STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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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. 41105 Based on observation, record review and interview the facility failed to provide a dignified existence for one Resident (#110) out of a total sample of 30 residents. Specifically: For Resident #110, who is dependent on staff for feeding, the staff stood beside the bed, looking down at Resident #110, rather than seated at eye level while feeding him/her meals. Findings include: The facility policy titled Dignity, dated February 2021, indicates the following: -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth ad self-esteem. -5. When assisting with care, residents are supported in exercising their rights. For example, residents are: e. provided with a dignified dining experience. Resident #110 was admitted to the facility in February 2024 and has diagnoses that include Alzheimer's disease, history of falling and hemiplegia affecting right dominant side. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/18/24, indicated that on the Brief Interview for Mental Status exam Resident #110 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #110 had no behavior of rejecting care and was dependent on staff for all Activities of Daily Living (ADLs). Review of the current care plan for Resident #110 indicated the following: -Focus: Resident is at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing eating, bed mobility, transfer, locomotion, toileting related to: recent illness, fall hospitalization , etc, resulting in fatigue, activity intolerance, confusion, etc. -Interventions include: Provide assist to the resident with meals-prefers to eat in his/her bedroom, initiated 2/19/24 (continued on next page)

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	Review of the Functional Abilities and Goals Assessment, dated 12/18/24, indicated Resident #110 was dependent on staff for all ADLs, including eating. Review of the Task documentation for eating, in the past 14 days, indicated Resident #110 was dependent on staff for eating. On 2/11/25 at 9:00 A.M., the surveyor observed Resident #110 in bed, while a staff person stood beside the bed, looking down at Resident #110 feeding him/her. On 2/12/25 between 9:02 A.M., and 9:08 A.M., the surveyor observed Resident #110 in bed, while a staff person stood beside the bed, looking down at Resident #110 feeding him/her. On 2/13/25 at 9:28 A.M., the surveyor observed Resident #110 in bed, while a staff person stood beside the bed, looking down at Resident #110 feeding him/her. There was a second staff person in the room, standing while feeding Resident #110's roommate. During an interview and observation on 2/13/25 at 9:33 A.M., with the Assistant Director of Nursing (ADON) she said staff should be seated at eye level while assisting with meals. The two CNAs were observed standing while feeding and the ADON instructed them to get chairs and sit while feeding the residents.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 41105 Based on observations and interviews, the facility failed to ensure resident protected health information (PHI) was secure and not visible to others on two of three nursing units. Findings include: Review of the facility policy titled Confidentiality of Information and Personal Privacy, dated as revised February 2021, indicated the following: 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his or her: b. medical treatment 4. Access to resident personal and medical records will be limited to authorized staff and business associates. On 2/11/25 at 8:28 A.M., the surveyor observed an unattended medication cart on the third-floor unit. The computer on top of the cart was open, displaying a resident's name and a list of his/her medications. During an interview on 2/11/25 at 8:31 A.M., with Nurse #5 said that the screen on her computer, displaying a resident's medical information, should be privatized and not left open when unattended. On 2/11/25 at 3:30 P.M., the surveyor observed an unattended nursing laptop in the first-floor unit's common area. The screen was open, displaying a resident's name, date of birth, and medication, visible to anyone who passed by. During an interview on 2/14/25 at 9:43 A.M., with the Director of Nursing said the computers with resident's information should be shut down or put to sleep when unattended.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations, record review and interviews, the facility failed to complete an assessment for an air mattress with bolsters for one Resident #87 out of a sample of 30 Residents. Specifically, the facility failed to complete a restraints assessment before applying an air mattress with bolsters in the Resident's bed. Findings include: A review of the facility policy titled 'Use of Restraints' with a revision date of April 2017 indicated the following: - Physical Restraints are defined as any manual method or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. -Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. -Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. Resident #87 was admitted to the facility in July 2022 with diagnoses including dementia. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated that the Resident is rarely/never understood. Further review of the MDS indicated the following: -Roll left to right-Dependent (Helper does all the effort. Resident does none of the effort to complete the activity). -Sit to lying-Dependent (Helper does all the effort. Resident does none of the effort to complete the activity). -Lying to sitting on side of the bed-Dependent (Helper does all the effort. Resident does none of the effort to complete the activity). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Chair/bed-Chair transfer. The ability to transfer to and from a chair or (wheelchair)-Dependent (Helper does all the effort. Resident does none of the effort to complete the activity). On 2/11/25 at 8:02 A.M., the surveyor observed the Resident in bed, sleeping, wiggling from side to side with both legs over the bolster of the air mattress. On 2/12/25 at 8:36 A.M., the surveyor observed the Resident in bed, sleeping, wiggling from side to side with both legs over the bolster of the air mattress. A review of Resident #87's February active and discontinued physician's orders indicated the following: -Low air loss mattress every shift per weight or resident's comfort, check setting and functioning. Start Date: 1/29/25, Discontinued. -Low air loss mattress with bolster every shift per weight and/or resident's comfort, check setting and functioning. Start Date, 2/12/25, Active. During an interview and observation on 2/12/25 at 9:34 A.M., Certified Nurse's Assistant (CNA) #4 and the surveyor observed Resident #87 in bed, Resident #87 was awake in bed, his/her legs were placed over the bolsters. CNA #4 said the air mattress with bolsters was put in place to prevent the Resident from coming out of the bed on his/her own. CNA#4 said the Resident does put his/her legs over the bolsters when he/she tries to get out of bed on his/her own. During an interview on 2/12/25 at 9:35 A.M., Unit Manager #3 said Resident #87 was recently hospitalized and he/she fell in the facility on 2/1/25 after returning from the hospital. She said the air mattress with bolsters was a fall intervention put in place on 2/1/25 to prevent the Resident from falling while he/she was in bed. She said the Resident does put his/her legs over the bolsters and wiggles while in bed. Unit manger #3 said she did not complete a written restraints assessment prior to adding the air mattress with bolsters in the Resident's bed. During an interview and observation on 2/12/25 at 8:33 A.M., the Assistant Director of Nurses observed Resident #87 with the surveyor. The Resident was in bed awake. The ADON said the Resident is able to put his/her legs over the bolsters. She said the air mattress with bolsters was added as a fall intervention to prevent the Resident from falling out of bed. She said a written restraints assessment was not completed prior to adding the air mattress with bolsters in the Resident's bed. During an interview on 2/13/25 at 10:02 A.M., the Director of Nurses said a written restraints assessment should have been completed prior to adding the air mattress with bolsters in Resident #87's bed.

