STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication pass error rate of less than five percent (%) for two Residents (#75 and #54), out of five applicable residents, out of 34 medication pass opportunities. The medication error rate was observed to be 5.88%. Specifically, 1. For Resident #75, the Resident was not encouraged to rinse his/her mouth and spit after the administration of an oral inhalation corticosteroid medication. 2. For Resident #54, the Resident was administered an oral medication that was dropped on the contaminated surface of the medication cart. Findings include: Review of the facility policy titled Medication Pass Guideline, effective 6/1/2012, indicated the following: -Purpose: To assure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely and sanitary manner. -Use sanitary techniques to place medications into a souffle or medicine cup. -The nurse is responsible for reading and following precautions and instructions on prescription labels. Review of professional standards article titled, Quick Guide to Using Your Symbicort Inhaler, Revised 2/2018, retrieved from https://www.symbicorttouchpoints.com/content/dam/physician-services/us/526-rwd-symbicort-hcp/pdf/03_usin indicated:-After using the Symbicort inhaler: - After you finish taking SYMBICORT (two puffs), rinse your mouth with water. Spit out the water. Do not swallow it.-SYMBICORT may cause serious side effects, including:>Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using SYMBICORT to help reduce your chance of getting thrush.>Pneumonia and other lower respiratory tract infections. People with COPD may have a higher chance of pneumonia and other lung infections. 1.Resident #75 was admitted to the facility in May 2025 with diagnoses including Chronic Respiratory Failure with Hypoxia, Chronic Combined Systolic and Diastolic Congestive Heart Failure, Major Depressive Disorder, and bipolar disorder. Review of Resident #75's Physician's order dated 8/6/25, indicated the following: -Symbicort (Budesonide - Formoterol Fumarate Dihydrate) Inhalation Aerosol 80/4.5 microgram (mcg/act [actuation]), 2 puffs. Inhale orally two times a day for Shortness of Breath. Rinse mouth after use, initiated 7/28/25. On 8/6/25 at 7:33 A.M., during a medication administration pass, the surveyor observed Nurse #1 administer 2 puffs of Symbicort oral inhalation medication into Resident #75's mouth. The Resident closed his/her mouth for five seconds after the medication was administered. When Nurse #1 asked Resident #75 if he/she would like a drink of water, the Resident declined and Nurse #2 left Resident #75's room and placed the Symbicort inhaler back in the medication cart without requesting that the Resident rinse his/her mouth and spit. During an interview on 8/6/25 at 10:02 A.M., Nurse #1 said she should have encouraged Resident #75 to rinse his/her mouth after the use of the Symbicort Inhalation medication to avoid oral thrush, but she did not. 2. Resident #54 was admitted to the facility in December 2021 with diagnoses including Pure Hyperglyceridemia, Alcohol Induced Disorder, Unspecified Intercranial Injury, Bipolar Disorder, and Alcohol Dependence with Alcohol-Induced Persisting Dementia. Review of Resident #54's Physician's orders dated 8/6/25, indicated: -Keppra (Levetiracetam) Oral Tablet 750 milligram (mg), give 750 mg by mouth three times a day related to Epilepsy, initiated 5/1/25. On 8/6/25 at 8:06 A.M., during a medication administration pass, the surveyor observed Nurse #2 prepare medications to be administered to Resident #54. Nurse #2 was (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	08/12/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed to drop the Keppra medication on the surface of medication cart. Nurse #2 was further observed to don gloves, use a spoon and picked up the dropped medication and then added the Keppra medication to the souffle cup which contained the other prepared medications to be administered to Resident #54. During an interview on 8/6/25 at 8:12 A.M., Nurse #2 said the medication administration cart had not been cleaned and/or disinfected prior to her beginning the medication pass procedure. Nurse #2 said she was unsure when the medication cart was last cleaned. Nurse #2 said she should have discarded the Keppra medication that had dropped on the top of the medication cart and should have administered a new Keppra medication but did not.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a dignified existence for two Residents (#2 and #64), out of a total sample of 23 residents. Specifically, 1) For Resident #2, the facility failed to ensure privacy was provided before exposing the Resident's buttocks during a dressing change procedure, putting the Resident at risk of having their private parts viewed by others. 2) For Resident #64, the facility failed to ensure that the Resident was dressed in his/her clothing and not a hospital gown while in common spaces in the facility with other residents. Findings include: Review of the facility policy titled Resident Privacy and Dignity, dated 9/4/24, indicated the following: -Care for residents in a manner that maintains dignity and individuality: >Dress in appropriate and desired clothing. -Examine and treat residents in a manner that maintains their privacy. >Use a closed door, drawn curtain, or both to shield the resident during all personal care and treatment procedures. -Drape and dress residents appropriately at all times to avoid exposure and embarrassment. 1) Resident #2 was admitted to the facility in February 2025 with diagnoses including Metabolic Encephalopathy. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a possible score of 15. On 8/7/25 at 10:30 A.M., during a wound care observation being provided by Nurse #7, the surveyor observed the following: -Nurse #7 positioned Resident #2 on his/her right side facing the wall and exposed the Residents' buttocks to the open bedroom door, with the Resident's privacy curtain not pulled far enough to prevent visualization of the Resident's buttocks from the doorway. -the surveyor intervened and indicated visibility from the doorway to where Resident #2 was lying exposed in bed, and Nurse #7 immediately pulled the curtain far enough to prevent visualization of the Resident from the doorway. During an interview on 8/7/25 at 11:00 A.M., Nurse #7 said that she should have provided privacy for the Resident before exposing him/her. During an interview on 8/7/25 at 11:05 A.M., the Director of Nursing (DON) said that the expectation was that before exposing a Resident, staff should always provide privacy to maintain the Resident's dignity. 2) Resident #64 was admitted to the facility in February 2025 with diagnoses including Traumatic Subdural Hemorrhage. Review of Resident #64's MDS assessment dated [DATE], indicated the Resident had severe cognitive impairment as evidenced by a BIMS score of 0 out of a possible score of 15. Review of Resident #64's Care Plan failed to indicate that the Resident had a preference for wearing a hospital gown. On 8/5/25 at 12:30 P.M., the surveyor observed Resident #64 seated in his/her Broda chair in the day room on the unit. Resident #64 was observed wearing a hospital gown with no blanket or sheet present. The surveyor observed that multiple residents were present in the day room at this time. On 8/7/25 at 8:11 A.M., the surveyor observed Resident #64 seated in his/her Broda chair in the day room on the unit. The Resident was further observed dressed in a hospital gown with a blanket in place covering his/her lower torso to feet. On 8/7/25 at 11:47 A.M., the surveyor observed Resident #64 lying in bed dressed in a hospital gown and covered with a sheet and blanket. Nurse #6 was observed entering the room to assist another staff member in repositioning Resident #64. During an interview on 8/7/25 at 11:50 A.M., Nurse #6 said that Resident #64 typically wore clothing and not a hospital gown. The surveyor reviewed with Nurse #6 several observations of Resident #64 in commons spaces on the unit and dressed in a hospital gown. Nurse #6 said that the Resident should have been dressed in clothing when he/she came out of his/her room for breakfast this morning. On 8/7/25 at 12:00 P.M., the surveyor observed Resident #64 was in his/her Broda chair in the unit day room dressed in a t-shirt and pants. During an interview on 8/7/25 at 12:15 P.M., the surveyor reviewed with the Administrator observations of Resident #64 dressed in a hospital gown in the day room. The Administrator said there was a concern for dignity with the Resident wearing a hospital gown in a common space. The Administrator further said that the (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was known to frequently move around and push blankets off increasing the potential that he/she could be further exposed.