STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225294	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andover Manor Rehab and Nursing	89 Morton Street Andover, MA 01810

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview, the facility failed to ensure it provided an environment free of potential safety hazards on one of one Dementia Special Care Units (DSCU). Specifically, the facility failed to ensure that a closet containing cleaning chemicals was kept locked and was not accessible to residents with dementia and wandering behaviors. Findings include:On 1/13/26 at 8:19 A.M., the surveyor observed the housekeeper on the A2 unit open the door marked closet to obtain some supplies, then walked away. The door was unlocked when the housekeeper accessed it. On 1/13/26 at 8:20 A.M., the surveyor was able to gain access to the unlocked closet. Housekeeping chemicals were observed in the closet. At this time there were three residents wandering and ambulating past the closet, up and down the hallway. On 1/13/26 at 8:21 A.M., the surveyor observed the housekeeper go back into the closet, which remained unlocked, for more supplies, then closed the door, leaving the closet unlocked. On 1/15/26 at 7:28 A.M., the surveyor observed a housekeeper on the A2 unit open the closet door, which was unlocked and obtain supplies. She then closed the door. Multiple residents were observed ambulating up and down the hallway at this time. On 1/15/26 at 7:44 A.M., the surveyor was able to access the unlocked closet and observed multiple housekeeping chemicals stored in the closet. During an interview on 1/15/26 at 7:45 A.M., Unit Manager #2 said that the closet should be locked at all times because of residents on the unit who wander and could potentially open the door and gain access to the chemicals. During an interview on 1/15/26 at 9:43 A.M., the Infection Preventionist said that the closet on the unit, containing housekeeping chemicals should be locked at all times because residents wander on that unit and go into rooms and areas that are not theirs. During an interview on 1/15/26 at 10:50 A.M., the Administrator said that the closet that houses cleaning chemicals should be locked at all times.

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 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. Based on observation, record review and interview, the facility failed to provide a dignified environment for one Resident (#77) out of a total of 32 sampled Residents. Specifically, the facility failed to ensure staff did not store personal items in Resident #77's room. Resident# 77 was admitted to the facility in May 2025 with diagnoses including Alzheimer's disease and vascular dementia. Review of the Minimum Data Set Assessment (MDS) 12/8/25 indicated Resident #77 is severely cognitively impaired evidenced by a score of 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. Resident #77 was unable to participate in the interview process. On 1/13/26 at 8:23 A.M., the surveyor observed Resident #77 asleep in his/her bed. Resident #77 did not have a roommate, but a tote bag with two fleece shirts draped on top of it was observed on the unoccupied bed's night table. On 1/14/26 at 7:39 A.M., and on 1/15/26 at 7:23 A.M., the tote bag and fleece shirts were observed on the top shelf of the closet in Resident #77's room. On 1/15/26 at 8:45 A.M., the Assistant Director of Nursing (ADON) and the surveyor observed Certified Nursing Aide (CNA) #1 in Resident #77's room holding the tote bag and taking items out of it. Resident #77 was not in the room at the time. When asked if she keeps her belongings in the Resident's room, CNA #1 said No. I was just looking for something and walked down the hall to place the tote bag at the nurse's station. The ADON said that staff do have areas where they can keep personal belongings and they should not keep personal belongings in resident rooms.

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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. Based on record review and interview, the facility failed to ensure it followed its grievance process for one Resident (Resident #17) out of 32 sampled residents. Specifically, the facility failed to document, investigate and provide a resolution to lost dentures. Findings include:Review of the facility policy Resident and Family Concerns and Grievances, dated as revised 10/5/25, indicated:- The facility Compliance and Ethics Officer or a designated staff will document and keep a log of all grievances expressed either orally and/or in writing on the day that it is received or as soon as possible after the event or events that precipitated the grievance. Management or supervisory staff will commence a formal investigation of the grievance as soon as practicable and advise the resident of the outcome of the investigation.Resident #17 was admitted to the facility in July 2021 with diagnoses that included heart disease and diabetes.Review of Resident #17's Minimum Data Set (MDS) assessment, dated 10/2/25, indicated he/she did not have broken or loosely fitting full or partial dentures, or mouth or facial pain, discomfort or difficulty with chewing. Resident #17 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition.Review of Resident #17's dental care plan, dated 3/31/25, indicated the Resident has altered oral/dental health related to lost upper denture and missing/cavity on bottom teeth. Care plan interventions did not indicate replacement of the lost dentures.Review of Resident #17's Dentist note, dated 9/5/25, indicated the Resident complained that he/she was having a tough time eating since losing his/her dentures a couple of months ago. The Dentist indicated he spoke with the Social Services department staff about the situation. The Dentist recommended fabrication of complete upper dentures and lower removable partial dentures to improve the Resident's ability to chew and quality of life. The Dentist recommend full mouth X-rays. The Dentist indicated he reviewed the recommendations with a staff nurse. The Dental note indicated: Action Required by Nursing Home Staff Recommended treatment. New Fabrication of partial lower denture; Fabrication of full upper denture. Review of the 2025 and 2026 grievance logs indicated there was no reference to Resident #17's loss of dentures. During an interview on 1/13/26 at 9:27 A.M., Resident #17 said he/she lost his/her dentures at the facility several months ago. The Resident said somebody told him/her that insurance would not cover the loss for another five years. The Resident said he/she could not afford to pay out-of-pocket for replacement dentures.During an interview with Family Member #1 on 1/14/26 at 11:43 A.M., she said several months ago Resident #17 left his/her dentures on a meal tray wrapped in a napkin. She said a staff member removed the tray and the dentures were subsequently lost. Family Member #1 said the Resident could not afford to pay for replacement dentures and so has gone without them. Family Member #1 said staff are aware of the loss, but the facility did not offer to pay for replacement dentures. During an interview with Nurse #6 on 1/13/26 at 10:05 A.M., she said she recalled that Resident #17's dentures were missing. Nurse #6 said she and other staff looked everywhere but were unable to locate them. Nurse #6 said she did not know whether the Resident or facility staff ordered replacement dentures. Nurse #6 said that if a staff member accidentally threw the dentures away then it was the facility's financial responsibility to reimburse the Resident or have new dentures made. Nurse #6 said the loss of dentures should have been recorded in the grievance log and a resolution provided to Resident #17.During an interview with the Director of Nursing (DON) on 1/14/26 at 10:45 A.M., she said she was unaware Resident #17 had missing dentures. The DON said that it is the facility's policy to include missing resident property, such as dentures, in the grievance log and for these losses to be investigated. The DON said the facility will pay for replacement dentures if the insurance company will not.