STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225290	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haverhill Rehabilitation and Healthcare Center	126 Monument Street Haverhill, MA 01832

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to respond to concerns voiced by residents in the monthly resident council meetings. Specifically, the facility failed to act promptly upon the grievances of the issues identified during the monthly resident council meetings. Findings include: A review of the facility policy titled 'Resident Council' with a revision date of February 2021 indicated the following: -The facility supports residents' rights to organize and participate in the resident council. -The purpose of the resident council is to provide a forum for discussion of concerns and suggestions for improvement. -Council meetings are scheduled monthly or more frequently if requested by residents. The date, time and location of the meetings are noted in the activities calendar. -A Resident council response form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item (s) of concern. A review of the Resident council minutes for the months of February, March and April 2025 indicated the following: -2/3/25-Nursing: Aides and nurses are still on their cell phones, especially service people, but also ours. The call lights are taking too long to be answered on all floors, all shifts. [sic] -3/6/25-Nursing: Nurses continue using their cell phones and ear buds on their med carts. Aides on Pentucket and [NAME] on 7-3 and 3-11 are speaking Spanish in the resident rooms and in the halls. Aides are on their phones in resident bathrooms. [sic] -4/7/25-Nursing: Residents in room [ROOM NUMBER] said they have to wait for long periods of time for call lights to be answered. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a Resident council meeting held on 4/23/25 at 11:08 A.M., 16 out of 16 residents in attendance said Aides and Nurses are still using their cell phones and using ear buds while working on the units. They said call lights are taking more than an hour to be answered, and staff are speaking Spanish in front of them. The residents said they have brought up these concerns in resident council meetings, but they are not being addressed. A review of the Resident Council Record failed to indicate supporting documentation for resolutions for the above resident concerns from the monthly resident council meetings from February-April 2025. During an interview on 4/23/25 at 3:08 P.M., the Activities Director said she runs resident council meetings every month and writes the Resident council minutes. The Activities Director said any concerns brought up by the residents in the resident council meetings should be reported to the Administrator so he can get the concerns addressed timely and get resolutions. The Activities Director said the concerns should be reported to the Administrator after each Resident council meeting every month. The Activities Director said after the resolutions are obtained, the supporting documentation should be filed in the Resident council binder. The Activities Director said she did report these concerns to the previous facility Administrator. During an interview on 4/23/25 at 2:06 P.M., the Administrator said all Resident Council concerns should be reported to him monthly so he can have the concerns/grievances addressed in a timely manner. The Administrator said he could not locate any resolutions about the concerns from the Resident Council meetings from February-April 2025 from the previous facility Administrator. The Administrator said the Resident Council concerns should be addressed with a resolution obtained each time they are brought up by the residents in the meeting. The Administrator said if the residents bring up concerns monthly, they should be addressed monthly. The Administrator said the supportive documentation of the resolutions obtained after the concerns have been addressed should be filed with the Resident Council minutes.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 45343 Based on interview and record review, the facility failed to provide a prompt resolution or follow up on a grievance for one Resident (#41) out of a total sample of 29 residents. Specifically, the facility failed to follow up on a grievance regarding a lost hearing aid. Findings Include: Review of the facility policy titled Resident and Family Grievances, dated 3/1/25, indicated the following: -It is the policy of this facility to support each resident's and family member rights to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. -Prompt efforts to resolve include the facility acknowledgement of complaint/grievance and actively working toward resolution of that