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to implement abuse prevention policies and procedures relative to alleged incidents of potential abuse for two Residents (#16 and #66) out of a total sample of 23 residents. Specifically, the facility failed to implement their abuse policies and procedures, relative to prohibition, identification, and investigation, to determine whether abuse had occurred:a. For Resident #16, who was allegedly pushed and sworn at by Resident #66, and Nurse #9 as an agent of the facility did not report the incident as required for the investigation of all allegations.b. For Resident #66, who had a known history of aggressive behavior toward other residents, had an altercation with Resident #16 and allegedly pushed and swore at him/her, and Nurse #9 as an agent of the facility failed to report the incident and prevent any further incidents from occurring. Findings include: Review of the facility's policy titled Abuse, Neglect, and Exploitation: Prohibition, revised 9/3/24, indicated: -Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined by Federal regulation. -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Willful means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. -Residents most at risk of neglect and abuse, i.e. residents who have dementia, ., or have needs or behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors . Review of the facility's policy titled Abuse, Neglect, and Exploitation: Identification, revised 9/3/24, indicated: -The purpose of the policy was to proactively identify any event that may be potential abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property. -The facility will be proactive in identification of any event that may potentially be or would lead a reasonable person to conclude that there was a potential for abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property. Review of the facility's policy titled Abuse, Neglect, and Exploitation: Investigation, revised 9/4/24, indicated: -The purpose of the policy was to gather pertinent information regarding an alleged, witnessed, or observed incident that will facilitate proper reporting and follow up as indicated. -The staff member to who such an allegation is reported either verbally or in writing, or who witnesses and/or suspects potentially inappropriate treatment . will report the event immediately to the nursing supervisor. (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All alleged violations involving abuse, neglect, exploitation or mistreatment, ., shall be reported immediately: >but not later than two hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or >not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to: >the Administrator and to other officials in accordance with State law. a. Resident #16 was admitted to the facility in May 2024 with diagnoses including Dementia with Mood Disturbance, Major Depressive Disorder, and Generalized Anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #16: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15 total possible points. -required the use of a wheelchair for mobility. -required substantial/maximal assistance to wheel 50 feet. b. Resident #66 was admitted to the facility in September 2024 with diagnoses including Dementia with Behavioral Disturbance. Review of Resident #66's Behavioral Health Evaluation dated 10/22/24, indicated that facility staff requested the Resident be evaluated after the Resident had an altercation with another resident. Review of Resident #66's Behavioral Health Evaluations, dated 10/24/24 and 10/29/24, indicated the Resident exhibited aggressive behavior toward other residents. Review of Resident #66's Behavioral Health Evaluation, dated 11/29/24, indicated facility staff requested for the Resident to be evaluated after the Resident allegedly slapped and grabbed the hair of another resident. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #66: -was severely cognitively impaired as evidenced by a BIMS score of six out of 15 total possible points. -exhibited wandering over one to three days during the observation period for the MDS Assessment. -exhibited verbal behavioral symptoms (threatening others, screaming at others, cursing at others) over four to six days during the observation period for the MDS Assessment. Review of Resident #66's Behavioral Symptoms Care Plan, initiated 9/12/24 and revised 10/3/24, indicated the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was at risk for behavioral symptoms due to Dementia. -mood lability with intermittent agitation. -can be combative with direct care. -history of altercations with other residents. -can be verbally and physically aggressive. -may yell or exit seek. -ensure when Resident is leaving the Dayroom, no other residents are in the doorway. -if the Resident becomes agitated with another resident, offer diversional activity . -observe for any changes in mood or behavior; document, notify MD/MP [sic. NP: Nurse Practitioner] . -Team review to assess. Review of Resident #66's June 2025 Behavior/Intervention Monthly Flow Record indicated the following for 6/1/25 on the evening (3:00 P.M. - 11:00 P.M.) shift: -The Resident experienced five episodes of yelling out. -The Resident experienced two episodes of hitting or bitting [sic]. -The Resident experienced three episodes of being verbally abusive. Review of Resident #66's Nursing Progress Notes, dated 6/1/25 indicated: -written at 4:02 P.M., indicated: . increased agitation, hitting, and yelling at residents. -written at 8:07 P.M., indicated the Resident was hitting and pushing other residents. During an interview on 8/6/25 at 5:00 P.M., the Administrator said that she was not made aware that Resident #66 had pushed and hit other residents on 6/1/25. The Administrator said if she had been made aware that Resident #66 had pushed and hit other residents, an investigation of the incident would have been initiated immediately to determine what occurred, who the residents involved in the incident were, and whether the incident needed to be reported. The Administrator said an investigation had not been conducted because she was not alerted by facility staff of the alleged incident between Resident #66 and other residents. The Administrator said she attempted to contact Nurse #9 after the surveyor's inquiry relative to Resident #66's alleged incident with other residents on 6/1/25, and Nurse #9 could not be reached, and she was still looking to get in touch with the Nurse. The Administrator said she needed to initiate an investigation to determine whether or not resident-to-resident abuse had occurred. During an interview on 8/7/25 at 12:09 P.M., UM #2 said that when an incident involving potential (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse occurred on a weekend, the Nurse was required to notify the supervising on-call Nurse of the incident. UM #2 said that the supervising on-call Nurse would then come into the facility to ensure the process for investigating the incident for alleged abuse was properly initiated. UM #2 said that 6/1/25 was a Sunday and that she was the supervising on-call Nurse. UM #2 said she did not receive any notification from the Nurse #9 relative to Resident #66 yelling at, hitting, and pushing other residents, and that Nurse #9 should have contacted the supervising on-call Nurse to ensure the incident was thoroughly investigated. During an interview on 8/7/25 at 4:20 P.M., Nurse #9 said Resident #66 experienced episodes of agitation. Nurse #9 said she was assigned to care for Resident #66 during the evening shift on 6/1/25. Nurse #9 said Resident #66 was agitated and attempted to enter the Dayroom. Nurse #9 said Resident #16 was seated in a wheelchair in the doorway of the Dayroom, in front of Resident #66. Nurse #9 said Resident #66 pushed Resident #16's wheelchair, while Resident #16 was sitting it, and was swearing at Resident #16. Nurse #9 said she did not alert a nursing supervisor or administration of Resident #66 pushing Resident #16's wheelchair and swearing at Resident #16 because Resident #66 did not make any physical contact with Resident #16.