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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** 43807 Based on record review and interviews, the facility failed to report injuries of unknown origin to facility administration for two Residents (#87 and #118) out of a sample of 30 Residents. Specifically: 1. For Resident #87, the facility failed to report an X-ray (X-radiation-images created inside of a body by passing beams of radiation through the body) positive for a fracture from an unknown origin. 2. For Resident #118 the facility failed to implement their abuse policy and notify facility administration of a new fracture (an acute right intertrochanteric [thigh bone] fracture) of unknown origin. Findings include: A review of the facility policy titled, 'Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating' with a revision date of September 2022 indicated the following: -All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. -If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. - Immediately is defined as, within two hours of an allegation involving abuse or result in serious bodily injury. 1. Resident # 87 was admitted to the facility in July 2022 with diagnoses including dementia. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated that the Resident is rarely/never understood. A review of Resident #87's X-ray results dated 1/21/25 indicated the following: -X-ray chest view. -Findings: Comparison is made to 6/28/2024. Minimal linear markings are seen in the lower left lung. Multilevel right rib multilevel right rib fractures are noted. [sic] -Conclusion: Minimal left lower lung atelectasis scarring. No CHF (Congestive Heart Failure) or pneumonia. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Electronically signed by the Medical Director 1/21/2025 3:57:27 PM Eastern. A review of the Nursing progress notes dated 1/21/25 at 22:31 (10:31 PM) indicated the following: -X-ray chest view. -Findings: Comparison is made to 6/28/2024. Minimal linear markings are seen in the lower left lung. Multilevel right rib multilevel right rib fractures are noted. [sic] -Conclusion: Minimal left lower lung atelectasis scarring. No CHF or pneumonia. No new orders at this time. All parties aware. During an interview and record review on 2/14/25 at 8:13 A.M., the Assistant Director of Nurses said she was made aware of the multilevel right rib fractures noted in the Resident's chest X-ray after staff received the results on 1/21/25. She said she did not notify the Director of Nurses about the chest X-ray results immediately after staff informed her. She said since the right rib fractures were an injury of unknown origin at that point, she should have reported the X-ray results to the Director of Nurses. The ADON said she reported this injury of unknown origin to the Director of Nurses on 1/23/25. During an interview on 2/14/25 at 7:21 A.M., the Director of Nurses said staff should notify her when injuries of unknown origin occur even though she is not in the facility. She said staff were aware of Resident #87's rib fractures on 1/21/25 but did not notify her until 1/23/25. 44095 2. Resident #118 was admitted to the facility in December 2024 with diagnoses including ataxia, vascular dementia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 12/14/24, indicated that Resident #118 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS indicated Resident #118 required assistance with transfers. Review of Resident #118's eMar - Electronic Medication Administration note, dated 1/4/25 at 9:00 A.M., indicated: - Acetaminophen (APAP) Tablet 325 milligrams, give 2 tablets by mouth every 6 hours as needed (PRN) for mild pain. Documented as administered by nursing. Review of Resident #118's nursing progress note, dated 1/4/25 at 10:38 P.M., indicated: - Resident complained of pain 8/10 to left leg, medicated with PRN APAP with ineffective results. Resident's pain level documented in Nurse Practitioner's (NP's) log. (The nurse who wrote this note clarified that the leg pain was the right leg) (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 10:01 A.M., Nurse #4 said that Resident #118 was experiencing right leg pain on 1/4/25 which was new, and she was not aware of any incident that may have occurred to cause the pain. Nurse #4 said that Resident #118 has poor safety awareness and Resident #118 could not get him/herself up off the floor if he/she had fallen. Nurse #4 thought that Resident #118 may have injured his/her leg during a self-transfer, but she was not certain. Review of Resident #118's consultant telehealth progress note, dated 1/5/25 at 12:58 P.M., indicated: - History Present Illness: Patient with new right hip and thigh pain. patient is unable to left/[lift] the right leg. [sic] when trying to move extremity the patient yells out in pain. when asking the patient where the pain is specifically points to his/her thigh and holds his/her right hip. there is no external S/S (signs and symptoms) of injury. no bruising or edema or redness noted. patient has no complaints with left leg. able to move extremity at baseline. will obtain STAT (immediately) x-rays. patient has not had any recent falls/injuries per RN. Review of Resident #118's health status note, dated 1/5/25, indicated: - Complained of severe pain to right leg, on call provider notified, new order for STAT X-ray to right hip/pelvis 2/3 views. Order to apply lidocaine patch topically to right leg and reassess pain, resident remains in pain when right leg is touched by staff. Review of Resident #118's radiology report, dated 1/5/25 at 8:29 P.M., indicated: - FINDINGS: There is an acute, mildly displaced right intertrochanteric (thigh bone) fracture. Mild bilateral hip degenerative joint changes. The bony pelvis is intact, but the soft tissues are unremarkable. CONCLUSION: Acute right intertrochanteric fracture. Review of Resident #118's PDPM Nursing Daily Skilled Pathway note, dated 1/5/25 at 11:05 P.M., indicated: - Resident is alert and pleasantly confused, stay in bed the whole day today complaints of pain right hip, with Tylenol with minimal effect, provider aware and stat right hip x-ray done around 7:00 P.M., will continue to monitor. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25 at 8:43 A.M., Nurse #11 said that on 1/5/24 around 11:30 P.M., she saw the x-ray results for the new fracture in the electronic health record. Nurse #11 said that there are no faxes sent directly to the facility and all x-ray results are uploaded in the electronic health record by the vendor. Nurse #11 said that she did not notify facility administration of the new fracture. Nurse #11 said that she was not sure what caused Resident #118's fracture, and that Resident #118 was confused. During an interview on 2/14/25 at 7:15 A.M., Nurse #3 said that he became aware of the fracture results on 1/6/25 between 4:30 A.M. and 5:00 A.M., when he saw the x-ray results printed on the fax machine. Nurse #3 said that he notified the provider, but he did not make facility administration aware of the injury of unknown because they would be coming in for the day around 8:00 A.M. Nurse #3 said that Resident #118 was confused and had poor safety awareness, and he was not aware of any event that would have caused the fracture. Review of Resident #118's consultant telehealth progress note, dated 1/6/25 at 8:01 A.M., indicated: - History Present Illness: Resident is presenting for radiology review of hip x-ray. Nurse denies any known trauma, but resident complained of right hip pain. Xray hip: Acute mildly displaced Right intertrochanteric fracture. Transfer to Emergency Department for acute right hip fracture and ortho evaluation Orders: Transfer to Emergency Department for acute right hip fracture and ortho evaluation Disposition: Transfer to Emergency Department Review of Resident #118's incident report, dated 1/5/25, indicated that Resident #118 had an injury of unknown, that was not witnessed. Conclusion: Resident sustained a right hip fracture. During the investigation and through staff interviews it was determined that the resident did not fall. The resident was observed transferring from his/her wheelchair to a standard chair at the nurses' station and plopped down hard into the chair before staff could assist him/her. According to the hospital paperwork resident has age related osteoporosis with pathological fracture. Investigative statements were obtained from Nurse #3, Nurse #4 and Unit Manager #2. Notifications of the following. Administrator on 1/6/25 at 9:00 A.M., Director of Nursing 1/5/25 at 7:00 P.M., and the Department of Health on 1/10/25 at 9:00 P.M. The incident report was signed off on 1/22/25 at 12:09 P.M., by the Director of Nursing. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 10:10 A.M., Unit Manager #2 said that Resident #118 had right leg pain, and he/she could not move his/her right leg which was new. Unit Manager #2 said that Resident #118 has poor safety awareness and did not have a fall. Unit Manager #2 said that faxes from the x-ray company are no longer provided and that the x-ray results are uploaded in the electronic record. During an interview on 2/13/25 at 1:27 P.M., the Assistant Director of Nursing (ADON), said she became aware of the fracture on 1/6/25 during clinical rounds around 9:00 A.M. The ADON said she was not aware of any event that caused the fracture. The ADON said that the Director of Nursing is responsible for reporting injuries of unknown to the state agency within 2 hours. During an interview on 2/13/25 at 10:47 A.M., the Director of Nursing said that Resident #118's fracture results came in around 12:00 A.M., on 1/6/25. The DON said she was not made aware of the injury of unknown until 1/6/25 around 8:30 A.M., when Nurse #3 made her aware. The DON said that although the incident report indicated she was made aware of the new injury of unknown on 1/5/25 at 7:00 P.M., this was not true, and she should have been immediately notified. The DON said she was not sure of an event the caused the fracture. During an interview on 2/13/25 at 10:40 A.M., the Administrator said that nursing staff should notify facility administration within 2 hours of an injury of unknown.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to report allegations of potential abuse (injuries of unknown, and an allegation of neglect) to the State Agency for three Residents (#87, #118, and #55) out of a sample of 30 Residents. 1. For Resident #87, the facility failed to report an X-ray (X-radiation-images created inside of a body by passing beams of radiation through the body) positive for a fracture from an unknown origin to the State Agency within two hours. 2. For Resident #118 the facility failed to notify the state agency of an injury of unknown within 2 hours once the Director of Nursing became of a new fracture (an acute right intertrochanteric [thigh bone] fracture) of unknown origin. 3. For Resident #55 the facility failed to notify the state agency of an allegation of neglect. Findings include: A review of the facility policy titled, 'Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating' with a revision date of September 2022 indicated the following: -All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. -If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. - Immediately is defined as, within two hours of an allegation involving abuse or result in serious bodily injury. 1. Resident # 87 was admitted to the facility in July 2022 with diagnoses including dementia. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated that the Resident is rarely/never understood. A review of Resident #87's X-ray results dated 1/21/25 indicated the following: -X-ray chest view. -Findings: Comparison is made to 6/28/2024. Minimal linear markings are seen in the lower left lung. Multilevel right rib multilevel right rib fractures are noted. [sic] (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Conclusion: Minimal left lower lung atelectasis scarring. No CHF (Congestive Heart Failure) or pneumonia. -Electronically signed by the Medical Director, 1/21/2025 3:57:27 PM Eastern. A review of the Nursing progress notes dated 1/21/25 at 22:31 (10:31 PM) indicated the following: -X-ray chest view. -Findings: Comparison is made to 6/28/2024. Minimal linear markings are seen in the lower left lung. Multilevel right rib multilevel right rib fractures are noted. [sic] -Conclusion: Minimal left lower lung atelectasis scarring. No CHF or pneumonia. No new orders at this time. All parties aware. During an interview and record review on 2/14/25 at 8:13 A.M., the Assistant Director of Nurses said she was made aware of the multilevel right rib fractures noted in the chest X-ray after staff received the results on 1/21/25. The ADON said she has access to the HCFRS (Health Care Facility Reporting System) but she had issues with her log in and did not report the injury of unknown origin after staff notified her. The ADON said she did not notify the Director of Nurses about the chest X-ray results immediately after staff informed her. She said since the right rib fractures were an injury of unknown origin at that point, she should have reported the X-ray results to the Director of Nurses immediately. The ADON said she reported this injury of unknown origin to the Director of Nurses on 1/23/25. The ADON said injuries of unknown origin should be reported to the state agency within two hours. During an interview on 2/14/25 at 7:21 A.M., the Director of Nurses said staff should notify her when injuries of unknown origin occur even though she is not in the facility. She said staff were aware of Resident #87's right rib fractures on 1/21/25 but did not notify her until 1/23/25. The DON said she reported the right rib fracture on 1/23/25 to the state agency. She said injuries of unknown origin should be reported to the state agency within two hours. Review of the HCFRS indicated that the facility reported Resident #87's injury of unknown origin on 1/23/25 after the ADON was first made aware of the injury of unknown origin on 1/21/25. 