complain/grievance. -A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (Long Term Care) facility stay. -The grievance official, or designee, will keep the resident appropriately apprised of progress towards the resolution of the grievances. -For investigations regarding allegations of neglect, abuse, injuries of unknown source, and/or misappropriation of resident property, a report of the investigative results will be submitted to the State Survey Agency, and or other officials in accordance with State law, within five working days of the incident. Review of the grievance book indicated a grievance dated 4/23/25, which indicated the following grievance from Resident #41: - Patient stated he/she is missing right hearing aid, dated 2/15/25. - Social worker interview Resident #41 who said he/she is missing her left hearing aid. At the time the social worker spoke to him/her at approximately 10:30 A.M., he/she had old left side hearing aid in, Resident #41 said he/she has a right hearing aid, but it whistles, note dated 2/17/25. - Confirmed on 2/20/25 with Resident and family missing left hearing aid. Wants to see audiologist here and get replacement, note dated 2/20/25. - Update: Referred to Health Drive, awaiting signed consent, note undated. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at approximately 11:00 A.M., during Resident Council Meeting, Resident #41 expressed to a surveyor that he/she was missing their hearing aid. The surveyor observed Resident #41 wearing a left hearing aid only and positioned herself on his/her left side for the duration of the meeting. During an interview on 4/23/25 at 1:40 P.M., Resident #41's daughter confirmed Resident was missing his/her left hearing aid, not her right, and it went missing shortly after the Resident was admitted to the facility in February. Resident #41's daughter said the Resident is currently wearing his/her old left hearing aid but it does not work very well. Resident #41's daughter said she filed a grievance report at the time the left hearing aid went missing but never heard anything after that about getting a replacement. Resident #41's daughter said she was just asked to fill out another consent form and dropped it off at the desk. Review of Resident #41's physician's orders indicated the following: CONSULT: Dentist, Podiatrist, Optometrist, Audiology Consult as needed, dated 2/12/25. Review of Resident #41's medical record failed to indicate the lost left hearing aid, or the Resident was seen by the audiologist. During an interview on 4/24/25 at 8:58 A.M., the Administrator said he was not aware of Resident #41's missing hearing aid. The Administrator said he would expect when a grievance is filed regarding a lost hearing aid, there would be an investigation, and the facility would work with the Resident and family to get the Resident a replacement hearing aid.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to develop and/or implement care plans for two Residents (#68 and #67) out of a sample of 29 Residents. Specifically, 1. For Resident #68, the facility failed to develop a substance use disorder care plan. 2. For Resident #67, the facility failed to implement geri sleeves (skin protectors) to bilateral arms and legs. Findings include: A review of the facility policy titled 'Safety for Residents with Substance Use Disorder' implemented on 3/1/25 indicated the following: -It is the policy of this facility to create an environment that is free of accident hazards as possible, for residents with a history of substance use disorder. -Care planning interventions will address risks by providing appropriate diversions for residents and encouraging residents to seek out facility staff to discuss their plan of care, including discharge planning, rather than leaving to seek out substances which could endanger the resident's health and/or safety. 1. Resident #68 was admitted to the facility in December 2023 with diagnoses including major depressive disorder, opioid abuse, PTSD (post-traumatic stress disorder) and alcoholic cirrhosis of liver without ascites. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15, indicating moderate cognitive impairment. A review of Resident #68's social service history and evaluation dated 1/5/24 indicated the following: -Psycho-social assessment, ETOH (Alcohol), Yes-Alcoholic Cirrhosis, Opioid Abuse. A review of Resident #68's care plan failed to indicate care plans for a history of alcohol abuse and opioid abuse that identified interventions, triggers and a plan for support for the Resident. During an interview and medical record review on 4/24/25 at 9:09 A.M., the Social Worker said the Resident should have care plans developed for a history of alcohol abuse and opioid abuse. 