. 3. Offer and administer Pneumococcal immunizations for each resident who was eligible for, and not up to date with Pneumococcal immunization, which increased each resident's risk for Pneumococcal disease. Findings include: Review of the facility policy titled Procedure of Pneumococcal Vaccination of Residents indicated the following: -Over age 50, prior vaccination received one dose of PCV13: recommend pneumococcal vaccine 1 dose of PCV20 or 1 dose of PCV21 at least 1 year after the last PCV13 dose. 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 PCV13 only has been administered, administer PCV20 or PCV21 at least one year later. -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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225283	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webster Manor Rehabilitation & Health Care Center	745 School Street Webster, MA 01570

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If PCV20 or PCV21 is used, a dose of PPSV23 is not indicated. 1. Resident #12 was admitted to the facility in January 2023 and was over the age of 50. Review of Resident #12's Resident Admission Vaccination Education Form, dated 1/11/23, failed to indicate documentation the Resident and/or Resident Representative had been offered a pneumonia vaccine, educated and provided with written information on the risks and benefits of the pneumonia vaccine, or if they consented or declined to have/update their pneumonia vaccinations. Review of the Massachusetts Immunization Information Sheet (MIIS) for Resident #12 provided by the facility indicated the following: -Resident #12 received the pneumococcal conjugate vaccine (PCV) 13 on 9/22/17. -Resident #12 received an unspecified Pneumococcal vaccine on 8/3/09. During an interview on 4/9/25 at 11:30 A.M., the Director of Nursing (DON) said pneumonia vaccination and education should have been offered at the time the Resident was admitted to the facility and she would need to look and see if Resident #12 was eligible and if so if he/she had been offered pneumococcal vaccination at the time he/she was admitted to the facility. During a follow-up interview on 4/9/25 at 12:21 P.M., the DON said Resident #12 was not up-to-date on the current recommended pneumonia vaccination and she was unable to find any documentation the Resident and/or Resident Representative was offered an updated pneumonia vaccine since being admitted to the facility. 42761 2. Resident #20 was admitted to the facility in February 2023 and was greater than [AGE] years of age. Review of Resident #20's clinical record indicated the following: -The Resident received one dose of PCV13 on 5/10/11. -A signed consent dated 10/2/24, for the Resident to receive the PCV20. Further review of Resident #20's clinical record failed to indicate any evidence the PCV20 immunization had been administered to the Resident or that the immunization was medically contraindicated for the Resident. 3. Review of the facility's Resident Pneumococcal Vaccine Initial Audit, printed 4/9/25, indicated the following: -A total of 75 residents in the facility eligible for Pneumococcal immunization were not up-to-date with Pneumococcal immunization. -Updated Pneumococcal immunizations had not yet been offered to the 75 residents. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/25 at 2:50 P.M., the Infection Preventionist (IP) in Training said that she was newly hired into the Infection Prevention role at the facility and that the designated IP was providing her with training for the position. The IP in Training said that there was no tracking in place relative to resident Pneumococcal immunizations when she started working in Infection Prevention at the facility, so she and the IP completed an audit of all residents' Pneumococcal immunization status and eligibility on 3/28/25. The IP in Training said Resident #20 was not up-to-date for Pneumococcal immunization and had consented to receive the Pneumococcal immunization, but an updated Pneumococcal immunization had not been administered for the Resident. The IP in Training also said the facility did have some supply of Pneumococcal immunization available for administration to residents. The IP in Training further said the facility had not yet offered any of the residents identified as not up-to-date for the Pneumococcal immunization on the Resident Pneumococcal Vaccine Audit with an updated Pneumococcal immunization.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on record reviews, and interview, the facility failed to ensure an updated COVID-19 immunization was administered for one Resident (#20) of five applicable residents, out of a total sample of 26 residents. Specifically, the facility failed to administer an updated 2024-2025 COVID-19 immunization for Resident #20 when the Resident had been previously immunized, was not up-to-date with the COVID-19 immunization, and consented to receive the updated 2024-2025 COVID-19 immunization, increasing the Resident's risk for COVID-19 infection. Findings include: Review of the facility's policy titled MA Coronavirus (COVID-19), undated, indicated the following: -The facility follows the professional standards and recommendations set forth by the Centers for Disease Control (CDC), CMS, and State health care agencies regarding Coronavirus. -The facility will follow all CDC and State specific guidance for vaccination . Review of the CDC guidance titled Staying Up to Date with COVID-19 Vaccines, dated 1/7/25 and found at https://www.cdc.gov/covid/vaccines/stay-up-to-date.html indicated the following: -It is especially important to get your 2024-2025 COVID-19 vaccine if you are: >ages 65 and older. >are at high risk for severe COVID-19. >Are living in a long-term care facility. -Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine. -COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. Resident #20 was admitted to the facility in February 2023 with diagnoses including Acute Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease (COPD), and Asthma. Review of Resident #20's clinical record indicated the following: -The Resident was greater than [AGE] years of age. -The Resident's most recent dose of COVID-19 immunization was 11/3/22. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A signed consent, dated 10/2/24, for the Resident to receive the 2024-2025 COVID-19 immunization. Review of the facility's Resident COVID-19 Immunization Audit, undated, indicated the following relative to Resident #20's COVID-19 immunization status: -The Resident's most recent does of COVID-19 immunization was received by the Resident on 11/3/22. -The Resident was not up to date for COVID-19 immunization. During an interview on 4/10/25 at 11:25 A.M., the IP in Training said that she was newly hired into the Infection Prevention role at the facility and that the designated IP was providing her with training for the position. The IP in Training said Resident #20 was not up-to-date for COVID-19 immunization and had consented to receive the 2024-2025 COVID immunization, but the updated COVID-19 immunization had not been administered for the Resident. The IP in training said the updated COVID-19 immunization should have been administered to Resident #20 when consent was obtained for the immunization to be administered.