44095 2. Resident #118 was admitted to the facility in December 2024 with diagnoses including ataxia, vascular dementia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 12/14/24, indicated that Resident #118 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS indicated Resident #118 required assistance with transfers. Review of Resident #118's health status note, dated 1/5/25, indicated: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Complained of severe pain to right leg, on call provider notified, new order for STAT X-ray to right hip/pelvis 2/3 views. Order to apply lidocaine patch topically to right leg and reassess pain, resident remains in pain when right leg is touched by staff. Review of Resident #118's radiology report, dated 1/5/25 at 8:29 P.M., indicated: - FINDINGS: There is an acute, mildly displaced right intertrochanteric fracture. Mild bilateral hip degenerative joint changes. The bony pelvis is intact, but the soft tissues are unremarkable. CONCLUSION: Acute right intertrochanteric fracture. During an interview on 2/14/25 at 7:15 A.M., Nurse #3 said that he became aware of the fracture results on 1/6/25 between 4:30 A.M. and 5:00 A.M., and he notified the Director of Nursing on 1/6/25 at around 8:30 A.M. Review of Resident #118's incident report, dated 1/5/25, indicated that Resident #118 had an injury of unknown, that was not witnessed. Notifications of the following. Administrator on 1/6/25 at 9:00 A.M., Director of Nursing 1/5/25 at 7:00 P.M., and the Department of Health on 1/10/25 at 9:00 P.M. The incident report was signed off on 1/22/25 at 12:09 P.M., by the Director of Nursing. During an interview on 2/13/25 at 1:27 P.M., the Assistant Director of Nursing (ADON), said she became aware of the fracture on 1/6/25 during clinical rounds around 9:00 A.M. The ADON said that the Director of Nursing is responsible for reporting injuries of unknown to the state agency within 2 hours. During an interview on 2/13/25 at 10:47 A.M., the Director of Nursing said she was made aware of Resident #118's fracture on 1/6/25 around 8:30 A.M., when Nurse #3 made her aware. The DON said that although the incident report indicated she was made aware of the new injury of unknown on 1/5/25 at 7:00 P.M., this was not true, and she should have been immediately notified. The DON said she did not report the fracture to the state agency within two hours when she found out about the fracture, but she should have. During an interview on 2/13/25 at 10:40 A.M., the Administrator said that injuries of unknown should be reported to the stage agency within 2 hours as required. Review of the Health Care Facility Reporting System (HCFRS) indicated that the facility reported Resident #118's injury of unknown on 1/10/25 at 9:46 P.M., 108 hours after the DON was first made aware of the injury of unknown. 45763 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #55 was admitted to the facility in November 2024 with diagnoses including cancer, other lack of coordination, difficulty in walking, cerebral infarction (lack of blood flow to the brain), and spinal stenosis (a condition where the spinal canal, the space within the spine that houses the spinal cord and nerve roots, becomes narrowed which can put pressure on the nerves, causing pain, numbness, weakness, and other symptoms.) Review of the most recent MDS assessment, dated 12/18/24, indicated that Resident #55 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Review of Resident #55's activities of daily living (ADL) care plan indicated the Resident had ADL self care performance deficit related to activity tolerance, deconditioned status post hospitalization , and fatigue with the following intervention: - Bed mobility: I require the assist of 1 staff and sheet for turning and repositioning, initiated 11/13/24. - Transfers: I require 1 staff assist for transfers, initiated 11/13/24. Review of Resident #55's documentation survey report, dated February 2025, indicated the Resident required staff assistance with bed mobility four out of the 21 recorded instances, and required assistance with lying to sitting on the side of the bed 13 out of 31 recorded instances, During an interview on 2/11/25 at 9:13 A.M., Resident #55 said that earlier that morning he/she was lying in bed and had asked a staff member for help getting up. Resident #55 said that the staff member refused, said you can get yourself up, and left the room without helping the Resident get up. Resident #55 said he/she could not get up because he/she was experiencing back pain, the Resident said he/she was able to eventually get him/herself up once the pain subsided which was later than he/she wanted to get up. Resident #55 said that he/she had not told anybody about this event. During an interview on 2/11/25 at 9:19 A.M., the surveyor told the administrator that Resident #55 was lying in bed earlier that morning, had asked a staff member for help getting up as he/she was not able to get up on his/her own due to pain, that the staff member refused, said you can get yourself up and left the resident without helping him/her. The administrator verbalized understanding. During an interview on 2/12/25 at 9:29 A.M., Social Worker #1 said that if a resident makes an allegation of abuse/neglect that nursing would call the social workers, the Director of Nursing (DON) and the administrator who would report the allegation to state agencies within two hours and then investigate whether abuse/neglect actually occurred. Social Worker #1 defined neglect as a situation if a resident needed help but staff refused to provide it. Social Worker #1 said she had been told that Resident #55 had a bad interaction with staff and that the Resident had trouble sitting up due to back pain. Social worker #1 said that Resident #55 had pain, and some days required help getting up as he/she could not do it on his/her own. Social Worker #1 said the facility had filed a grievance instead of reporting the allegation. Social Worker #1 said she would have expected the DON to report the allegation as what the Resident reported was not okay, it was neglectful and that the Resident felt bad yesterday about the situation. Social Worker #1 said Unit Manager #1 had taken over the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/25 at 9:55 A.M. Unit Manager #1 said Social worker #1 had brought Resident #55's allegation to his attention, Unit Manager #1 said Resident #55 had asked for assistance but the staff member could not provide the assistance. Unit Manager #1 said he did not have concern for neglect because he trusted the staff and that the situation was not one that he had heard before. Unit Manager #1 said he had interviewed staff who denied the allegation and he believed them; Unit Manager #1 said that despite him being new the staff were good so far. Unit Manager #1 defined neglect as when a resident needed assistance, but staff pass by and ignore the resident. Unit Manager #1 said when an allegation of neglect is made, he would expect the administrator to report the