45343 2. Resident #67 was admitted to the facility in January 2025 with diagnoses that included Type 2 Diabetes Mellitus, myexedema coma (thyroid hormone regulation disruption), bipolar, and depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #67's most recent Minimum Data Set (MDS) dated [DATE], revealed that he/she had a Brief interview for Mental Status (BIMS) score of 8 out of a possible 15, indicating moderate cognitive impairments. Further review of the MDS indicated Resident #67 required total dependence with personal hygiene and is at risk for pressure ulcers. On 4/22/25 at 8:12 A.M. and 10:30 A.M., on 4/23/25 at 7:00 A.M., 8:12 A.M., and 12:30 P.M., and on 4/24/25 at 7:54 A.M. and 8:40 A.M., Resident #67 was observed lying in his/her bed. Resident #67 was not wearing his/her bilateral upper and lower extremity geri-sleeves. Review of Resident #67's physician order, dated 3/1/25, indicated the following: Geri-sleeves to lower arms and legs at all times. Remove for care. Review of Resident #67's nursing progress notes for the past 30 days failed to indicate the Resident refused bilateral upper and lower extremity geri-sleeves. During an interview on 4/24/25 at 8:11 A.M., Resident #67 said he/she used to wear sleeves on his/her arms and legs but has not worn them in about a month. During an interview on 4/24/25 at 8:24 A.M., Nurse #3 said she was not aware if Resident #67 should be wearing geri-sleeves and has not seen them in his/her room. Nurse #3 said the geri-sleeves should be worn as ordered by the physician. During an interview on 4/24/25 at 8:38 A.M., Nurse #2 said she thought Resident #67 came in with orders for booties but unsure if there were orders for geri-sleeves. Nurse #2 said the physician's order should be followed and any refusals should be documented in the medical record. During an interview on 4/24/25 at 9:01 A.M., the Administrator said he expects the geri-sleeves to be worn as ordered and documented in the nurse's note if the resident refuses.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 36797 Based on observation, record review and interview, the facility failed to ensure one Resident (#154) received care in accordance with professional standards of practice, out of a total sample of 29 residents. Specifically, for Resident #154 the facility failed to obtain physician's orders for the placement and care of a Midline (an intravenous (IV) line inserted into the upper arm to deliver medications and fluids over a longer period of time than a standard IV). Findings include: Review of the facility policy titled Midline/Extended Dwell Catheter, dated January 2022 indicated a prescriber's order is required for a vascular access device. Resident #154 was admitted to the facility in April 2025 with diagnoses including urinary tract infection, recent fall and high blood pressure. Review of the document titled Infusion Support Systems and dated 4/16/25, indicated that a Midline was placed in Resident #154's basilic vein of the right upper arm at 11:50 A.M. Review of the physician's orders dated April 2025 failed to indicate a physician's order for the placement of a Midline. Further review failed to indicate an order for the care of the Midline. Review of the treatment administration record dated April 2025 failed to indicate the use of a Midline or for the care of a Midline. Review of the care plan failed to indicate the use of a Midline. During an interview on 4/23/25 at 12:23 P.M. Unit Manager #1 said she could not find a physician's order for the Midline or for the care of the Midline. During an interview on 4/23/25 at 12:29 P.M. the Director of Nursing said that there should be a doctor's order for the placement of a Mid Line and how to care for the Midline.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to obtain rehab services to maintain one Resident's (#88) activities of daily living (ADL) out of a total sample of 29 residents. Findings include: Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated March 2018 indicated the following: - Residents will be provided with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). - Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. - A resident's ability to perform ADL's will be measured using clinical tools, including the MDS (minimum data set) Review of the facility policy titled Patient Care Management- Evaluation and Treatment, dated 9/8/21, indicated the following: - All patients identified as needing an assessment of functional status and potential to benefit from rehabilitation services, are to be evaluated to determine the appropriate plan of care. - Evaluations are initiated within 24 hours, or per facility policy, of receipt of physician's order or authorization. - Therapy intervention is based on the initial evaluation, with changes to the treatment plan based on an ongoing assessment of the patient requiring physician orders. Resident #88 was admitted in August 2024 with diagnoses including anxiety, dementia, and unsteadiness on feet. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #88 scored a 10 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. Review of the MDS indicated Resident #88 requires substantial/maximal assistance to dependence with activities of daily living. Review of the physical therapy discharge summary for Resident #88, dated 9/6/24, indicated Resident #88 was discharged with the following: - Roll left and right- Setup or clean-up assistance - Sit to Stand- Supervision or touching assistance - Chair/bed to chair transfer- Supervision or touching assistance (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Toilet transfer- Partial/moderate assistance - Tub/shower transfer- Partial/moderate assistance Review of the nursing progress note, dated 11/20/24, indicated the following: Discussed residents care needs with interdisciplinary team. Decline in ADL's noted since last MDS completion, decided will change to a significant change MDS. Resident #88 is awake/alert today, oriented to self. Sometimes understands, staff dependent for care needs, oversight and coaxing at meal time. Pleasantly confused as is baseline. Review of the care task sheet for November 2024 indicated Resident #88 required the following: - Toileting- Substantial/maximal assistance to dependence - Shower/bathing- Substantial/ maximal assistance to dependence - Roll left and right- Substantial/maximal assistance to dependence - Sit to Stand- Substantial/maximal assistance to dependence - Toilet Transfer- Varies from supervision to dependence Review of the medical record and therapy notes failed to indicate that Resident #88 was evaluated by therapy after a decline in activities of daily living. During an interview on 4/23/25 at 9:01 A.M., the Director of Rehab said he was not here at the time of Resident #88's decline, but if there is a decline in a Resident's ability, then the rehab department should be notified so a screen and evaluation can be done to determine if a Resident is appropriate for rehab services. The Director of Rehab said he could not find a screen or evaluation for Resident #88 after his/her decline in ADL's in November 2024.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on record review and interview, the facility failed to provide services to maintain adequate hearing for one Resident (#41) out of a total sample of 29 residents. Specifically, the facility failed to assist the Resident with replacing his/her lost hearing aid. Findings include: Resident #41 was admitted to the facility in February 2025 with diagnoses including left femur fracture, anemia, and anxiety. Review of Resident #41's most recent Minimum Data Set (MDS), dated [DATE], indicates the Resident has a Brief Interview for Mental Status (BIMS) Exam score of 13 out of 15 which indicates he/she is cognitively intact. The MDS also indicates Resident #41 requires substantial/maximal assistance from staff for functional daily tasks. On 4/23/25 at approximately 11:00 A.M., during Resident Council Meeting, Resident #41 expressed to a surveyor that he/she was missing their hearing aid. The surveyor observed Resident #41 wearing a left hearing aid only and positioned herself on his/her left side for the duration of the meeting. During an interview on 4/23/25 at 1:40 P.M., Resident #41's daughter confirmed the Resident was missing his/her left hearing aid, that it went missing shortly after the Resident was admitted to the facility in February, and Resident #41 is currently wearing an old left hearing aid that doesn't work very well. Resident #41's daughter said she filed a grievance report at the time but never heard anything after that about getting a replacement. Resident #41's daughter said she was just asked to fill out another consent form and dropped it off at the desk. Review of Resident #41's physician's orders indicated the following: CONSULT: Dentist, Podiatrist, Optometrist, Audiology Consult as needed, dated 2/12/25. Review of Resident #41's medical record failed to indicate the Resident was seen by the audiologist. During an interview on 4/24/25 at 8:48 A.M., Nurse #2 said the social worker, the director of nursing and the unit manager would work together to setup audiology services and to facilitate getting the Resident a replacement hearing aid. During an interview on 4/24/25 at 8:58 A.M., the Administrator said he would expect Resident #41 to be seen by an audiologist and be provided with a replacement hearing aid.