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	225296	A. Building B. Wing	08/12/2025

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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 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. Based on observation, record review, and interview, the facility failed to provide services that met professional standards of quality relative to medication management for two Residents (#75 and #54), out of a total sample of 23 residents. Specifically, the facility failed to: 1. For Resident #75, encourage the Resident to rinse his/her mouth as required after the administration of an oral corticosteroid inhalation medication, placing the Resident at risk of developing fungal infection of the mouth and airways. 2. For Resident #54, ensure that the Resident was not administered medication that was dropped on the medication cart surface, putting the Resident at risk of being administered contaminated medications. Findings include: Review of the facility policy titled Medication Pass Guideline, effective 6/1/12, indicated the following: -Purpose: To assure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely and sanitary manner. -Use sanitary techniques to place medications into a souffle or medicine cup. -The nurse is responsible for reading and following precautions and instructions on prescription labels. Review of professional standards article titled, Quick Guide to Using Your Symbicort Inhaler, Revised 2/2018, retrieved from https://www.symbicorttouchpoints.com/content/dam/physician-services/us/526-rwd-symbicort-hcp/pdf/03_usin indicated: -After using the Symbicort inhaler: After you finish taking SYMBICORT ., rinse your mouth with water. Spit out the water. Do not swallow it. >SYMBICORT may cause serious side effects, including: -Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using SYMBICORT to help reduce your chance of getting thrush. -Pneumonia and other lower respiratory tract infections. People with COPD may have a higher chance of pneumonia and other lung infections. 1.Resident #75 was admitted to the facility in May 2025 with diagnoses including Chronic Respiratory Failure with Hypoxia, Chronic Combined Systolic and Diastolic Congestive Heart Failure, Major Depressive Disorder, and bipolar disorder. Review of Resident #75's Physician's order dated 8/6/25, indicated the following: -Symbicort (Budesonide/Formoterol Fumarate Dihydrate) Inhalation Aerosol 80/4.5 micrograms (mcg/act) 2 puffs. Inhale orally two times a day for Shortness of Breath. Rinse mouth after use, initiated 7/28/25. On 8/6/25 at 7:33 A.M., during a medication administration pass procedure, the surveyor observed Nurse #1 administering two puffs of the Symbicort oral inhalation medication into Resident #75's mouth. The Resident was observed to close his/her mouth for approximately five seconds after the administration of the medication and Nurse #1 asked Resident #75 if he/she would like a drink of water. Resident #75 responded that he/she did not want a drink of water and Nurse #1 then walked out of Resident #75's room and placed the Symbicort Inhaler back in the medication cart without having the Resident rinse and spit as required after the medication use. During an interview on 8/6/25 at 10:02 A.M., Nurse #1 said she should have encouraged Resident #75 to rinse his/her mouth after the use of the Symbicort Inhalation medication to avoid oral thrush, but she did not. Nurse #1 said this not allowing Resident #75 to rinse his/her mouth after the use of the Symbicort Inhalation did not meet professional standards of care. 2. Resident #54 was admitted to the facility in December 2021 with diagnoses including Pure Hyperglyceridemia, Alcohol Induced Disorder, Unspecified Intercranial Injury, Bipolar Disorder, and Alcohol Dependence with Alcohol-Induced Persisting Dementia. Review of Resident #54's Physician's orders dated 8/6/25, indicated the following: -Keppra (Levetiracetam) Oral Tablet 750 milligram (mg), give 750 mg by mouth three times a day related to Epilepsy. Start date 5/1/25. On 8/6/25 at 8:06 A.M., during medication administration pass, the surveyor observed Nurse #2 to drop the Keppra medication on top of the medication administration cart. Nurse #2 was observed to don gloves and pick up the Keppra Medication using a spoon and placed the medication into a souffle cup with other medications prepared for Resident #54. Nurse #2 was observed to then administer the medications to Resident #54. During an interview on 8/6/25 at 8:12 A.M., Nurse #2 said the (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication administration cart had not been cleaned and/or disinfected prior to the beginning of her medication pass and she was unsure of when the medication cart was last cleaned. Nurse #2 said she should have discarded the Keppra medication that was dropped, and administered a new Keppra medication, but she did not. Nurse #2 said this did not meet professional standards and/or quality of care.

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	225296	A. Building B. Wing	08/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide care consistent with professional standards of practice to prevent deterioration of a pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) for one Resident (#2) of two applicable residents reviewed for pressure ulcer care and services, out of a total sample of 23 residents.Specifically, for Resident #2, the facility failed to ensure that the dressing change for a Stage 4 Pressure Ulcer of the left and right buttocks was completed per Physician's orders, when collagen powder and Calcium Alginate AG were not administered as ordered, placing the Resident at risk for complications related to the pressure ulcers. Findings included:Review of the facility policy titled Clean Dressing Change, dated September 2024, indicated the following:-Apply dressing and secure as ordered. Resident #2 was admitted to the facility in February 2025 with diagnoses including Metabolic Encephalopathy. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #2:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a possible score of 15.-has two Stage 4 Pressure ulcers that were present on admission. Review of Resident #2's August 2025 Physician orders indicated:-an active order initiated 6/18/25 for Dressing to left buttock: cleanse w/ns (with normal saline [solution of salt water used to clean wounds]), pat dry. Apply collagen powder (powder that is used to promote moist wound healing) to wound base, cover with Calcium Alginate AG (Silver: dressing material that is absorbent and due to the presence of AG/silver, has antimicrobial properties), then cover with foam border every day and evening shift.-an active order initiated 6/18/25 for Dressing to right buttock: cleanse w/ns, pat dry. Apply collagen powder to wound base, cover with Calcium Alginate AG, then cover with foam border every day and evening shift. On 8/7/25 at 10:30 A.M., the surveyor observed the following during wound care for Resident #2 provided by Nurse #7:-Nurse #7 performed hand hygiene and donned (put on) a gown and gloves-Nurse #7 removed the dressing from the Resident's right and left buttock-Nurse #7 doffed (removed) gloves and donned new gloves-Nurse #7 cleansed the wounds with normal saline soaked gauze-Nurse #7 doffed gloves and donned new gloves-Nurse #7 patted dry the wounds with clean, dry gauze-Nurse #7 doffed gloves, set up dressing material supplies, and donned new gloves-Nurse #7 placed a collagen matrix dressing material (solid dressing pad dressing material used to promote moist wound healing) on the wound beds of the right and left buttocks, covered it with Calcium Alginate (an absorbent dressing material that does not contain silver) and then covered the Calcium Alginate with a bordered foam dressing-Nurse #7 did not apply the collagen powder and Calcium Alginate AG as ordered by the Physician.-Nurse #7 doffed gloves and proceeded to complete the remaining dressing changes. During an interview on 8/7/25 at 11:00 A.M., Nurse #7 said that she had used collagen matrix dressing instead of the ordered collagen powder. Nurse #7 further said that she used a regular Calcium Alginate dressing instead of the ordered Calcium Alginate AG dressing. Nurse #7 said that the dressing order for the collagen had been changed from collagen matrix to collagen powder when the facility supply had changed to the collagen powder but when the facility supply available changed back to the collagen matrix, an order to resume use of the collagen matrix should have been obtained. Nurse #7 said that using the incorrect dressing could result in the wound worsening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care consistent with professional standards relative to an indwelling urinary catheter (a thin flexible tube inserted into the bladder to drain urine outside the body) for one Resident (#2), of two applicable residents reviewed for indwelling urinary catheter care and services, out of a total sample of 23 residents.Specifically, for Resident #2, the facility failed to obtain Physician's orders for the use of an indwelling urinary catheter placing the Resident at risk for urinary tract complications. Findings include:Review of the facility policy titled Indwelling Urinary Catheter: Policy, revised 9/1/24, indicated the following:-A physician's order must be obtained for insertion of an indwelling catheter. The order must include catheter size, balloon size and frequency of change. Resident #2 was admitted to the facility in February 2025 with diagnoses including Metabolic Encephalopathy. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #2:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a possible score of 15-utilized an indwelling urinary catheter Review of Resident #2's August 2025 Physician's orders failed to indicate an order for use of an indwelling urinary catheter. On 8/7/25 at 10:30 A.M., during a wound care observation with Nurse #7, the surveyor observed an indwelling urinary catheter tubing was secured to Resident #2's right leg and the urinary collection bag was secured to the bed below the level of the bladder. During an interview on 8/7/25 at 2:45 P.M., the surveyor and Unit Manager (UM) #1 reviewed Resident #2's Physician orders and UM #1 said there should be an order for the size of catheter, balloon size and what frequency the urinary catheter should be changed but there was not.

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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 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. Based on observation, interview, and record review, the facility failed to ensure care and services for respiratory equipment was maintained in accordance with professional standards of practice related to cleaning, storage, and infection control practices for one Resident (#86) out of a total sample of 23 residents.Specifically, for Resident #86, the facility failed to ensure that Resident #86's Bilevel Positive Airway Pressure (BiPAP) machine and accessory equipment were appropriately maintained and:-the humidifier chamber was cleaned per manufacturer recommendations to prevent growth of microorganisms and mineralization, putting the Resident at risk of inhaling microorganisms when the BiPAP device was in use.-the BiPAP mask and tubing was stored in a clean equipment bag when not in use to prevent contamination of equipment and potential sinus and respiratory infections for the Resident. Findings include: Review of the facility policy titled Chapter: Pulmonary, Care and Handling of Respiratory Equipment, revised 9/24, indicated the following:-Equipment should be changed based on the following schedule: >Daily: Empty and wipe clean before filing each day with distilled water. Wipe dust and debris from the external surface of machine. >Weekly: Wash chamber in warm water and mild soap (such as Dove unscented or Ivory). If the chamber does not open, soak with one part vinegar and 2 parts water. Rinse and dry before filling with distilled water.-When not in use, store masks and cannulas in plastic bags labeled with the resident's name and date. Resident #86 was admitted to the facility in June 2023 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure with Hypoxia or Hypercapnia, contracture right and left hand, morbid obesity, Quadriplegia, and Obstructive Sleep Apnea (OSA). Review of the most recent Minimum Data Set (MDS) Assessment, dated 5/6/25 indicated Resident #86:-was cognitively intact as indicated by a Brief Interview of Mental Status (BIMS) score of 15 out of 15.-was dependent for upper body care and personal hygiene.-utilized noninvasive mechanical ventilation. On 8/5/25 at 10:31 A.M., the surveyor observed Resident #86 lying in bed and a BiPAP machine located on his/her bedside table. The surveyor observed the BiPAP mask was directly in contact with the Resident's bedside table and was not stored in a bag. The surveyor also observed the humidifier chamber was dry with debris on the bottom. During an interview at the time, Resident #86 said he/she wore the BiPAP machine each evening and nursing assisted him/her with putting it on and filling the humidifier chamber with water. Resident #86 said he/she could not remember when his/her BiPAP mask, tubing, and humidifier chamber had been cleaned by the nursing staff. Resident #86 further said he/she was physically not able to clean the BiPAP device him/herself. On 8/6/25 at 8:24 A.M., the surveyor observed Resident #86 lying in bed. During an interview at the time, Resident #86 said he/she was able to remove his/her BiPAP mask and laid it on the bed as no staff have been in to assist him/her as yet. The surveyor observed the humidifier chamber on the BiPAP machine had debris floating in the water. On 8/6/25 at 9:03 A.M., the surveyor observed Resident #86 lying in bed and his/her BiPAP mask was now laying in direct contact with the Resident's bedside table. During an interview at the time, Resident #86 said a Certified Nurse Aide (CNA) came in to provide care and moved the BiPAP mask to the bedside table and did not put it in a bag. Review of Resident #86's August 2025 Physician orders indicated the following:-Change Oxygen tubing that goes to BiPAP weekly on Saturday, every night shift 11:00 P.M. - 7:00 A.M., every Saturday, start date of 6/14/25.-BiPAP Orders: IPAP (Inspiratory Pressure) 14.0 cm (centimeter) H2O (water), EPAP (Expiratory Pressure) 6.0 cm H20, FiO2 - 2 Liters Per Minute (LPM) daily at bedtime and during naps, every shift, start date of 6/17/23Further review of the Physician's orders failed to indicate orders for the cleaning and maintenance of Resident #86's BiPAP machine and equipment. During an interview on 8/6/25 at 8:42 A.M., Unit Manager (UM) #3 said it was the Respiratory Therapist's (RT) job to ensure the BiPAP machine is cleaned weekly. UM #3 said nursing does not put in Physician's orders for cleaning of the BiPAP machine since it is taken care of by the RT. During an interview on 8/6/25 at 9:44 A.M., the RT said she came into the facility weekly to see any residents with respiratory needs. The RT said she (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	does not see all residents in the facility every week. The RT said residents who have BiPAP machines are seen at least yearly, and she ensures that they are using their equipment appropriately and provides education to the residents if needed. The RT said she did not clean BiPAP equipment unless she was visiting a resident when she was in the facility. The RT said routine cleaning should be done by the nursing staff at the facility and this included cleaning the tubing and mask in warm soapy water weekly and emptying the humidifier chamber and wiping it clean daily. The RT said it is important to clean the BiPAP equipment on a regular basis as it reduced the risk for a resident acquiring a respiratory illness. The RT said it is also important to make sure debris was cleaned out of the humidifier chamber to ensure mineralization (buildup of minerals from water) did not occur. On 8/6/25 at 10:07 A.M., the surveyor and Nurse #4 observed Resident #86 lying in bed and his/her BiPAP mask was laying directly in contact with the bedside table. During an interview at the time, Nurse #4 said any staff member who assists the Resident with his/her BiPAP mask should bag the mask (in an equipment storage bag). Nurse #4 looked for a storage bag and said there was no bag in the room to store the BiPAP mask. The surveyor and Nurse #4 also observed the water in the humidifier chamber and Nurse #4 said there was debris in the chamber, and it should have been cleaned prior to the Nurse adding water the previous night. Nurse #4 said there should be Physician's orders in place for cleaning of the BiPAP machine which should include how to clean the different parts of the BiPAP machine. The surveyor and Nurse #4 reviewed Resident #86's current Physician's orders and Nurse #4 said Resident #86 did not have any orders in place for the cleaning of his/her BiPAP machine and orders should be in place. Nurse #4 said it was important to ensure respiratory equipment was maintained and cleaned regularly to reduce the chance of the Resident acquiring a respiratory infection. During an interview on 8/6/25 at 11:14 A.M., the Director of Nursing (DON) said there should be Physician's orders for BiPAP machine cleaning. The DON said those orders should include wiping down the mask and humidifier chamber daily and cleaning all parts with warm soapy water weekly. The DON said once an order was in place nursing would sign off each time cleaning was completed on the Treatment Administration Record (TAR) or Medication Administration Record (MAR). The DON said since Resident #86 did not have orders for the care of his/her BiPAP she could not be sure when the last time the equipment had been cleaned which put the Resident at risk for acquiring a respiratory infection.