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview the facility failed to develop and implement a comprehensive care plan for one Resident (#38) out of a total sample of 32 residents. Specifically, the facility failed to develop and implement a comprehensive plan of care for a pacemaker. Findings include: Review of the facility policy titled Comprehensive care Plan, dated as revised 10/25/25, indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Review of the facility policy titled Pacemaker Function and Testing, dated as revised 10/25/25, indicated results of testing should be documented in the medical record. Resident #38 was admitted to the facility in October 2021 with diagnoses including presence of a pacemaker, atrial fibrillation and congestive heart failure. Review of the Minimum Data Set assessment, dated 10/8/25, indicated that Resident #38 is cognitively intact, scoring a 13 out of 15 on the Brief Interview for Mental Status exam. Further review indicated Resident #38 required supervision to partial assistance with activities of daily living. Review of the physician's orders dated January 2025 failed to indicate an order for the care of the pacemaker. Review of the Care plan failed to indicate the type of pacemaker, the programed heart rate and the baseline blood pressure. Further review indicated that pacemaker checks are to be completed every 12 months at the cardiologist's office. Review of the facility document titled Report of Consultation, dated 10/18/24, indicted that Resident #38 was scheduled to be sent to a cardiologist for a pacemaker check however, the document was blank other than the Resident's name, date and that the reason was for a pacemaker check. No results were documented. Review of the medical record failed to indicate Resident #38 was sent to the cardiologist every 12 months. During an interview on 1/14/26 at 10:54 A.M., the Director of Nursing (DON) said that she expects that when the facility sends a resident out for a consultation, including a pacemaker check, that there would be documentation in the medical record of the results of the consultation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs) for dependent residents. Specifically, the facility failed to provide assistance with showers for two Residents (#64 and #12) out of a total sample of 32 Residents.Findings include:Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated as revised 12/5/25, indicated but was not limited to the following: 1. Residents will be provided with care treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL). Residents who are unable to carry out activities of daily living independently will receive the service is necessary to maintain good nutrition, grooming and personal oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); and 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with their residents' assessed needs, preferences, stated goals, and recognized standards of practice 7. The residents' response to interventions will be monitored evaluated and revised as appropriate. 1. Resident #64 was admitted to the facility in December 2024 with diagnoses which included hemiplegia, and diabetes. Review of Resident #64's Minimum Data Set (MDS) assessment, dated 12/3/25, indicted a Brief Interview for Mental Status score of 13 out of 15, signifying intact cognition. In addition, the MDS indicated the Resident was dependent on staff for showers and baths, and he/she rejected care one to three days per week. Review of Resident #64's care plan for activities of daily living (ADL) indicated he/she was dependent on staff for most ADL care. During an interview on 1/13/26 at 8:20 A.M., Resident #64 was lying in bed wearing a hospital gown and eating breakfast. The Resident was not malodorous, and his/her hair was covered by a towel. The Resident said he/she prefers to have a shower rather than a bed bath, but it has been over a year since staff gave him/her a shower. Resident #64 said that when he/she asks for a shower staff tell him/her there is not enough time. Resident #64 said he/she believes that because he/she has hemiplegia (paralysis on one side of the body) and it takes time and two staff to transfer him/her, staff avoid giving him/her showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #64's December 2025 and January 2026 shower schedules indicated he/she was to have a shower every Friday during the 3:00 P.M. to 11:00 P.M. shift. The schedule indicated that staff did not give Resident #64 a shower for the past three weeks (12/26/25, 1/2/26, or 1/9/26). The schedule failed to indicate that the Resident refused a shower or was unable to have a shower. Review of Resident #64's progress notes dated December 2025 and January 2026 and Treatment Administration Records for December 2025 and January 2026 failed to indicate that the Resident refused to be bathed or showered. Review of Resident #64's Certified Nurse Aide (CNA) assignment for January 2026, indicated CNA #3 and CNA #4 were scheduled to give the Resident showers on 1/2/26 and 1/9/26. The surveyor attempted to contact CNA #3 and CNA #4 by telephone on 1/20/26 at 9:18 A.M. and 9:20 A.M. respectively. Voice mail messages were left but as of the completion of this survey there was no response. During an interview with Nurse #6 on 1/14/26 at 8:10 A.M., she said she was unaware that Resident #64 had been asking staff for a shower, or that staff had not bathed him/her for the past three weeks. Nurse #6 said it was the responsibility of the aide to tell the nurse if a resident declines a shower or bed bath. Nurse #6 said a nurse would then document the refusal in the chart, either as a progress note or on the Treatment Administration Record. Nurse #6 said that if the Resident preferred to have a shower, then staff should accommodate him/her. 2. Resident #12 was admitted to the facility in July 2025 with diagnoses that include but not limited to asthma, depression, iron deficiency anemia (low red blood cells), pain in left hip, muscle spasm, arthropathy, osteonecrosis (bone disease), left femur, primary osteoarthritis, right shoulder, primary osteoarthritis left shoulder, major depressive disorder, osteoporosis, anemia (low oxygen carrying blood cells), limitation of activities due to disability and epilepsy. Review of Resident #12's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, which indicated Resident #12 was cognitively intact. The MDS also indicated Resident #12 was dependent on staff for all functional tasks. During an interview on 1/14/26 at 8:45 A.M., Resident #12 told the surveyor that he/she has not had a shower in months and would like one and said the facility did not have a shower chair he/she could sit in that would fit into the shower. Review of Resident #12's ADL self-care performance care plan dated as revised on 8/10/25, indicated, I currently have an alteration to my ability to care for self and need assistance d/t (due to) Decrease strength and endurance, Depression, Pain, Weakness. The care plan interventions indicated: -TRANSFER: (Resident) is Extensive Assistance on 2 staff for transferring. The care plan failed to indicate the level of assistance needed for showers. Review of the shower schedule for Resident #12's unit indicated that Resident #12's scheduled shower day was scheduled for Thursday, during the 7:00 A.M to 3:00 P.M., shift. Review of the shower and bathing documentation records for the months of July 2025 through January 2026, failed to indicate any documented showers for Resident #12, and also failed to indicate (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the Resident had refused any showers. During an interview on 1/14/26 at 8:38 A.M., Certified Nursing Assistant (CNA) #1 said Residents have scheduled shower days and CNA's document in the electronic medical record when care is provided. When asked about Resident #12, she said Resident #12 does not take showers, just bed baths because it is too hard to get him/her into the shower chair. During an interview on 1/15/26 at 9:07 A.M., Unit Manager #1 said any resident who would like to take a shower, should be provided with a shower. Unit Manager #1 said if the resident refuses a shower, then the CNAs should be documenting that. Unit Manager #1 continued to say the nursing unit had a recent renovation and that the shower chair that Resident #12 needed was able to fit into the shower located on another unit, but said staff could have taken Resident #12 to the other shower.