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on observation, record review and staff interviews, the facility failed to ensure that one Resident (#67) out of a total sample of 29 residents, received proper foot care (Podiatry services). Findings include: Resident #67 was admitted to the facility in January 2025 with diagnoses that included Type 2 Diabetes Mellitus, myexedema coma (thyroid hormone regulation disruption), bipolar, and depression. Review of Resident #67's most recent Minimum Data Set (MDS) dated [DATE], revealed that he/she had a Brief interview for Mental Status (BIMS) score of 8 out of a possible 15, indicating moderate cognitive impairments. Further review of the MDS indicated Resident #67 required total dependence with personal hygiene. Review of the facility policy titled Activities of Daily Living (ADL's), dated 3/1/25, indicated the following: -The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. -Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming, and oral care. -The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on comprehensive assessment. Review of the facility policy titled Nail Care, dated 3/1/25, indicated the following: -The purpose of this procedure is to provide guidelines for the provision of care to resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines: -Identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke. -If a resident has a toe infection, diabetes mellitus, neurological disorder, renal failure, or PVD (peripheral vascular disease), toenail trimming should be performed by a physician or practitioner. During an observation and interview on 4/23/25 at 8:10 A.M., Resident #67's toenails were observed as being long, jagged and yellow. The Resident said he/she has not had their toenails cut and has not been seen by a podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67's medical record failed to indicate the Resident had ever been seen by podiatry. Further review of the medical record indicated Resident #67 signed a consent form for podiatry services on 1/23/25. During an interview on 4/24/25 at 8:26 A.M., Nurse #3 said when the nurse or Certified Nursing Assistant (CNA) observe long toenails, they will notify the unit secretary, and the resident will be added to the next scheduled podiatry visit. Nurse #3 said she was not aware Resident #67 needed his/her toenail cut. During an interview on 4/24/25 at 9:01 A.M., the Administrator said he would expect residents who need their toenails cut to be seen by the podiatrist as needed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to follow up on significant weight changes for one Resident (#94) out of a total of 29 residents. Findings include: Resident #94 was admitted in February 2025 with diagnoses including dysphagia (difficulty chewing/swallowing) Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #94 could not participate in the Brief Interview for Mental Status exam due to severe cognitive impairment. Review of the care plan for Resident #94 indicated Resident #94 is at altered nutrition and hydration status due to cerebral infarct and cognitive deficits. The care plan did not indicate any interventions related to nutrition. Review of the care plan indicated Resident #94 requires a tube feeding related to dysphagia. Review of the weight record for Resident #94 indicated the following weights: * 02/24/25 - 172 pounds * 03/06/25 - 151.1 pounds (12% significant loss from previous weight) * 03/10/25 - 172.1 pounds (12% significant gain from previous weight) * 03/13/25 - 149 pounds (13% loss from previous weight) * 03/18/25 - 160.5 pounds (7% gain from previous weight) * 03/19/25 - 159.3 pounds * 04/09/25 - 159.3 pounds Review of the weights indicated Resident #94's weights fluctuated significantly from 3/6/25 to 3/18/25. Review of the initial nutrition assessment, dated 3/3/25, indicated Resident #94's weight was 172 pounds with recommendations to monitor intake, weight, labs, and skin integrity. During an interview on 4/24/25 at 8:17 A.M., the Dietitian said that she is usually notified in morning meeting of significant weight changes. The Dietitian said she would expect to be notified of any change of 5 pounds or more so she could evaluate the Resident. The Dietitian said that the weights entered into the electronic medical record should be accurate and that the nurses should re-weigh a resident if there is a large fluctuation in weight. The Dietitian said that she would typically write a note for any resident she saw for a significant weight change, but was not notified of the weight changes. (continued on next page)

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Haverhill Rehabilitation and Healthcare Center	126 Monument Street Haverhill, MA 01832

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record failed to indicate that the dietitian, physician, or nursing staff followed up on the significant weight changes.