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	225296	A. Building B. Wing	08/12/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record reviews, the facility failed to provide care and services consistent with professional standards of practice for dialysis (process that filters waste, salt, and fluid from your blood when the kidneys are unable to work adequately) services, for one Resident (#6) out of one applicable dialysis resident, out of a total sample of 23 residents.ˆ Specifically, for Resident #6, the facility failed to:ˆ -Accurately monitor daily fluid intakes as ordered by the Physician, when the Resident was dependent on Renal Dialysis, placing the Resident at risk for fluid status changes, difficulty breathing, edema (swelling caused by a buildup of fluids in the body's tissues) and dehydration (when the body uses or loses more fluid than it takes in). Findings include: Review of the Facility Policy titled Care of Renal Dialysis Resident, dated 9/1/14, indicated the following: -Dietary management involves restriction or adjustment of protein, sodium, potassium, or fluid intake. Staff to provide education on risk vs benefits of not adhering to restrictions. -Document the daily intake and output total on the 24-Hour Intake and Output (I & O) Record or Medication Administration Record. Review of the Facility Policy titled Intake & Output (I & O) Measurement, revised 9/4/24 indicated the following: >To ensure the resident's fluid balance is assessed and managed appropriately in order to prevent dehydration. -All nursing personnel are responsible for recording on the Intake and Output (I & O) Record. -The licensed nurse is responsible for totaling the intake and output each shift during his/her tour of duty and assessing the resident for necessary interventions. -Intake and Output may be ordered by the physician or by the licensed nurse to assess fluid balance. >Residents with the following risk factors/clinical characteristics will be placed on intake and output as indicated below: -Fluid Restriction - duration of therapy. -Renal/Peritoneal Dialysis - duration of therapy or as ordered by physician. -All oral (PO) fluids are recorded in the Intake column after consumption. -If a resident does not consume any oral fluids during a given shift, a zero of NPO (Nothing by Mouth) will be recorded in the shift total column. Never leave this column blank. -The Certified Nurse Aide (CNA) and licensed nurse are responsible for recording intake and output in the Daily Intake & Output Worksheet for identified residents. -The nurse calculates the 8-hour total on the I & O worksheet and records the total on the permanent 24-Hour Intake and Output Record/MAR (Medication Administration Record). -The 3:00 P.M. - 11:00 P.M or 11:00 P.M. - 7:00 A.M. shift nurse (to be determined by DON [Director of Nursing]) totals the I & O for all 3 shifts and records the total on the 24-Hour Intake and Output Record/MAR. Review of the Facility Policy titled MD (Medical Director) Notification, dated 9/1/24, included but not limited to the following: >Is to notify the resident's physician of any changes in the resident's condition, treatment, and/or medication issues. -At any point, the licensed nurse should immediately notify the resident's attending physician of an identified change in the resident's medical condition, treatment plan, or issues or medications concerns. Review of the Facility Policy titled Charting and Documentation, dated 9/1/24, indicated the following: >It is the policy of the facility that all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. -All observations, medications administered, services performed, etc., (et cetera) must be documented in the resident's clinical records. >Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: -The assessment data and/or any unusual findings during the procedure/treatment. -Notification of family, physician or other staff, if indicated. Resident #6 was admitted to the facility in October 2024, with diagnoses including End Stage Renal Disease (ESRD), Dependence on Renal Dialysis, and Hypertension. Review of the Minimum Data Set (MDS) Assessment, dated 7/17/25, indicated Resident #6: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a total possible score of 15. -was on dialysis. -was on a Therapeutic diet. Review of Resident #6's Comprehensive Person-Centered Care Plan initiated 11/10/24, indicated:-was at risk for fluid imbalance secondary to ESRD on Hemodialysis (HD) and fluid restriction requiring therapeutic diet with interventions that included: >1500 milliliter (ml) fluid (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restriction - 840 ml via kitchen and monitor intake and record every (q) meal. -needed dialysis related to renal failure with intervention to monitor intake and output. Review of Resident #6's August 2025, Physician orders indicated: -No Salt Packet diet Regular (level 7) texture, thin consistency, 1500 cubic centimeter (cc: unit of volume that is equivalent to a milliliter) fluid restriction; 840 ml from kitchen, initiated 11/7/24. -1500 cc Fluid Restriction - 24 Hour Total to be totaled by 11:00 P.M. Nurse every night shift (11:00 P.M.- 7:00 A.M.) for Total Fluid Intake - Restriction Monitoring. Notify Provider if fluid restriction exceeded, initiated 6/13/25. -1500 cc Fluid restriction; (840 ml provided with meals from dietary) nursing breakdown is 220 ml: 7:00 A.M.- 3:00 P.M. (day shift), 220 ml: 3:00 P.M. - 11:00 P.M. (evening shift), 220 ml: 11:00 P.M. - 7:00 A.M. (night shift) every shift, initiated 6/13/25. -Intake & Output every shift for 1500 cc fluid restriction, initiated 3/8/25. -Dialysis Center Monday, Wednesday and Friday - pick-up at 7:15 A.M., Return 12:30 P.M., initiated 5/23/25 Review of Resident #6's Treatment Administration Record (TAR) for April 2025 through August 2025, indicated that Resident #6 exceeded the prescribed fluid restriction as follows: >April 2025 - 4/5/25: 1780 ml, 4/13/25: 1580 ml, 4/14/25: 1560 ml, 4/18/25: 2720 ml, 4/19/25: 2640 ml, 4/20/25: 1680 ml. >May 2025 - 5/3/25: 2180 ml, 5/4/25: 1680 ml, 5/16/25: 1580 ml, 5/17/25: 1700 ml, 5/18/25: 2400 ml, 5/22/25: 1840 ml, 5/23/25: 1800 ml, 5/29/25: 2140 ml, 5/31/25: 1620 ml. >June 2025 - 6/17/25: 2760 ml, 6/18/25: 1860 ml, 6/20/25: 1950 ml, 6/24/25: 1800 ml, 6/25/25: 2060 ml, 6/27/25: 1920 ml. > July 2025 - 7/1/15: 2000 ml, 7/2/25: 2000 ml, 7/3/25: 1940 ml, 7/4/25: 1600 ml, 7/5/25: 1680 ml, 7/9/25: 1550 ml, 7/19/25: 2540 ml, 7/24/25: 1880 ml, 7/25/25: 1680 ml, 7/26/25: 1720 ml. > August 2025 - 8/1/25: 1540 ml, 8/7/25: 1860 ml. Further review of Resident #6's Nursing Progress Notes failed to provide evidence that the Resident's Physician was notified of fluid intakes exceeding 1500 cc. Review of