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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** Based on observation, record review and interview, the facility failed to ensure that respiratory care and services consistent with professional standards of practice, and in accordance with physician's orders were provided for three Residents (#40, #72 and #15) out of a total sample of 32 residents. Specifically:1. For Resident #40 the facility failed to ensure oxygen tubing and humidification bottle was changed and dated.2. For Resident #72, the facility failed to ensure oxygen tubing and humidification bottle was changed and dated.3.For Resident #15, the facility failed to ensure nebulizer equipment and tubing was changed/dated and b) failed to ensure the oxygen concentrator filter was cleaned.Findings include: Review of the facility policy titled Oxygen Administration and Storage dated revised 10/25/25 indicated that the humidifier bottle is to be labeled with the date of application and changed weekly if refillable. If it is disposable . it is to be changed at least weekly . Further review indicated that the nasal cannula should be changed weekly or more often if soiled. 1. Resident #40 was admitted to the facility in November 2025 with diagnoses including chronic obstructive pulmonary disease, lung cancer and heart failure. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #40 was severely cognitively impaired and scored a 3 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #40 was dependent on staff for activities of daily living and was receiving oxygen therapy. Review of the physician's orders dated December 2025, and January 2026 indicated the following orders: -Oxygen at 2 L/min (liters per minute) via Nasal Cannula to keep O2 > 90% every shift. -O2 (oxygen) Tubing: Change Tubing On Sunday 11-7 &PRN (as needed) for Infection Control Change every Sunday when in use. On 1/13/26 at 8:13 A.M., the surveyor observed Resident #40 lying in bed receiving oxygen via nasal cannula at 2L/minute. The surveyor also observed that the oxygen humidification bottle and tubing were dated 12/29/25. During an interview on 1/13/26 at 8:13 A.M., Nurse #2 said that the tubing and bottle should have been changed last week. 2. Resident #72 was admitted to the facility in May 2024 with diagnoses including respiratory failure and sleep apnea. Review of the Minimum Data Set assessment, dated 10/15/25, indicated that Resident # 72 was cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated Resident #72 required assistance with activities of daily living and was receiving oxygen therapy. Review of the care plan, dated revised 10/29/25, indicated the following focus: I currently have an (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alteration to my Respiratory System d/t (due to) DOE (dyspnea on exertion), acute hypoxia, may need to use oxygen. Further review indicated an intervention to clean equipment per facility protocol. Review of the physician's orders dated December 2025, and January 2026 indicated the following orders: Oxygen supplemental at 2L (liters) via nasal cannula to maintain O2 (oxygen) sats > 90%. O2 Tubing: Change Tubing on Sunday night and PRN (as needed) every night shift, every Sun (Sunday) for Infection Control AND as needed for Infection Control, Change every Sunday night when in use. On 1/13/26 at 8:45 A.M., the surveyor observed Resident #72 sitting next to the bed with oxygen via nasal cannula, running at 2L (liters) per minute. The surveyor observed that the oxygen humidification bottle and tubing were dated 12/29/25. During an interview on 1/13/26 at 8:45 A.M., Resident #72 said that the staff have not changed the bottle and tubing for a long time. During an interview on 1/14/26 at 10:54 A.M., the Director of Nursing (DON) said that she expects that the oxygen tubing and humidification bottle are changed according to physician's orders. Review of the facility policy titled Oxygen Administration and Storage, dated as revised 10/25/25, indicated but was not limited to: To ensure staff follow safety guidelines and regulation for storage and use of oxygen. Procedure: 1.Verify provider's order for the procedure. 10. Turn on oxygen and set the flow rate to prescribed amount. Only a nurse may set the flow rate. 12. Label the tubing connected to the oxygen cylinder with time and date. 15. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. Humidification as ordered by provider. General Guidelines 4. The nasal cannula or mask should be changed weekly or when soiled. 5. The extension tubing (the tubing used to lengthen the cannula but is not connected directly to the resident) should be changed monthly or when soiled. 6. Nasal cannula and/or mask should be stored in a manager to prevent from touching the floor when not in use. If the mask or nasal cannula touches the floor it should be changed to prevent pathogens from entering the respiratory system. 7. The humidifier bottle is to be labeled with the date of application and change weekly if refillable. If it is disposable (single use) humidification bottle is to be changed at least weekly and more frequently (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as it near empty or to maintain humidification. 8. Filters should be removed and cleaned by rinsing with clear cool water weekly to maximize flow rate of clean air. 3a. Resident #15 was admitted to the facility in July 2025 with diagnoses including, chronic obstructive pulmonary disease, chronic systolic congestive heart failure, chronic respiratory failure with hypoxia Review of the most recent Minimum Data Set (MDS) assessment, dated 10/29/25, indicated the Resident scored a 10 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. On 1/13/26 at 8:55 A.M., the surveyor observed a nebulizer mask placed partially inside a plastic bag. The mask was dated "12/29 and written in black ink directly on the face mask, however the tubing and plastic bag were undated. On 1/13/26 at 12:15 P.M., the surveyor observed a nebulizer mask placed partially inside a plastic bag. The mask was dated "12/29 and written in black ink directly on the face mask, however the tubing and plastic bag were undated. Review of Resident #15's Oxygen care plan dated 7/29/25, indicated the following: -Clean equipment per facility protocol. -My Oxygen tubing and mask/nasal cannula every Sunday 11-7. [sic] Further review of Resident #15's care plans failed to indicate the use of nebulizer treatments. Review of Resident #15's active physician orders indicated the following: -Ipratropium- Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 4 hours as needed for SOB (shortness of breath) or Wheezing Pretreatment evaluation in supplemental documentation. In progress note document response to instructions and education and any adverse reactions. Notify the provider of any adverse reactions. Start Date: 7/31/25. Review of Resident #15's medical record including Treatment Administration Record (TAR) and Medication Administration Record (MAR) for the month of January indicated the order for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 4 hours as needed for SOB or Wheezing was documented as administered on 1/12/26. Review of Resident #15's medical record failed to indicate a physician's order or care plan for the care of the nebulizer machine, including tubing or mask, was developed or implemented. During an interview on 1/14/26 at 9:22 A.M., Unit Manager #1 said the nebulizer mask and tubing should be cleaned and changed weekly and said the mask should be stored fully inside the bag and dated. During an interview on 1/14/26 at 10:58 A.M., the Director of Nursing (DON) said respiratory (continued on next page)

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Andover Manor Rehab and Nursing	89 Morton Street Andover, MA 01810