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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** 36797 Based on observations, interviews, and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#97) out of sample of 29 residents. Specifically, 1. For Resident # 27, the facility failed to include a physician's order for the use of oxygen in the medical record and have oxygen set at a specified flow rate. Findings include: Review of the facility policy titled Oxygen Administration dated revised October 2010, indicated to verify there is a physician's order for the administration of oxygen before applying. Further review indicated to review the resident's care plan to assess for any special needs of the resident. 1. Resident #97 was admitted to the facility in April 2025 with diagnoses including asthma, anxiety and malnutrition. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #97's cognition is moderately impaired as evidenced by a scored 10 out of 15 on the Brief Interview for Mental Status assessment. Further review indicated that Resident #97 requires partial to maximal assistance with activities of daily living. On 4/22/25 at 8:10 A.M. the surveyor observed Resident #97 sitting on the edge of the bed receiving oxygen (O2) via nasal cannula at 1 L/min (liters per minute). On 4/23/25 at 7:35 A.M. the surveyor observed Resident #97 sitting on the edge of the bed receiving O2 via nasal cannula at 1 L/min (liters per minute). Review of the physician's orders dated April 2025 failed to indicate an order for the administration of oxygen. Review of the care plan failed to indicate a care plan was developed for the use of oxygen. During an interview on 4/23/25 at 9:47 A.M. Nurse #1 said Resident #97 should have had a physician's order and a care plan developed for the use of oxygen. During an interview on 4/23/25 at 12:29 P.M. the Director of Nursing said that there should be a physician's order and a care plan developed for the use of oxygen.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to develop a personalized Post Traumatic Stress Disorder (PTSD) care plan for one Resident #68 out of a sample of 29 Residents. Specifically, the facility failed to develop a care plan for the Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the Resident. Findings include: A review of the facility policy titled 'Trauma Informed Care implemented on 3/1/25 indicated the following: -It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing and/or re-traumatization. -The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others. -The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which retraumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. Resident #68 was admitted to the facility in December 2023 with diagnoses including major depressive disorder, opioid abuse, PTSD and alcoholic cirrhosis of liver without ascites. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 indicating moderate cognitive impairment. A review of a brief trauma questionnaire dated 1/5/24 indicated the following: -Serious accident at work, home or during recreational activities-it happened to the Resident personally. -Exposure to toxic substance (for example, dangerous chemicals, radiation)-it happened to the Resident personally. -Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)-it happened to the Resident personally. -Any other very stressful event or experience- it happened to the Resident personally. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plans initiated 3/26/24, 6/5/24 and 4/14/25 respectively indicated the following: -Potential for alteration in mood related: Resident has a diagnosis of Anxiety disorder, PTSD. [sic] -Resident receives antipsychotic medication related: Resident has a diagnosis of Anxiety Disorder, PTSD. [sic] -Resident is at risk of skin breakdown related to decreased mobility and lack of motivation at times, PTSD. [sic] Further review of the care plans above failed to indicate that the Resident's traumatic experiences had been documented with interventions to mitigate triggers. During an interview and medical record review on 4/24/25 at 9:09 A.M., the Social Worker said the Resident's PTSD care plan was not personalized. She said the Resident's PTSD care plan should include all the traumatic events identified in the brief trauma questionnaire, identify triggers which may re-traumatize the Resident and identify ways to reduce the exposure to the triggers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, interviews and policy review, the facility failed to ensure staff stored drugs and biological's in accordance with State and Federal requirements. Specifically; the facility failed to ensure medications were not left at the bedside for one Resident (#97) out of a total of 29 sampled residents. Findings include: Review of the facility policy titled Medication Labeling and Storage dated 2001, indicated that the nurse is responsible for maintaining medication storage . in a clean, safe and sanitary manner. Further review indicated that medications stored at bedside are to be kept locked in a secure container. Resident #97 was admitted to the facility in April 2025 with diagnoses including asthma, anxiety and malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #97's cognition is moderately impaired as evidenced by a score of 10 out of 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. Further