Resident #6's Physician Progress Notes from October 2024 through July 2025 indicated the Physician documented the Resident had low extremity edema: -November 2024: bilat (bilateral) 1-2+ (pitting [indentation] measurement) edema -March 2025: bilateral lower extremity edema was documented on 3/12/25 and 3/26/25: 1+, 3/14/25:1 - 2+, 3/28/25: 2+. -April 2025: bilateral lower extremity edema was documented on 4/2/25 and 4/23/25: 1+, 4/9/25: 2+, 4/13/25: 2 - 3+. -May 2025: bilateral lower extremity edema was documented on 5/11/25: 2+. -July 2025: bilateral lower extremity edema was documented on 7/25/25: 2+. During an interview on 8/8/25 at 12:35 P.M., Unit Manager (UM) #1 said that Resident #6 was prescribed a 1500 ml fluid restriction but sometimes had soda beverage at his/her bedside that the Resident drank. UM #1 said that the nursing staff added fluids to Resident #6 meal trays prior to serving the trays to the Resident. UM #1 said that the Physician should be notified when Resident #6 exceeds the 1500 ml fluid restriction order. UM #1 said that Resident #6 was at risk for weight gain when the 1500 ml Fluid Restriction is exceeded. During an interview on 8/8/25 at 12:41 P.M., the Director of Nursing (DON) said that the nursing staff should notify the Physician and the Dialysis Center each time Resident #6 was over the 1500 ml fluid restriction order. The surveyor and the DON reviewed Resident #6 progress notes and the DON said that there was no documentation in Resident #6's clinical records that indicated the Resident's Physician was notified about the Resident exceeding the fluid restriction order. The DON said when Resident #6 exceeds the fluid restriction order the Resident could be at risk for fluid overload and renal failure. ˆDuring an interview on 8/8/25 at 1:20 P.M., with the Registered Dietician (RD) and the Administrator, the Administrator said if Resident #6 was exceeding the prescribed 1500 ml fluid restriction, then the team should have brought the concern forward at risk management meetings to discuss the situation, review the orders, and contact the Dialysis Center and the Resident's Nephrologist for recommendations.ˆThe RD said that she was unaware that Resident #6 was exceeding his/her fluid restriction because the nursing staff had not brought it to her attention. The RD said that the Resident's fluid restriction had been an ongoing education topic with nursing staff to ensure that the Resident's fluid restriction orders were followed.

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	225296	A. Building B. Wing	08/12/2025

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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, interview and record review, the facility failed to ensure that medications were stored in a safe and secure manner for one Resident (#123) out of a total of 23 sample residents.Specifically, for Resident #123, the facility failed to ensure that:-two over-the-counter medications were secured and not left at the Resident's bedside and readily accessible to other residents on the unit.-a Physician's order was obtained for the use of two over-the-counter medications brought into the facility by the Resident's family.-an assessment was completed to ensure the Resident was capable of self-administering medications. Findings include:Review of the facility policy titled Medication Pass Guidelines, dated 6/1/2012, indicated:-Purpose: To assure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely and sanitary manner.-Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with the guideline for self-administration of medication.-Medications are administered in accordance with written orders of the attending physician. Review of facility policy titled, Bedside Storage of Medications, dated 4/2024, indicated:-Bedside medication storage is permitted for residents who are willing and able to self-administer medications upon the written order of the prescriber, when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team.-a written order for the bedside storage of medication is placed in the resident's medical record.-The nurse performs a self-administration assessment and determines the resident's capability to self-administer using a self-medication assessment form documenting any limitations.-Bedside storage of medications is indicated on the resident medication administration record for the appropriate medications.>For residents who self-administer some or all medications, the following conditions are met for bedside storage to occur:-locked drawer at bedside.-the resident will have a key to the drawer and will be able to unlock the drawer independently.-the resident is instructed in the proper use of bedside medications including what the medication is used for, how it is to be used, how often it may be used, proper cleaning of inhaler, proper storage. Resident #123 was admitted to the facility in July 2025 with diagnoses including Overactive Bladder, Hypertension and vertebrogenic Low Back Pain. Review of Resident #123's Minimum Data Set (MDS) assessment, dated 7/30/25, indicated that the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. On 8/6/25 at 8:02 A.M., during a medication administration pass, the surveyor observed Nurse #1 administer medications to Resident #123. The surveyor observed the following medications on the Resident's bedside table:-Biotene Dry Mouth Moisturizing Spray (two boxes) labeled with the Resident's name, with indications as saliva stimulant.-Simple Saline Nasal Spray Instant Relief, every day for congestion.During an interview at the time, Resident #123 said the Biotene Dry Mouth Moisturizing Spray and Simple Saline nasal spray were medications that were brought from home upon his/her admission to the facility. Resident #123 said he/she used the medications whenever he/she desired due to dry mouth and nasal stuffiness. During an interview on 8/6/25 at 8:30 A.M., the surveyor and Nurse #1 reviewed Resident #123's medications and Nurse #1 said Resident #123 did not have Physician orders for the Biotene and the Simple Saline nasal spray medications. Nurse #1 also said the Resident had not been assessed for safe self-administration of medications. Nurse #1 further said the Biotene dry mouth spray and saline nasal spray were not supposed to have been left at Resident #123's bedside and should have been locked up for safety. During an interview on 6/6/25 at 10:15 A.M., Unit Manager (UM) #3 said Resident #123 should have been assessed for indication for use of the medication. UM #3 said Resident #123 should have been assessed for self-administration of the medications, a Physician's order should have been obtained, and the medications should have been secured but none of these had been done.