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment must be cleaned and changed weekly and said she would expect orders and care plans to but updated and followed for the care of the respiratory equipment. 3b. For Resident #15, the facility failed to ensure oxygen concentrator filter was cleaned or changed as necessary. On 1/13/26 at 8:55 A.M., the surveyor observed Resident #15 wearing an oxygen nasal cannula. The oxygen filter on the concentrator was covered with a thick coating of dust. On 1/13/26 at 12:15 P.M., the surveyor observed Resident #15 wearing an oxygen nasal cannula. The oxygen filter on the concentrator was covered with a thick coating of dust. Review of Resident #15's Oxygen care plan dated 7/29/25, indicated the following: -Clean equipment per facility protocol. Review of Resident #15's active physician orders indicated the following: - Oxygen at 3L/min via Nasal Cannula continuously with Humidification every shift related to chronic obstructive pulmonary disease, unspecified. Start Date: 7/30/25. Review of Resident #15's medical record including Treatment Administration Record (TAR) and Medication Administration Record (MAR) for the month of January indicated the order for Oxygen at 3L/min via Nasal Cannula continuously with Humidification every shift was documented as administered daily as ordered. Review of Resident #15's medical record failed to indicate a physician's order or care plan for the care of the oxygen concentrator, was developed or implemented. During an observation and interview on 1/14/26 at 9:20 A.M., the surveyor and Unit Manager #1 observed Resident #15 in bed wearing an oxygen nasal cannula, the oxygen tubing was dated 1/13/26. UM #1 observed the oxygen filter, and said the filter needs to be cleaned and said there should not be a thick layer of dust on the filter. UM #1 said the filter should be cleaned weekly. During an interview on 1/14/26 at 10:57 A.M., the Director of Nursing (DON) said the filter to the oxygen concentrator must be cleaned weekly and documented in the medical record.

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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. Based on observation, record review and interview, the facility failed to: 1. Ensure medications and biologicals were labeled in one out of four medication carts.2. Ensure medications were stored securely for one Resident #38 out of a total sample of 32 residents. Findings include:1. On 1/15/26 at 8:25 A.M., the surveyor observed the following in the medication cart on the A3 unit:One Anoro Ellipta inhaler (used to treat asthma) open and not labeled with a date. Review of the pharmacy label indicated the inhaler was dispensed 11/5/25. Review of the manufacturer's directions indicated the inhaler is to be discarded 6 weeks after opening. One Anoro Ellipta inhaler dated as opened on 11/16/25 inside a box dated as opened 10/31/25. Review of the pharmacy label indicated the inhaler was dispensed 10/30/25. Review of the manufacturer's directions indicated the inhaler is to be discarded 6 weeks after opening. During an interview on 1/15/26 at 8:25 A.M., Nurse #3 said that the inhalers should be labeled accurately. 2. Review of the facility policy titled Administering Medication, dated as revised 10/15/25, indicated that medications may be self-administered by residents who have been assessed and determined to be safe and upon physician's order. Further review indicated that self-administration of drugs is permitted when approved by the attending physician and the interdisciplinary care planning team. Resident #38 was admitted to the facility in October 2021 with diagnoses including presence of a pacemaker, atrial fibrillation and congestive heart failure. Review of the Minimum Data Set (MDS) assessment, dated 10/8/25, indicated Resident #38 was cognitively intact scoring a 13 out of 15 on the Brief Interview of Mental Status exam. Further review indicated Resident #38 required supervision to partial assistance with activities of daily living. On 1/13/26 at 8:00 A.M., and 4:10 P.M., the surveyor observed a bottle of Fluticasone nasal spray on Resident #38's nightstand. On 1/14/26 at 8:05 A.M., and 4:10 P.M., the surveyor observed a bottle of Fluticasone nasal spray on Resident #38's nightstand. Review of the physician's orders dated January 2025 indicated an order for Fluticasone Propionate Suspension 50 MCG/ACT 1 spray in each nostril one time a day for nasal discomfort. Further review failed to indicate an order for the self-administration of medication. Review of the medical record failed to indicate an assessment for the ability to self-administer medications and store medications safely in the Resident's room. During an interview on 1/14/26 at 8:07 A.M., Nurse #2 said that if the Resident does not have a doctor's order to self-administer the medication, then it should not be in the Resident's room. During an interview on 1/14/2026 at 10:54 A.M., the Director of Nursing (DON) said that it is her expectation that a resident is assessed for the ability to self-administer medications and that a physician's order is obtained before a resident is able to self-administer medications and store safely in their room. The DON then said that all medications are to be stored safely and locked when not using.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide dental services to one resident (Resident #17) of 32 sampled residents. Specifically, the Dentist recommended replacement dentures, and the facility did not review or implement the recommendation. Findings include: Resident #17 was admitted to the facility in July 2021 with diagnoses that included heart disease and diabetes.Review of Resident #17's Minimum Data Set (MDS) assessment dated [DATE] indicated he/she did not have broken or loosely fitting full or partial dentures, or mouth or facial pain, discomfort or difficulty with chewing. Resident #17 scored a 15 on the Brief Interview for Mental Status exam, indicating intact cognition.Review of Resident #17's dental care plan dated 3/31/25 indicated the Resident has altered oral/dental health related to lost upper denture and missing/cavity on bottom teeth. Care plan interventions did not indicate replacement of the lost dentures.Review of Resident #17's Dentist note dated 9/5/25 indicated the Resident complained that he/she was having a tough time eating since losing his/her dentures a couple of months ago. The Resident had complete upper denture and lower removable partial denture fabricated at an outside dentist in March 2025. Per the Resident, he/she spoke to the insurance company and was told that they would cover a one-time replacement of the dentures. The Dentist indicated he spoke with the Social Services department staff about the situation. The Dentist recommended fabrication of complete upper dentures and lower removable partial dentures to improve the Resident's ability to chew and quality of life. The Dentist recommend full mouth X-rays. The Dentist indicated he reviewed the recommendations with a staff nurse. The Dental note indicated: Action Required by Nursing Home Staff Recommended treatment. New Fabrication of partial lower denture; Fabrication of full upper denture.Review of Resident #17's medical record indicated there was no reference to the Dentist's recommendation and no indication dentures were ordered. Review of correspondence between the facility and the Dentist's office dated 1/15/26 indicated the Dentist's office was unaware the Dentist recommended a replacement set of dentures.During an interview on 1/13/26 at 9:27 A.M., Resident #17 said he/she lost his/her dentures at the facility several months ago. The Resident said somebody told him/her that insurance would not cover the loss for another five years. The Resident said he/she could not afford to pay out-of-pocket for replacement dentures.During an interview with Family Member #1 on 1/14/26 at 11:43 A.M., she said several months ago Resident #17 left his/her dentures on a meal tray wrapped in a napkin. She said a staff member removed the tray and the dentures were subsequently lost. Family Member #1 said the Resident could not afford to pay for replacement dentures and so has gone without them. Family Member #1 said staff are aware of the loss, but the facility did not offer to pay for replacement dentures. During an interview with Nurse #6 on 1/13/26 at 10:05 A.M., she said she recalled that Resident #17's dentures were missing. Nurse #6 said she and other staff looked everywhere but were unable to locate them. Nurse #6 said she did not know whether the Resident or facility staff ordered replacement dentures, or if there was a dental recommendation for new dentures. During an interview with the Director of Social Services on 1/15/26 at 8:41 A.M., he said he was unaware of a dental recommendation for Resident #17 to have new dentures fabricated.During an interview with the Director of Nursing (DON) on 1/14/26 at 10:45 A.M., she said she was unaware Resident #17 was missing dentures. The DON said the facility will pay for replacement dentures if the insurance company will not.