allegation. Unit Manager #1 said allegations of neglect should be reported right away, and that Resident #55's allegation was considered something that needs follow up. Unit Manager #1 said that administration never asked him if he considered the allegation concerning for neglect/abuse. During an interview on 2/12/25 at 10:12 A.M., the DON said when a resident makes an allegation of neglect/abuse she will initiate an investigation, which includes an interview with the resident, to determine if abuse had occurred. The DON said she had spoken with Resident #55 who had told her that although the Resident usually got up on his/her own that yesterday morning the Resident needed help, had asked staff for help, and that the staff would not help the Resident get up but instead encouraged him/her to get up on his/her own. The DON said that if a resident asks for help that staff should help the resident regardless of what the Resident's ADL status was. The DON said that she had filed a grievance regarding the Resident's allegation and that the Grievance had not yet been resolved. Review of Resident #55's grievance summary, dated 2/11/25, indicated that the Resident had asked nursing staff for help to sit up, and that nursing staff had encouraged her to sit up on his/her own as the Resident was independent with positioning. During a follow-up interview on 2/12/25 at 12:57 P.M. Resident #55 said he/she did not feel that staff were trying to encourage him/her to get up as the staff member had her head turned, was walking out the door, and sounded annoyed/irritated. Resident #55 said this made him/her feel alone, and that the staff member was not trying to help at all. During an interview on 2/12/25 at 1:05 P.M. the Administrator defined neglect as if we were doing something on purpose not to take care of somebody, and that the investigation into Resident #55's allegation hadn't yet been concluded at that time. The Administrator said that neglect/abuse would need to be reported to state agencies within two hours. Review of the Health Care Facility Reporting System (HCFRS) indicated that the facility reported Resident #55's allegation of neglect to state agencies on 2/12/25 at 2:34 P.M., 29 hours after the administrator was made aware of the Resident's allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 44095 Based on record review and interviews, the facility failed to thoroughly investigate an injury of unknown origin (a fracture), for one Resident (#118) out of a total sample of 30 residents. Specifically for Resident #118 who on 1/4/25 experienced pain which was new and on 1/5/25 Resident #118 was found to have an acute right intertrochanteric (thigh bone) fracture, the facility failed to conduct interviews from staff members (on all shifts) who had contact with the resident during the period of the alleged incident. Findings include: Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated as revised September 2022, indicated that all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. - Investigating Allegations 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. documents the investigation completely and thoroughly. 8. The following guidelines are used when conducting interviews: d. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement. 11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator. - Follow - Up Report 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. 3. The follow-up investigation report will provide as much information as possible at the time of submission of the report. Resident #118 was admitted to the facility in December 2024 with diagnoses including ataxia, vascular dementia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 12/14/24, indicated that Resident #118 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS indicated Resident #118 required assistance with transfers. Review of Resident #118's eMar - Medication Administration note, dated 1/4/25 at 9:00 A.M., indicated: - Acetaminophen (APAP) Tablet 325 milligrams, give 2 tablets by mouth every 6 hours as needed (PRN) for mild pain. Documented as administered by nursing. Review of Resident #118's nursing progress note, dated 1/4/25 at 10:38 P.M., indicated: - Resident complained of pain 8/10 to left leg, medicated with PRN APAP with ineffective results. Resident's pain level documented in Nurse Practitioner's (NP's) log. (The nurse who wrote this note clarified that the leg pain was the right leg) During an interview on 2/13/25 at 10:01 A.M., Nurse #4 said that Resident #118 was experiencing right leg pain on 1/4/25 which was new, and she was not aware of any incident that may have occurred to cause the pain. Nurse #4 said that Resident #118 has poor safety awareness and Resident #118 could not get him/herself up off the floor if he/she had fallen. Nurse #4 thought that Resident #118 may have injured his/her leg during a self-transfer, but she was not certain. Review of Resident #118's consultant telehealth progress note, dated 1/5/25 at 12:58 P.M., indicated: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- History Present Illness: Patient with new right hip and thigh pain. patient is unable to left/[lift] the right leg. [sic] when trying to move extremity the patient yells out in pain. when asking the patient where the pain is specifically points to his/her thigh and holds his/her right hip. there is no external S/S (signs and symptoms) of injury. no bruising or edema or redness noted. patient has no complaints with left leg. able to move extremity at baseline. will obtain STAT (immediately) x-rays. patient has not had any recent falls/injuries per RN. Review of Resident #118's health status note, dated 1/5/25, indicated: - Complained of severe pain to right leg, on call provider notified, new order for STAT X-ray to right hip/pelvis 2/3 views. Order to apply lidocaine patch topically to right leg and reassess pain, resident remains in pain when right leg is touched by staff. Review of Resident #118's radiology report, dated 1/5/25 at 8:29 P.M., indicated: - FINDINGS: There is an acute, mildly displaced right intertrochanteric (thigh bone) fracture. Mild bilateral hip degenerative joint changes. The bony pelvis is intact, but the soft tissues are unremarkable. CONCLUSION: Acute right intertrochanteric fracture. Review of Resident #118's PDPM Nursing Daily Skilled Pathway note, dated 1/5/25 at 11:05 P.M., indicated: - Resident is alert and pleasantly confused, stayed in bed the whole day today complaints of pain right hip, with Tylenol with minimal effect, provider aware and stat right hip x-ray done around 7:00 P.M., will continue to monitor. During an interview on 2/14/25 at 8:43 A.M., Nurse #11 said that she was not sure what caused Resident #118's fracture, and that Resident #118 was confused. During an interview on 2/14/25 at 7:15 A.M., Nurse #3 said that Resident #118 was confused, and he/she had poor safety awareness, and he was not aware of any event that would have caused the fracture. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #118's consultant telehealth progress note, dated 1/6/25 at 8:01 A.M., indicated: - History Present Illness: Resident is presenting for radiology review of hip x-ray. Nurse denies any known trauma, but resident complained of right hip pain. Xray hip: Acute mildly displaced Right intertrochanteric fracture. Transfer to Emergency Department for acute right hip fracture and ortho evaluation Orders: Transfer to Emergency Department for acute right hip fracture and ortho evaluation Disposition: Transfer to Emergency Department Review of Resident #118's incident report, dated 1/5/25, indicated that Resident #118 had an injury of unknown, that was not witnessed. Conclusion: Resident sustained a right hip fracture. During the investigation and through staff interviews it was determined that the resident did not fall. The resident was observed transferring from his/her wheelchair to a standard chair at the nurses' station and plopped down hard into the chair before staff could assist him/her. According to the hospital paperwork resident has age related osteoporosis with pathological fracture. Investigative statements were obtained from Nurse #3, Nurse #4 and Unit Manager #2. The incident report was signed off on 1/22/25 at 12:09 P.M., by the Director of Nursing. During an interview on 2/13/25 at 10:10 A.M., Unit Manager #2 said that Resident #118 had right leg pain, and he/she could not move his/her right leg which was new. Unit Manager #2 said that Resident #118 has poor safety awareness and did not have a fall. Unit Manager #2 said that she wrote a statement regarding Resident #118's fracture, but she was not part of the investigation. During an interview on 2/13/25 at 1:27 P.M., the Assistant Director of Nursing (ADON) said she was not aware of any event that caused the fracture. The ADON said that she interviewed Nurse #3, Nurse #4 and Unit Manager #2 and she received statements from them. The ADON said she did not interview any other staff members. During an interview on 2/13/25 at 10:47 A.M., the Director of Nursing said she started the investigation into the injury of unknown and she spoke with the nurses and did not obtain any witness statements from the Certified Nurse Assistants (staff who provided direct care to the resident) or any other staff member. The DON thought that the fracture may have occurred when Resident #118 self-transferred and bumped him/herself on a standard chair. The DON reviewed the investigation file and said there were only statements from 2 nurses and the Unit Manager and that is all she had. During an interview on 2/13/25 at 10:40 A.M., the Administrator said that investigations should include statements from all staff who are working, including CNAs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44095 Based on record review and interviews, the facility failed to meet professional standards of practice for one Resident (#113) out of a total of sample of 30 residents. Specifically, for Resident #113, the facility failed to ensure nursing clarified a physician's orders for two different suprapubic (SPT) catheter flushes. Findings include: Resident #113 was admitted to the facility in April 2024 with diagnoses including neuromuscular dysfunction of the bladder, diabetes, and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated that Resident #113 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. The MDS further indicated Resident #113 required an indwelling catheter. Review of Resident #113's active physician's order, dated 12/7/24, indicated: -Flush SPT three times daily (3x/day) by using 50 cc catheter tip syringe and normal saline and injecting through yellow port of the SPT into the bladder and aspirating to ensure drainage, three times a day. Scheduled three times daily at 6:00 A.M., 2:00 P.M., and 10:00 P.M., Review of Resident #113's active physician's order, dated 1/24/25, indicated: -Flush suprapubic tube (SPT) with 50 milliliters (ml) normal saline, two times a day. Scheduled twice daily at 6:00 A.M. and 6:00 P.M. During an interview on 2/12/25 at 11:43 A.M., Nurse #4 said she routinely works the day shift. Nurse #4 said she flushes Resident #113's SPT based on the physician's order and said she has already flushed the SPT today. (prior to the 2:00 P.M. scheduled time) During an interview on 2/13/25 at 7:32 A.M., Nurse #3 said that he routinely works the overnight shift. Nurse #3 said he routinely flushes the catheter around midnight and again at 6:00 A.M. (twice during his shift but there are two orders both with a 6:00 A.M. administration time) During an interview on 2/14/25 at 8:52 A.M., Nurse #11 said she routinely works the evening shift, and she said that she follows the orders, and she flushes Resident #113's SPT once a shift. (once during her shift, however, there are orders at 6:00 P.M. and 10:00 P.M.) During an interview on 2/13/25 at 11:26 A.M., Unit Manager #2 said nursing should flush Resident #113's suprapubic catheter according to the physician's orders. Unit Manager #2 said on 1/24/25 Resident #113 said he/she did not want his/her catheter to be flushed three times daily and she made the provider aware, and the provider said that it was ok to flush the catheter twice a day. Unit Manager #2 said that she did not discontinue the previous order but should have. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/24 at 3:13 P.M., the Director of Nursing said that nursing should have clarified the two orders for SPT flushes.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review and staff interview, the facility failed to document the recapitulation of the Resident's stay that included his/her course of illness/treatment for one Resident (#123), of two closed records Findings include: Review of the facility policy titled Discharge Summary and Plan, dated as revised October 2022, indicated the following: -When a resident's discharge is anticipated, a discharge summary and post discharge plan is developed to assist the resident with discharge. 1. The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's stats at the time of discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: 1. current diagnosis; b. medical history; c. current illness, treatment and/or therapy since entering the facility; d. current laboratory, radiology, consultation and diagnostic test results; e. physical and mental functional status; f. ability to perform activities of daily living; g. sensory and physical impairments; h. nutritional status and requirements including: 1. weight and height; 2. nutritional intake; and 3. eating habits, preferences and dietary restrictions; i. special treatments and procedures; j. mental and psychosocial status; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. discharge potential; l. dental condition; m. activities potential; n. rehabilitation potential; o. cognitive status; and p. medication therapy. 11. A member of the IDT (interdisciplinary team) reviews the final post-discharge plan with the resident and family at least twenty-four (240 hours before the discharge is to take place. 12. A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical record: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge summary. Resident #123 was admitted to the facility in October 2024 and had diagnoses that included fracture of the right wrist, and a stage 3 pressure ulcer of the sacral region with a wound vacuum in place. Review of the medical record indicates that Resident #123 was discharged on [DATE]. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 10/26/24, indicated that on the Brief Interview for Mental status exam Resident #123 scored a 10 out of a possible 15, indicating moderately impaired cognition. Review of Resident #123's electronic and paper medical record: -Failed to indicate a discharge note was written; and -Failed to indicate a Discharge Summary was completed. The section titled Recapitulation of stay was blank and the section titled Social Service (which indicates any home services) was blank. The record indicated that on 12/13/24 Resident #123 received a notice from the facility titled Less than 30 Day Notice of Intent to Discharge/Transfer Resident. The notice was served by the facility on 12/13/24 for a discharge for 12/13/24 and the following line was checked: -Your health has improved sufficiently so that you no longer need the services provided by the facility. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25 at 10:19 A.M., the Director of Nursing (DON) said that when a resident is discharged a discharge note should be written and a discharge summary, including a recapitulation of stay should be completed. During a follow-up interview on 2/14/25 at 10:40 A.M., the DON said that Resident #123 is in a Community based program and they make all decisions about the resident's stay and discharge. The DON said that Nursing should have written a discharge note and probably should have completed the discharge summary's recapitulation of stay.

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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** 45763 Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADLs) for three dependent Residents (#61, #15 and #48) out of a total sample of 30 residents. Specifically, the facility failed to: 1) Provide assistance with grooming for Resident #61. 2) Provide supervision with meals for Resident #15. 3) Provide assistance with grooming for Resident #48. Findings Include: Review of the undated facility policy, titled Activities of Daily Living (ADL), Supporting, revised in March 2018, indicated, but was not limited to, the following: - Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). - Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 1) Resident #61 was admitted to the facility in October 2024 with a diagnosis of debility, cardiorespiratory conditions. Review of the MDS, dated [DATE], indicated that Resident #61 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. Further review of the MDS indicated the Resident was dependent on staff for assistance with personal hygiene. Review of Resident #61's ADL care plan indicated that the Resident required assistance with ADL care in grooming related to limited mobility with the following intervention: - Provide resident with assist of 1 for personal hygiene (grooming), initiated on 9/17/24. On 2/11/25 at 8:45 A.M., the surveyor observed that a few of Resident #61's fingernails were elongated and protruding approximately half an inch beyond the Resident's nail bed; there was a dark substance beneath the Resident's nails. The surveyor observed Resident #61's chin hair which was approximately an inch in length. On 2/11/25 at 11:22 A.M., the surveyor observed that a few of Resident #61's fingernails were elongated and protruding approximately half an inch beyond the Resident's nail bed; there was a dark substance beneath the Resident's nails. The surveyor observed Resident #61's chin hair which was approximately an inch in length. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 2/12/25 at 8:58 A.M., the surveyor observed that a few of Resident #61's fingernails were elongated and protruding approximately half an inch beyond the Resident's nail bed; there was a dark substance beneath the Resident's nails. The surveyor observed Resident #61's chin hair which was approximately an inch in length. Resident #61 said his/her nails and facial hair were too long and that he/she would like to have them cut. Certified Nursing Aide (CNA) #1 said that CNA's were responsible for checking Resident nails and facial hair every day during care. CNA #1 said Resident #61's nails were disgusting and that the Resident's nails and facial hair should be cut. CNA #1 said that if a resident refused care that the CNA should re-attempt offering assistance, and if the resident continues to refuse that the CNA will communicate with the nurse who will document the refusal. During an observation and interview on 2/12/25 at 9:05 A.M., Nurse #9 said CNA's will defer to care plans to determine what level assistance a resident needs with ADLs. Nurse #9 said CNA's should check for grooming needs daily, when caring for the resident and throughout the day; Nurse #9 said that CNAs should be offering grooming assistance to residents who need it. Nurse #9 said if a resident refuses care the CNA will reattempt and then communicate the refusal to the nurse who would document it. Nurse #9 said that Resident #61 doesn't refuse assistance with grooming and that the Resident is unable to groom his/her own nails or facial hair. Nurse #9 said that she would have expected CNAs to offer assistance with grooming based on how Resident #61's nails and facial hair looked. During an interview on 2/12/25 at 4:59 P.M., the Director of Nursing (DON) said CNAs should be offering to take care of Resident's nails and hair during daily care. The DON said that refusals would be documented. Review of Resident #61's medical record failed to indicate that the Resident refused assistance with grooming. 48671 2. Resident #15 was admitted to the facility in July 2022 with diagnoses including dysphagia (difficulty swallowing), muscle weakness, chronic kidney disease and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/24, indicated that Resident #15 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 10 out of 15. Further review of the MDS indicated that Resident #15 had a swallowing disorder including holding food in mouth/cheeks or residual food in mouth after meals and required a mechanically altered diet. Review of Resident #15's hospital discharge summary, dated 12/13/2024, indicated Resident #15 was admitted to the hospital on 12/10/24 for recurrent aspiration (inhaling something into the airway) with pneumonia. The Resident had ongoing aspiration events and recommendations include pureed solids, thin liquids, resident to be sitting upright with meals and continuously observed while eating to prevent aspiration. Review of Resident #15's physician's order dated 12/13/24, indicated: Aspiration precaution at all times, every shift for Aspiration PNA (pneumonia) 1:1 (one to one) feed at mealtimes. (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 #15's nursing progress note, dated 12/14/24, indicated the following: Resident was readmitted back to the facility s/p (status post) aspiration PNA, and respiratory failure. The Resident is on aspiration precautions and requires supervision with meals at all times. On 2/11/25 at 9:01 A.M., the surveyor observed Resident #15 eating breakfast alone in his/her room. There were no staff in the Resident's room or within eyesight of the Resident, his/her hand was trembling while attempting to self-feed. On 2/12/25 at 8:30 A.M. the surveyor observed Resident #15 eating breakfast alone in his/her room. There were no staff in the Resident's room or within eyesight of the Resident, his/her hand was trembling while attempting to self-feed. On 2/13/25 at 8:45 A.M. the surveyor observed Resident #15 eating breakfast alone in his/her room. There were no staff in the Resident's room or within eyesight of the Resident, and the Resident was coughing. During an interview on 2/13/24 at 12:41 P.M., Certified Nurse Assistant (CNA) #1 said Resident #15 can't eat alone and needs supervision with meals because he/she sometimes coughs when eating and was hospitalized due to pneumonia. During an interview on 2/13/24 at 1:15 P.M., Nurse #10 said Resident #15 should not be eating alone and required supervision while eating because he/she chokes food and was hospitalized last year due to pneumonia. Nurse #10 said Resident #15 remains on aspiration precautions and must be supervised. During an interview on 2/14/24 at 9:51 A.M., the Director of Nurses said Resident #15 requires supervision with all meals and said aspiration precautions must be followed according to the physician orders. 