review indicated that Resident #97 requires partial to maximal assistance with activities of daily living. On 4/22/25 at 7:50 A.M., the surveyor observed an albuterol inhaler (used to treat asthma) on Resident #97's over the bed table. Resident #97 was in his/her room and said that he/she uses it sometimes. On 4/22/25 at 1:34 P.M., the surveyor observed an albuterol inhaler on Resident #97's over the bed table. Resident #97 was not in the room and the room door was open. On 4/23/25 at 7:35 A.M., the surveyor observed an albuterol inhaler on Resident #97's over the bed table. Review of the physician's orders dated April 2025 failed to indicate an order for self administration of medications. Review of the care plan failed to indicate a plan of care was develope for the self administration of medications. Review of the facility document titled Atlas- NSG: Admission/Readmission Evaluation - V 7 - - V 2, dated 4/5/25 indicated that Resident #97 did not want to self administer medications. Review of the medical record failed to indicate Resident #97 was assessed for the ability to self administer medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 9:47 A.M., the surveyor and Nurse #1 observed an Albuterol inhaler on Resident #97's over the bed table. During an interview on 4/23/25 9:47 A.M. Nurse #1 said Resident #97 should not have an inhaler at bedside. During an interview on 4/23/25 9:47 A.M. Resident #97 said one of the staff left it for him/her.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to follow a physician's order for a fluid restriction for one Resident (#46) out of a total sample of 29 residents. Findings include: Review of the facility policy titled Fluid Restriction, dated 3/1/25, indicated the following: - It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders. - The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. - Water will not be provided at bedside unless calculated into the daily total fluid restriction. - The resident has the right to refuse the fluid restriction, and if refused, documentation should support the reason for the refusal, the education of the risks and benefits, and any supporting documentation of the resident's continued refusal, assessment for any changes in condition related to the refusal, and the notification of the physician about the resident's refusal. Resident #46 was admitted in May 2024 with diagnoses including heart failure, end stage renal disease, and dependence on renal dialysis. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #46 scored a 13 out of a possible 15 on the Brief Interview for Mental Status, indicating intact cognition. Review of the MDS indicated Resident #46 requires dialysis. During an observation and an interview on 4/24/25 at 7:32 A.M., Resident #46 was lying in bed and had a styrofoam cup next to him/her with liquid inside, as well as one 16 oz and two 8 oz bottles of water at his/her bedside. Resident #46 said he/she is aware of his/her fluid restriction and tries to follow it as best as he/she can. Review of the physician's orders indicated Resident #46 required a 1,200 milliliter (ml) fluid restriction per every 24 hours. The breakdown of the fluid restriction for nursing is indicated as follows: - 250 ml on day shift - 200 ml on evening shift - 150 ml on night shift Review of the medical record indicated that the remaining 600 ml are provided by dietary. Review of Resident #46's tray tickets indicated he/she receives 600 ml total for the day from the dietary department. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for April 2025 indicated Resident #46 was receiving 237 ml of a nutritional supplement daily from 4/1/25 to 4/17/25 from nursing. Review of the Medication Administration Record (MAR) for April 2025 indicated Resident #46 received the following amount of fluid for the day between nursing and dietary: - 1,487 ml on 4/2/25 - 1,357 ml on 4/5/25 - 2,217 ml on 4/6/25 - 2,537 ml on 4/13/25 - 1,537 ml on 4/18/25 During an interview on 4/24/25 at 8:21 A.M., the Dietitian said that she would expect nursing to monitor if the Resident was consuming fluids out of the fluid restriction range and would at least expect to have a conversation with the Resident and his/her dialysis center if the fluid restriction could not be met. The Dietitian was unaware that Resident #46 was receiving fluids outside of his/her fluid restriction. During an interview on 4/24/25 at 9:29 A.M., the Director of Nursing said that she would expect the fluid restriction to be followed as ordered for Resident #46.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to maintain an effective way to track and measure performance of the Quality Assurance and Performance Improvement (QAPI) program. Findings include: Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI), dated 3/1/25, indicated the following: - It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. - The QAPI plan shall address the following elements: * Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: * Tracking and measuring performance. * Establishing goals and thresholds for performance improvements. * Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. - The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: - Data collection and analysis at regular intervals. Review of the QAPI minutes for March 2025 indicated the following: - Topic : Antipsychotic Use Report - Discussion: 22 Residents utilizing antipsychotic medications - Recommendations/ Actions: The next meeting for psych rounds will be scheduled 4/29/25 at 2 P.M. Review of the QAPI minutes for April 2025 indicated the following: - Topic: Pharmacy - Discussion: Triggering High (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Recommendations/Actions: Putting a plan in place with Medical Director PRN antipsychotics. - Topic: Maintenance Repairs - Discussion: Discussing a timeframe - Recommendations/Actions: Outside vendors, help from other facilities, ongoing rounds/repairs - Topic: Falls - Discussion: 15 falls in March 2025. 