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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** Based on observation, record review and interview, the facility failed to provide one Resident (#25) with a therapeutic diet as ordered by the physician out of a total sample of 32 Residents. Specifically, the facility failed to ensure that Resident #25 received a Dysphagia Advanced, textured diet as prescribed by the physician.Findings includeReview of the facility policy titled Diet/Fluid/Supplement, dated as revised 4/12/25, indicated but was not limited to:According to the Academy of Nutrition and Dietetics in Massachusetts Long-Term Care regulations, Physicians shall write a diet order in the medical record for each resident, indicating whether the resident is to have a general (regular) or a therapeutic diet. A therapeutic diet is defined as a diet order by the physician as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., via supplements) or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet) All therapeutic diets shall be medically prepared prescribed and shall be planned or approved by a dietician. Refer to the speech-language pathologist (SLP) if a patient has difficulty chewing/swallowing prescribed food texture and/or liquid consistency.Food Textures/Liquids Consistencies Offered at the Facility: All food textures and liquids consistency are ordered by the resident MD. If a patient is demonstrating difficulty chewing/swallowing the prescribed diet, the speech-language pathologist (SLP) or dietician may modify a patient's food texture and or liquid consistency following a screen or evaluation. Any changes to the diet require a new order from the MD. Food texture options- bolded are the orders and Electronic Medical Record. Mechanical Soft Chopped/Dysphagia Advanced/Soft and Bite Sized IDDSI 6.Review of the facility policy titled Resident Nutrition Status, dated as revised 10/15/25 indicated but was not limited to: Each resident shall receive the correct diet, with preferences accommodated as feasible, and shall receive prompt mail service and appropriate feeding assistance.1. Food services and/or nursing personnel will assure that residents are served the correct food.2. Prior to serving the food, the dietary aid/nurse must check the tray card to assure that the correct food is being served to the resident. If there is doubt, the nurse supervisor will check their written physicians order.3. Nursing staff and the clinical dietitian will assess each resident's foods dislikes, and eating habit. They will correct this information on the resident care plan.Review of the Level 6 SOFT AND BITE SIZED guidelines, last reviewed July 2019 (https://www.iddsi.org/images/Publications-Resources/DetailedDefnTestMethods/English/V2DetailedDefnEngl indicated the following:- No regular dry bread, sandwiches or toast of any kind.- No regular dry bread due to high choking risk.-Soft, tender and moist, but with no thin liquid leaking/dripping from the food.-Ability to chew ?bite-sized' pieces so that they are safe to swallow is required.-Bite-sized' pieces no bigger than 1.5cm x 1.5cm in size.-Food can be mashed/broken down with pressure from fork-A knife is not required to cut this foodFood Characteristics to AVOID: Crust formed during cooking or heading- Crust or skin that forms on food during cooking or after heating, for example, cheese topping; mashed potato. Large or hard lumps of food. Casserole pieces larger than 1.5cmx1.5cm, fruit, vegetable, meat, pasta or other food pieces larger than 1.5 cm x 1.5cm.Resident #25 was admitted to the facility in October 2025 and has diagnoses that include dysphagia (difficulty swallowing), gastro esophageal reflux disease, esophagitis (inflammation of the esophagus), muscle weakness, hemiplegia and hemiparesis (paralysis / weakness on one side of the body) following cerebral infarction affecting left dominant side and cognitive communication deficit.Review of Resident #25's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, indicating intact cognition. The MDS also indicated Resident #25 required a Mechanically altered diet. Further review of the MDS indicated that the Resident requires supervision or touching assistance with eating.Review of (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25's medical record indicated the following physician orders:-NAS (No Added Salt) diet Dysphagia Advanced texture, Regular/Thin (0) consistency. Dated 10/29/25. - Aspiration Precautions every shift for Aspiration Precautions Aspiration Precautions- Administered= no signs/ symptoms aspiration; Not administered= signs/ symptoms observed, see progress note. Dated 12/22/25Further review of the medical record indicated a physician order dated 10/17/25, for (NAS) diet Regular texture, Regular/Thin (0) consistency, diet for Diet, was discontinued on 10/29/25 due to increased s/s (signs/symptoms) of dysphagia.On 1/13/26 at 8:38 A.M., the surveyor observed Resident #25 in bed, with his/her breakfast on the overbed table attempting to eat the meal. The Resident had two slices of dry French toast, and one slice of toasted wheat bread on his/her plate and one bowl of oatmeal. The Resident was peeling the crust off the French toast and breaking the French toast into pieces approximately 2 inches in size. There was one syrup packet located on the overbed table. The French toast was dry and did not have syrup on it. Resident #25 said he/she can't swallow food well and can't eat what is given because it is hard.Review of Resident #25's dietary slip dated 1/13/26, indicated: Regular DYS-ADV. (dysphagia soft advanced) NAS (no added salt)/extra gravy on the side. French toast 2 SL (slices) or Pancakes or Muffin when available. Hashbrown 3/8 cup. Oatmeal cereal 4 0Z (ounces). Bread 1 SL. On 1/13/26 at 12:42 P.M., the surveyor observed Resident #25 sitting on the edge of the bed, the lunch meal was on the overbed table, and Resident #25 was attempting to eat the meal. There was one large round dinner roll and one whole chocolate chip cookie on the Residents lunch plate.Review of Resident #25's care plans indicated: Focus: Aspiration precautions r/t (related to) Diet texture alteration, dysphagia. Interventions: Ask family/ care giver about history of choking-food item, when, positioning. Aspiration Precautions. I will be monitored for changes in condition that would require further evaluation and intervention. Monitor/document/report to MD (medical doctor) PRN (as needed) any s/sx (signs/symptoms) of aspiration or dysphagia: choking, 12/22/25.Focus: Weight loss and difficulty swallowing. Interventions: Cut up food prn. Diet to be followed as prescribed. Instruct resident to eat in upright position, to eat slowly, and to chew each bite thoroughly. Keep head of bed elevated at least 45 degrees during meal and for at least 30 minutes afterwards, 10/22/25.Review of Resident #25's Nutrition Assessment conducted by the Registered Dietitian (RD) dated 10/22/25, indicated the following: Diet: NAS (No Added Salt) Diet Texture: Regular Food Likes: broth, extra gravy, soft food ice cream. Food Dislikes: ToastReview of the Dietary Progress note dated 10/22/25, indicated: He/she reports that there is too much food for him/her and can't eat all that is served. He/she also stated he/she has some nausea. Sounds like he/she has h/o (history of) esophageal dysmotility and is requesting softer food, broth and extra gravy on side. Swallowing difficulty 2/2 h/o esophageal strictures a/e (as evidenced) by pt (patient) report that he/she does better with soft food, cut up. Updated preferences, extra gravy broth. Cut up food prn (as needed). Review of