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	225296	A. Building B. Wing	08/12/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to adhere to infection control standards of practice for one Resident (#2) out of a total sample of 23 residents and on one unit ([NAME]) out of four total units observed. Specifically, the facility failed to:1a.for Resident #2, ensure that staff performed hand hygiene as required between glove changes while providing wound care to the Resident.-b. ensure that staff wore the indicated Personal Protective Equipment (PPE: items such as gown and gloves used to mitigate the spread of infection) when providing care for a Resident who required Enhanced Barrier Precautions (EBP: protective barrier gowns and gloves used as an infection control intervention designed to reduce transmission of multi-drug-resistant organisms [MDRO] during high contact resident care).2. ensure that staff disinfected the glucometer machine between residents while performing finger stick blood sugar checks, increasing the risk for the potential spread of infection from one resident to another.Findings include: 1a. Review of the facility policy titled Hand Washing: Employee, dated February 2022, indicated the following: -Wash hands with soap and water when they are visibly dirty or soiled with blood or other body fluids. -If hands are not visibly soiled, an alcohol-based hand rub or gel may be used in place of soap and water. -Handwashing must be performed under the following conditions: >if hands will be moving from a contaminated body site to a clean body site during resident care. >after removing personal protective equipment (e.g., gloves, gown, facemask). Review of the facility policy titled Clean Dressing Change, dated September 2024, indicated the following: -.14. remove soiled dressing and gloves, place in bag for disposal -15. Perform hand hygiene -16. Put on clean gloves -17. Clean wound as ordered, carefully dry skin around wound. -18. Remove gloves -19. Perform hand hygiene -20. Put on clean gloves. Resident #2 was admitted to the facility in February 2025 with diagnoses including Metabolic Encephalopathy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE] indicated the following: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a possible score of 15 -has 2 stage 4 pressure ulcers that were present on admission Review of Resident #2's August 2025 Physician orders indicated the following: -an active order initiated on 2/13/25 to maintain Enhanced Barrier Precautions (EBP). On 8/7/25 at 10:30 A.M., the surveyor observed the following during wound care provided to Resident #2 by Nurse #7: -Performed hand hygiene and donned (put on) a gown and gloves. -Remove the soiled dressing from the Resident's right and left buttocks. -doffed (removed) gloves, performed hand hygiene and donned new gloves. -cleansed the wounds with normal saline soaked gauze. -doffed gloves and donned new gloves without performing hand hygiene. -patted dry the wounds with clean, dry gauze. -doffed gloves, set up dressing material supplies without performing hand hygiene, and donned new gloves without performing hand hygiene. -completed the dressing application to the right and left buttock. -doffed gloves and donned new gloves without performing hand hygiene. -repositioned the Resident to his/her left side and removed the dressing to the right gluteal fold. -doffed gloves and donned new gloves without performing hand hygiene. -cleansed the right gluteal fold wound with normal saline soaked gauze and then patted the wound dry with dry, clean gauze. -doffed gloves, set up dressing material supplies without performing hand hygiene, and donned new gloves without performing hand hygiene. -applied the dressing as ordered to the right gluteal fold. -cleaned up and discarded items into trash, removed gown and gloves, performed hand hygiene and exited Resident #2's room. During an interview on 8/7/25 at 11:00 A.M., Nurse #7 said that hand hygiene should be performed (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every time that gloves are changed to prevent cross-contamination, but she did not perform hand hygiene each time she changed her gloves. 1b. On 8/6/25 at 2:14 P.M., the surveyor observed the following from the hallway outside Resident #2's room: -Enhanced Barrier Precaution (EBP) sign and a three drawer Personal Protective Equipment (PPE) bin located outside of the Resident's room that contained multiple items including disposable gowns and gloves. -Resident #2's curtain was drawn but the Resident's feet and end of the bed were visible. -CNA #1 was observed coming around the bed with bed sheets in her gloved hands. -CNA #1 was not observed to don a gown. On 8/6/25 at 2:17 P.M, the surveyor requested Nurse #5's observation of personal care being provided to Resident #2. During an interview at the time, when Nurse #5 exited the Resident's room, she said the Resident was on EBP for multiple reasons that included infections but was not completely sure what those infections were. Nurse #5 said the Resident was also on EBP due to his/her wounds and urinary catheter. Nurse #5 said when she went into the room, she observed CNA #1 providing care for Resident #2 and the CNA should have had on a gown but did not have a gown on as required. 2. Review of the facility policy titled Blood Glucose Meter: Cleaning and Disinfecting, revised 9/1/24, indicated: -Cleaning and disinfection of fingerstick glucose machines are needed to help decrease infection prevention of bloodborne pathogens. Staff must follow infection control guidelines. -Equipment – blood glucose monitoring device with Isopropyl alcohol (70% - 85%) and 1:10 bleach solution or EPA – registered disinfectant detergent or germicide that is approved for healthcare settings. -Cleaning 1. Wear appropriate protective gear such as disposable gloves. 2. Open the cap of the disinfectant container and pull out one towelette and close the cap. 3. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids. 4. Dispose of the used towelette in a trash bin. 5. Pull out one new towelette and wipe the entire surface of the meter three times horizontally and three times vertically using a new towelette to remove blood borne pathogens. 6. Dispose of the used towelette in a trash bin. (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Allow exteriors to remain wet for the corresponding contact time for each disinfectant. 8. After disinfection, the user's gloves should be removed to be thrown away and hands washed before proceeding to the next patient. On 8/6/25 at 8:08 A.M., the surveyor observed Nurse #2 perform a blood glucose finger stick check on a resident. Nurse #2 was observed cleaning the glucometer machine with a facility provided Sani Hand Wipes (pre-moistened wipes designed for quick and effective hand hygiene, particularly in situations where soap and water are not readily available). Nurse #2 was observed performing finger stick blood glucose checks on four other residents and using the Sani Hand Wipes as the cleaning agent between glucometer use. The surveyor observed that one of the four residents was on EBP, and Nurse #2 failed to clean the glucometer as required after use. During an interview on 8/6/25 at 8:45 A.M., Nurse #2 said she was a full-time employee at the facility and had always used the Sani Hand Wipes to clean the glucometer machine after performing finger stick blood glucose checks on any resident. During an interview on 8/6/25 at 9:02 A.M., Unit Manager (UM) #2 said facility staff are expected to use Super Sani-Cloth Germicidal disposable wipes (Isopropyl alcohol (70% - 85%) and 1:10 bleach solution or EPA – registered disinfectant detergent or germicide that is approved for healthcare settings) on equipment. During an interview on 8/6/25 at 9:06 A.M., with Nurse #2 and UM #2, Nurse #2 said that she had always used the Sani Hand Wipes to clean the glucometer machine after each finger stick blood glucose on residents.