6 on [NAME] (1:45 pm-4:45 pm), 5 on Pentucket (7:10 am, 7p3-10pm [sic]), and 4 on [NAME] (8:30 am, 2 pm, dinnertime. - Recommendations/Actions: Utilizing day rooms more, what is working?, what is not? Review of the minutes and QAPI plan failed to indicate any measures of tracking QAPI performance and/or outcomes of QAPI performance. During an interview on 4/24/25 at 1:35 P.M., the Administrator said that he follows performance through morning meetings and the Director of Nursing keeps track of falls. The Administrator said he keeps identified issues on the QAPI plan until compliance is achieved or the target goal. The Administrator could not say what the compliance or target goal was for the issues identified on the QAPI plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 36797 Based on record review and interview the facility failed to maintain a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents. Findings include: Review of the facility policy titled Infection Prevention and Control Program, dated revised 2/1/24, indicated that the facility maintains an infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Further review indicated a system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents . Review of the facility's infection control line listing dated January 2025 indicated that the name of the resident, the suspected infection, the signs and symptoms a resident is exhibiting, the dates of treatment, the antibiotic prescribed and the name of the organism is documented. Further review indicated that for 10 out of 23 listed infections the signs and symptoms column was blank. Review of the facility's infection control line listing dated February 2025 indicated that 13 out of 23 listed infections the signs and symptoms column was blank. Further review indicated that for 4 out of 8 urinary tract infections the organism column was blank. Review of the facility's infection control line listing dated March 2025 indicated that 9 out of 20 suspected infections the signs and symptoms column is blank. Further review indicated that 3 out 6 suspected urinary tract infections had no listed organism. During an interview on 4/24/25, at 1:49 P.M., the Infection Preventionist (IP) said that the documents she handed the surveyor were the past three months of infection surveillance line listing the facility completed. The IP said that the facility uses the Mcgeers criteria for determining if the suspected infection qualifies for treatment. She then said that the Mcgeers criteria requires a specific number of signs and symptoms for each type of suspected infection to qualify as a treatable infection. The IP then said that the facility does not document the outcomes of treatment to see if the treatment was effective. The IP said that she does not look for trending to determine if there is a particular group of rooms or staff member that would be responsible for the spread of infections. The IP said that all of the columns in the monthly line listings should be complete in order to accurately track the infections in the building. The IP said that the line listings should include outcome and trends should be identified and acted upon.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 36797 Based on record review, policy review and interview the facility failed to implement an Antibiotic Stewardship Program to promote and monitor the appropriate use of antibiotics. Findings include: Review of the facility policy titled Antibiotic Stewardship -Review and Surveillance of Antibiotic Use and Outcomes dated revised December 2016 indicated that antibiotic usage and outcome data will be collected and documented using a facility approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. Further review indicated that the IP (infection Preventionist) will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. Further review indicated that the outcome of the use of the antibiotic will be reviewed and documented, but failed to indicate when that review will take place. Review of the current January, February and March 2025 line listings with the Infection Preventionist (IP), indicated that 32 antibiotics were prescribed and started in January, 20 in February and 25 in March. The line listings failed to failed to indicate any follow up or review with the physician or nurse practitioner following the initiation of the antibiotic for 77 out of the 77 antibiotics prescribed. During an interview on 4/24/25 at 1:49 P.M. the IP said that when an antibiotic is prescribed there is no review for the appropriateness or the efficacy of the antibiotic until she has time to review the infection control line listings that are completed each month. The IP then said that antibiotics should be reviewed within 48-72 hours of initiation of the antibiotic.