the Physiatry progress note dated 10/28/25, indicated: Resident reports he/she has been having difficulty with his/her meals. He/she reports he/she has not been receiving the food that he/she has been requesting. He/she also endorses that the textures of the food have been difficult for him/her given his/her history of strictures and esophageal dilation. He/she states that sometimes he/she has a cough, and hoarseness of his/her voice. He/she states he/she has been eating the bread and leaving the crust. Requesting having broth for his/her meals since that is something he/she could tolerate swallowing stenosis of his/her throat. Assessment and Plan: Dysphagia: Endorsing difficulty tolerating some of the textures with eating, reporting change in his/her vocal quality and cough. He/she has Hx (history of) CVA (stroke), and esophageal stricture, requiring dilation in the past. He/she is currently on regular textured thin liquid diet consistency. Will consult with SLP to evaluate on current textures. Encouraged to sit up 30 minutes after eating. Will continue to monitor closely for any barriers this may pose rehab. Review of the Speech Therapy Discharge summary dated [DATE], indicated: Diet: Soft + Bite Size Dys-Adv (dysphagia advanced). Strategies: To facilitate safety and efficiency, it is recommended that the patient uses the following strategies and/or maneuvers during oral intake: alternation of liquid/solids, second dry swallow and (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	general swallow techniques/precautions upright posture during meals and upright posture > 30mins after meals.During an interview on 1/14/26 at 12:18 P.M., Certified Nursing Assistant (CNA) #1 said Resident #25 eats in his/her room and will ask for different foods if he/she does not like something and said the nurses check the trays before meals are passed out.During an interview on 1/14/26 at 3:15 P.M., the Dietician said Resident #25 requires a dysphagia advanced diet due to his/her swallowing issues and said he/she needs help with cutting up foods. The Dietician said Resident #25 should not be eating dry breads or toast as it is hard to swallow and said the care plan should reflect the diet order. The Dietitian said she would expect staff to check the diet slip and not give Resident #25 whole toast, whole French toast or dinner rolls.During an interview on 1/15/26 at 7:35 A.M., Unit Manager #1 said Resident #25 is on a dysphagia diet because sometimes he/she has difficulty swallowing.During an interview on 1/15/26 at 11:20 A.M., the Director of Nursing (DON) said she expects diet orders to be followed and said the care plan should indicate the dietary needs. The DON said staff must check order to ensure Residents are not given foods that are not appropriate for their dietary needs and said foods not appropriate could cause the resident to choke if he/she can't swallow them.During an interview on 1/15/26 at 1:34 A.M., Nurse Practitioner (NP) #1 said staff should be following dietary orders and recommendations and said she expects the meal trays to be checked prior to ensuring the foods are appropriate.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and records reviewed, the facility failed to ensure for one Resident (#12), out of a total sample of 32 residents, a physical therapy evaluation was completed timely.Findings include:Resident #12 was admitted to the facility in July 2025 with diagnoses including pain in the left hip, muscle spasm, arthropathy (joint disorder), osteonecrosis left femur (bone disorder), primary osteoarthritis (joint disease) right shoulder, primary osteoarthritis left shoulder, major depressive disorder, osteoporosis (deterioration of bone tissues), anemia (low oxygen carrying blood cells), limitation of activities due to disability and epilepsy.Review of Resident #12's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, which indicated Resident #12 had no cognitive impairment. The MDS also indicated Resident #12 was dependent on staff for all functional tasks. Section GG of this MDS indicated Resident #12 has functional impairments to his/her range of motion of his/her bilateral upper and lower extremities.During an observation and interview on 1/14/26 at 8:45 A.M., Resident #12 was observed lying in bed. Resident #12 said he/she was getting up into the wheelchair and was able to stand on both legs with staff assistance before he/she was hospitalized in October and said he/she is unable to stand and unable to bend the left leg at all now and said the right leg is also worse. Resident # 12 said he/she has not received any therapy services since he/she was readmitted in October.Review of Resident #12's physician orders indicated the following:-Physical Therapy 5 times per week for 30 days for PT (physical therapy) Evaluation. Therapeutic Exercises, Neuro Re-Ed, Therapeutic Activities, W/C (wheelchair) mngmnt (management)/mobility, Manual Therapy. PT, OT (occupational therapy), ST (speech therapy) Screen, Eval (evaluation) and Treat as Indicated. Dated 9/24/25.-Clarification of OT orders. skilled OT 5 x week x 2 weeks for ADL (activities of daily living) training, therapeutic exercises, and wheelchair management one time only for 2 weeks. Dated 10/9/25.Review of Resident #12's Physical Therapy Evaluation & Plan of Treatment, dated 9/24/25, indicated:Reason for Referral: Pt referred to PT due to limited functional mobility. Pt (patient) would benefit from PT in order to decrease risk of contractures and further loss of ROM (range of motion).Contracture Functional Limitations Present d/t Contracture = Yes; Functional Limitations as Result of Contracture(s): Pt has ROM deficits and severe crepitus to most joints.Is skilled therapy needed to address impairments? = No (Pt would benefit from therapy to decrease risk of worsening contractures and further decrease in ROM.Reason for Therapy: Continued Pt services are necessary in order to assess functional abilities., decrease risk of worsening ROM. To assess need for environmental adaptations, establish and instruct in compensatory strategies and establish and instruct in FMP (functional maintenance programs).Risk Factors: Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: Immobility and decrease in level of mobility, limited OOB (out of bed) time, increased pain.Further review of the medical record indicated a Physical Therapy Discharge summary dated the same day as the initial assessment dated [DATE], was signed on 10/6/25 and indicated Resident #12 was discharged to the hospital at the end of September and was readmitted to the facility in early October. The medical record failed to indicate Resident #12 had a physical therapy evaluation completed after he/she was readmitted early in October.Review of progress notes in Resident #12's medical record from 10/7/25 through 1/14/26 failed to indicate any refusal or documented obstacles impacting the physical therapy evaluation.During an interview on 1/15/26 at 12: 34 P.M., Occupational Therapist (OT) #1 said Resident #12 was not evaluated by physical therapy after he/she was readmitted to the facility in early October and said Resident #12 needs physical therapy and should have been evaluated to continue services. During an interview on 1/15/26 at 12:48 P.M., Director of Rehabilitant (DOR) said Resident #12 had an occupational therapy evaluation done but should have been reevaluated by physical therapy when he/she was re-admitted from the hospital in October and (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the resident was receiving physical therapy services prior and should have continued with the screening and evaluation upon return.