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	225296	A. Building B. Wing	08/12/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide education on the benefits and risks of Pneumococcal Vaccination for one Resident (#15) of five applicable residents reviewed for vaccination, out of a total sample of 23 residents. Specifically, the facility failed to provide evidence that education was provided to the Resident #15's invoked Health Care Proxy (HCP) when the Resident was offered the Pneumococcal Vaccine and refused administration of the vaccine. Findings include: Review of the facility's policy titled Immunization and Vaccines- residents, last revised February 2022, indicated but is not limited to the following:-Vaccine information statements and consent for pneumococcal and influenza will be part of the resident's admission packet. Consent for these vaccinations will be obtained from the resident or resident representative at the time of admission. -Orders for administration of pneumococcal and annual influenza vaccine will be obtained/ or written by the resident's MD/NP (Medical Doctor/ Nurse Practitioner) on admission. -Persons with previous vaccination with PPSV23 (Pneumovax 23: vaccine used to help protect against serious infections caused by 23 types of pneumococcal bacteria): Adults 65 years or older who have previously received one or more doses of PPSV23 also should receive a single dose of PCV13 (Prevnar 13: vaccine used to protect against 13 types of pneumococcal bacteria that commonly cause serious infections) if they have not received it. A dose of PPCV23 should be given 1 year or > after the receipt of the most recent PPSV23 dose. For those whom an additional dose of PPSV23 is indicated this subsequent PPSV23 dose should be given 1 year or > after the PCV13 and 5 years after the most recent dose of PPSV23. -Before offering pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization: - And the resident or resident's legal representative has had the opportunity to refuse immunization; and -The resident's medical record includes documentation that indicates, at a minimum, the following: >The resident or resident's legal representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization: and >That the resident either received the pneumococcal immunization or did not receive the immunization due to medical contraindication or refusal. Resident #15 was admitted to the facility in December 2024 with diagnoses including Dementia and Dysphagia. Review of the MDS (Minimum Data Set) assessment dated [DATE], indicated Resident #15: -was cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of nine out of a total possible 15. -Health Care Proxy (HCP) was invoked. -was over the age of 65. -had declined the Pneumonia Vaccine. Review of Resident #15's Vaccine Consent Form dated 12/3/24, indicated the form was signed by the HCP and consent was given for Pneumococcal Vaccination. Review of Resident #15's Immunizations Record indicated the following: -PPSV23: Received on 7/30/14. -PCV20: Resident Refused on 2/4/25. Review of the Resident's Progress Notes, dated 2/4/25, indicated Resident #15 was approached by Nursing staff twice and refused twice when the Pneumococcal Vaccine was offered. During an interview on 8/8/25 at 7:59 A.M., the Infection Preventionist (IP) said that if a Resident is offered a vaccine and refuses, staff should educate the Resident and their HCP on the risks and benefits of vaccination. During an interview on 8/8/25 at 8:30 A.M., Nurse #8 said that Resident #15 refused the offered Pneumococcal Vaccine twice on 2/4/25. Nurse #8 said he provided education to the Resident and had also contacted the Resident's HCP. Nurse #8 said that when a Resident refuses an offered vaccination, the refusal would be documented and include if education was provided. During an interview on 8/8/25 at 9:05 A.M., the IP said that she monitors resident immunizations by running a weekly report which also indicates refusals or acceptances of vaccines offered. The IP said that if a resident refused a vaccination, she would speak with the Unit Manager (UM), the Resident, and the Responsible Party regarding the benefits and risks of the vaccination and provide the Vaccine Information Sheets. The IP said they also will re-approach any residents that may refuse a couple of weeks later and involve (continued on next page)

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	225296	A. Building B. Wing	08/12/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family support or behavioral interventions as needed. Further review of Resident #15's medical record failed to indicate that the Resident or HCP were provided education on the benefits and risks of the Pneumococcal Vaccination when the Resident refused on 2/4/25.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review, and interview, the facility failed to ensure that discharge tracking Minimum Data Set (MDS) Assessments were completed as required for three Residents (#25, #27, and #82) of four applicable residents, out of a total sample of 23 residents. Specifically, the facility failed to ensure that Discharge MDS Assessments were completed when Residents #25, #27 and #82 were discharged from the facility to the community. Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) version 3.0 Manual dated 10/1/24, reviewed at https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf Section 2.8 Skilled Facility Prospective Payment System Assessment Schedule indicated the following:-Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility . 1. Resident #25 was admitted to the facility in February 2025. Review of Resident #25's clinical record indicated he/she was discharged to the community on 3/10/25. Further review of the clinical record failed to indicate that a Discharge MDS was completed, as required. 2. Resident #27 was admitted to the facility in February 2025. Review of Resident #27's clinical record indicated he/she discharged to the community 3/10/25. Further review of the clinical record failed to indicate that a Discharge MDS was completed, as required. 3. Resident #82 was admitted to the facility in March 2025.Review of Resident 82's clinical record indicated he/she discharged to the community on 4/25/25. Further review of the clinical record failed to indicate that a Discharge MDS was completed, as required. During an interview on 8/8/2025 at 12:59 PM, the MDS Coordinator said that she utilizes the RAI manual which indicates a Discharge MDS is required when Residents discharge to the community. The surveyor and the MDS Coordinator reviewed Resident's #25, #27, #82 records and the MDS Coordinator said that Discharge MDS assessments should have been completed for the three Residents as required and had not been completed.

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	225296	A. Building B. Wing	08/12/2025

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post required nurse staffing information daily that included the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides. Specifically, the facility failed to post the required nurse staffing information and the actual hours worked by licensed and unlicensed nursing staff on 8/6/25, 8/7/25, and 8/8/25. Findings include: On 8/6/25 at 3:48 P.M., the surveyor observed a staff posting form in the lobby dated 8/6/25 that included the census and the number of staff broken down by job type per shift. The posted nurse staffing information failed to indicate the actual hours worked or hours in a shift for licensed and unlicensed staff. On 8/7/25 at 8:35 A.M, the surveyor observed a staff posting form posted in the lobby that was still dated 8/6/25 and included the census and number of staff broken down by job type per shift but failed to indicate the actual hours worked or hours in a shift for licensed and unlicensed staff. On 8/8/25 at 2:25 P.M., the surveyor observed a staff posting form posted in the lobby that was still dated 8/6/25 and included the census and number of staff broken down by job type per shift. The posted nurse staffing information failed to indicate the actual hours worked or hours in a shift for licensed and unlicensed staff. During an interview on 8/8/25 at 2:27 P.M., the surveyor and the Administrator reviewed the nurse staff posting form posted in the lobby. The Administrator said the nurse staff form should be updated every day but had not been updated. The Administrator said she was unaware of the requirement to post the actual hours worked for staff.