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	225294	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andover Manor Rehab and Nursing	89 Morton Street Andover, MA 01810

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to accurately document in the medical record for two Residents (#40 and #72) out of a total sample of 32 residents. Specifically for Residents #40 and #72 the facility failed to accurately document that oxygen (O2) tubing and humidification bottles were changed as ordered. Findings include:Review of the facility policy titled Charting and Documentation dated revised 10/25/25 indicated that each resident will have an active medical record that contains accurately documented information, systematically organized and readily accessible to authorized persons.1. Resident #40 was admitted to the facility in November 2025 with diagnoses including chronic obstructive pulmonary disease, lung cancer and heart failure.Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #40 was severely cognitively impaired and scored a 3 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #40 was dependent on staff for activities of daily living and was receiving oxygen therapy.Review of the physician's orders dated December 2025, and January 2026 indicated the following orders:-Oxygen at 2 L/min (liters per minute) via Nasal Cannula to keep O2 > 90% every shift.-O2 (oxygen) Tubing: Change Tubing On Sunday 11-7 &PRN (as needed) for Infection Control Change every Sunday when in use. -On 1/13/26 at 8:13 A.M., the surveyor observed Resident #40 lying in bed receiving oxygen via nasal cannula at 2L/minute. The surveyor also observed that the oxygen humidification bottle and tubing were dated 12/29/25. Review of the Medication Administration Record dated January 2026 indicated that on 1/4/26, the nurse inaccurately signed that the oxygen tubing and humidifier bottle were changed as ordered.During an interview on 1/13/26 at 8:13 A.M., Nurse #2 said that the tubing and bottle should have been changed last week.2. Resident #72 was admitted to the facility in May 2024 with diagnoses including respiratory failure and sleep apnea.Review of the Minimum Data Set assessment dated [DATE], indicated that Resident # 72 was cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated Resident #72 required assistance with activities of daily living and was receiving oxygen therapy.Review of the care plan dated as revised 10/29/25 indicated the following focus: I currently have an alteration to my Respiratory System d/t DOE (dyspnea on exertion), acute hypoxia, may need to use oxygen. Further review indicated an intervention to clean equipment per facility protocol. Review of the physician's orders dated December 2025, and January 2026 indicated the following orders:-Oxygen supplemental at 2L (liters) via nasal cannula to maintain O2 (oxygen) sats > 90%.-O2 Tubing: Change Tubing on Sunday night and PRN (as needed) every night shift, every Sun (Sunday) for Infection Control AND as needed for Infection Control, Change every Sunday night when in use.On 1/13/26 at 8:45 A.M., the surveyor observed Resident #72 sitting next to the bed with oxygen via nasal cannula, running at 2L (liters) per minute. The surveyor observed that the oxygen humidification bottle and tubing were dated 12/29/25. During an interview on 1/13/26 at 8:45 A.M., Resident #72 said that the staff have not changed the bottle and tubing for a long time.Review of the Medication Administration Record dated January 2026 indicated that on 1/4/26 the nurse inaccurately signed that the oxygen tubing and humidifier bottle were changed as ordered.During an interview on 1/14/26 at 10:54 A.M., the Director of Nursing (DON) said that nurses should not be documenting in the medical record that they had completed a physician's order when they did not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, on the A2 -unit, a housekeeper failed to implement proper hand hygiene and stored her personal beverage on the housekeeping cart. Findings include:Review of facility policy titled Hand Washing, dated as revised October 25, 2025, indicated the following:-Hand washing is an integral part of an effective infection control program. Its purpose is to reduce the risk of blood borne illness and prevent cross contamination.-Hands should be washed before resident care, after resident care, after breaks, after using the restroom, after smoking or eating, after blowing nose, after disposing of trash, after handling dirty dishes, after picking anything up from the floor, and at any other time deemed necessary. Review of facility policy titled Personal Protective Equipment, dated as revised October 25, 2025, indicated the following:-Policy: to provide guidance for the use and selection of appropriate personal protective equipment (PPE) based on risk of exposure to blood borne pathogen or body fluids, in accordance with state and federal regulations.-Gloves: 5. Immediately wash hands after removing gloves; glove use does not replace hand hygiene. On 1/13/26 at 8:03 A.M., the surveyor observed a housekeeper in the hallway on the A2 unit with gloves on. The housekeeper removed the gloves and did not perform hand hygiene. The Housekeeper then, without performing hand hygiene, went into a resident room after applying a new pair of gloves. With the same pair of gloves on, returned to the housekeeping cart to obtain supplies, the broom and then the mop. At 8:07 A.M., the housekeeper exited the resident room, removed her gloves and used a towel to dry the floor in the hallway. Without performing hand hygiene pushed the housekeeping cart down the hallway, with potentially contaminated hands, to another resident room. Without performing hand hygiene, she entered into another resident room and emptied the trash in the bathroom. Without performing hand hygiene applied another pair of gloves and cleaned the resident room. At 8:13 A.M., the surveyor exited the resident room, removed her gloves and without performing hand hygiene wiped her face and adjusted her clothing before then pushing the cart down the hallway to another resident room with potentially contaminated hands. Without performing hand hygiene, the housekeeper applied new gloves and then entered the room to clean. On 1/13/26 at 8:32 A.M., a housekeeper was observed on the A2 unit drinking from a bottle that was stored on her housekeeping cart and then placing it back on the cart. On 1/15/26 at 7:26 A.M., the surveyor observed a housekeeper on the A2 unit cleaning the bathroom in the hallway. When finished, she removed her gloves and without performing hand hygiene, took the mop off the cart and mopped the floor in the bathroom. At 7:29 A.M., without performing hand hygiene, applied a new pair of gloves and moved on to clean a bathroom labeled nurses rest room. The housekeeper exited the bathroom with the same gloves on and touched the housekeeping cart in many places then obtained a trash bag for the bathroom. At 7:32 A.M., the housekeeper exited the bathroom, removed her gloves and without performing hand hygiene, and with potentially contaminated hands, pushed the housekeeping cart down the hall to clean a room labeled office. Without performing hand hygiene, applied gloves and entered the room to clean. She exited the room, removed her gloves, and without performing hand hygiene, went to the dining room to mop up a spill on the floor. On 1/15/25 at 7:46 A.M., the surveyor observed the housekeeper push the cart down the hallway to a resident's room. The housekeeper was observed blowing her nose into a tissue, and without performing hand hygiene or applying gloves, went into the resident room to open the blind in the room with potentially contaminated hands. She then emptied the trash in the bathroom with ungloved hands and brought the trash to the housekeeping cart. Then, without performing hand hygiene, she applied gloves and entered the resident room to clean. During an interview 1/15/26 at 9:41 A.M., the Infection Preventionist said that staff should be changing gloves between resident rooms and performing hand hygiene in between glove changes in an effort to stop the spread of any infections. She said that the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation is hand hygiene when entering and exiting a resident room and before and after all glove changes. She further said that the housekeeper should not be storing personal drinks on the housekeeping cart. During an interview on 1/15/26 at 11:38 A.M., the Director of Nurses said that she would expect staff to follow the policy regarding hand hygiene and glove use.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one Resident (#12), out of a total sample of 32 residents had a bed that was in operating condition. Specifically, Resident #12 was unable to raise the head of the bed to sit at an upright position.Findings include:Resident #12 was admitted to the facility in July 2025 and has diagnoses that include but not limited to asthma, PTSD (post-traumatic stress disorder), depression, iron deficiency anemia (low red blood cells), pain in left hip, muscle spasm, arthropathy, osteonecrosis, left femur, primary osteoarthritis, right shoulder, primary osteoarthritis left shoulder, major depressive disorder, osteoporosis, anemia (low oxygen carrying blood cells), limitation of activities due to disability and epilepsy.Review of Resident #12's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, which indicated Resident #12 had no cognitive impairment. The MDS also indicated Resident #12 was dependent on staff for all functional tasks.On 1/13/26 at 12:20 P.M., Resident #12 was observed eating lunch in bed. The head of the bed was raised, and Resident #12 was sitting in a semi-sitting position, the head of the bed was in a low fowlers position (approximately 15-30 degrees).On 1/14/26 at 8:47 A.M., Resident #12 was observed eating breakfast in bed. The head of the bed was raised, and Resident #12 was sitting in a semi-sitting position, the head of the bed was in a low fowlers position (approximately 15-30 degrees). Resident #12 said he/she does not get out of bed much and said it would be easier to eat if the head of the bed went up higher, but it does not. Resident #12 showed the surveyor the bed remote and pressed the button on the remote to raise and lower the head of the bed. The bed did not move any higher when the Resident pressed the arrow indicating the up position. Resident #12 said he/she is supposed to keep his/her head of the bed raised and told the surveyor he/she had a choking incident recently and sometimes has shortness of breath.On 1/14/26 at 12:12 P.M., Resident #12 was observed eating lunch in bed. The head of the bed was raised, and Resident #12 was sitting in a semi-sitting position, the head of the bed was in a low fowlers position (approximately 15-30 degrees).Review of the nursing progress note dated 1/5/26 indicated: Change in Condition s/p (status post) choking episode: Pt. (patient) resident in bed denies pain or discomfort head @ 45 degrees in bed stated I want to keep my head up, tolerated meds and food well this shift. [sic]On 1/15/26 at 7:20 A.M., Resident #12 was observed sitting up in bed. The head of the bed was raised, and Resident #12 was sitting in a semi-sitting position, the head of the bed was in a low fowlers position (approximately 15-30 degrees).Review of Resident #12's active physician orders on 1/13/26, indicated:-Head of bed elevated at __ degrees as needed for Shortness of breath while lying flat every shift for Shortness of Breath Head of bed elevated. Start Date: 7/7/25.The physician order failed to indicate an elevation degree and was left blank.Review of Resident #12's January 2026 Medication Administration Record indicated that Resident #12's scheduled physician order was documented. During an interview and observation on 1/15/26 at 7:23 A.M., the surveyor along with the Director of Maintenance observed Resident #12's bed. The Director of Maintenance tried raising the head of the bed and checked the setting located under the bed and said Resident #12's head of the bed does not go any higher. The Director of Maintenance said Resident #12's head of the bed should be able adjust to a higher position so the Resident can sit upright. The Residents bed and the headboard distance was approximately ten inches. The surveyor and the Director of Maintenance then observed a different bed of the same make and model. The Maintenance Director checked the settings under the bed to confirm they were the same as Resident #12 and was able to raise the head of the bed to a higher position. The Residents bed and the headboard distance was approximately 14 inches. He said there could be an issue with motor not raising the head of the bed all the way. The Director of Maintenance said Resident #12's bed should be replaced. During an interview on 1/15/26 at 12:22 P.M., The Director of Nurses said she would expect the Resident to be able to raise the head of the (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed so he/she can sit upright and said Resident #12 should not be laying back when eating.During an interview on 1/15/26 at 1:10 P.M., The Administrator said she would expect residents to have beds that are in good working condition.