3. Resident #48 was admitted to the facility in December 2022 with diagnoses including tinea unguium (nail fungus), low back pain, and difficulty walking. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/11/24, indicated that Resident #48 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 7 out of 15. Further review of the MDS indicated that Resident #48 required partial/moderate assistance with personal hygiene. Review of Resident #48's Activities of Daily Living (ADL) care plan indicated that the Resident requires assistance and may be dep. (dependent) in ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to Recent illness, fall, hospitalization , resulting in fatigue, activity intolerance, Impaired balance, limited mobility, with the following interventions initiated on 12/11/22: -Provide resident assist of 1 for personal hygiene, grooming, may be Dep. at times. -Provide resident with assist of 1 for bathing, may be Dep. at times. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/11/25 at 9:06 A.M. the Surveyor observed Resident #48 in his/her room, the Residents fingernails were elongated with visible dirt beneath. The Resident's fingernails were approximately 1/2 an inch in length extending beyond the nail bed. Resident #48 said his/her nails are too long and wants to have the nails cut but staff do not cut them when he/she asks them to cut them. On 2/12/25 at 12:19 P.M. the Surveyor observed Resident #48 in his/her room, the Residents fingernails were elongated with visible dirt beneath. The Resident's fingernails were approximately 1/2 an inch in length extending beyond the nail bed. During an observation and interview on 2/12/25 at 3:54 P.M., Nurse #9 said Resident #48 did not refuse assistance with care. Nurse #9 observed the Resident's fingernails; said they were long and that they should be cut. Resident #48 agreed to have his/her nails cut and said I've been trying to get them cut but I can't find anyone to do it. During an interview on 2/12/25 at 4:59 P.M., the Director of Nursing (DON) said CNAs should be offering to take care of Resident's nails and hair during daily care. The DON said that refusals would be documented. On 2/13/25 at 8:48 A.M. the Surveyor observed Resident #48 in his/her room, the Residents fingernails were elongated with visible dirt beneath. The Resident's fingernails were approximately 1/2 an inch in length extending beyond the nail bed. During an interview on 2/13/25 at 12:45 P.M., Certified Nursing Assistant #1 said the Resident can have his/her nails cut if he/she wants them to be cut. During an interview on 2/13/25 at 1:03 P.M., Nurse #1 said that Resident #48 can't trim his/her own nails and needs help from staff to do so.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, interviews, and records reviewed, the facility failed to provide the necessary services to ensure one Resident (#15) out of a total sample of 30 Residents, was able to effectively communicate his/her needs. Findings include: Review of the facility policy titled Translation and/or Interpretation Services, dated 2021, indicated the following: -This facility will ensure that individuals who are non-English speaking or have a communication disability will have access to translation and/or interpretation methods. Policy Interpretation and Implementation 1. The facility will determine a means to communicate with any resident admitted who is non-English speaking and/or has a communication disability. 2. The facility utilizes Interactive Voice Response (IVR) to connect to an interpreter for limited Englich proficient residents. 3. The facility uses Cue Cards (Communication Boards) to assist health professionals and residents who have English language difficulties or communication difficulties to communicate. Resident #15 was admitted to the facility in July 2022 with diagnoses including dysphagia (difficulty swallowing), muscle weakness, chronic kidney disease and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/24, indicated that Resident #15 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 10 out of 15. Further review of the MDS indicated the Residents' preferred language is Bosnian and requires an interpreter to communicate with doctors and healthcare staff. Review of Resident #15's communication care plan indicated the following: I require the services of an interpreter because my primary language is not English. Primary Language: Bosnian Date Initiated: 12/20/24. - I will be able to communicate adequately with my care team and to have my needs met through review date. Date Initiated: 12/20/24. - Resident requires an interpreter (In Person / Language Link). Date Initiated: 12/20/24. - Provide resident with a communication board with common words in English and (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents preferred language to [NAME] [SIC] in communication for simple daily needs. Date Initiated: 12/20/24 -Use Language Line [which includes Video Remote Interpretation (VRI) services] as needed to provide adequate communication with Resident. 12/20/24 Residents preferred language: [Specify]. Date Initiated: 12/20/24. - Monitor Resident for signs of withdrawing from attempts to communicate, s/sx (signs and symptoms) of depression, anger, or expressing feelings of frustration. Date Initiated: 12/20/24. - I speak Bosnian as my primary language. Staff and family able to translate. Table and translation line also available. Date Initiated: 01/10/25. Review of Resident #15's active Kardex (form indicating type and level of care assistance needed), indicated the following: -Ask yes/no questions when possible in order to help determine my needs and preferences. -Resident requires an interpreter (In Person / Language Link). -Use Language Line [which includes Video Remote Interpretation (VRI) services] as needed to provide adequate communication with Resident. -Residents' preferred language: [Specify]. During an observation on 2/11/25 at 8:55 A.M., Resident #15 was observed sitting up in bed. A staff member entered the room and was observed placing the breakfast tray on the Resident's overbed table. The staff member removed the hot plate cover, said she was dropping off breakfast and in English, asked the Resident if she needed anything. Resident #15 did not answer, and the staff member then walked out of the room. The staff member did not knock on the door, introduce herself, or speak to Resident #15 in his/her language during the observation. There was no communication board visible in the room and interpreter services were not utilized. During an observation on 2/11/25 at 11:01 A.M., Resident #15 was observed lying in bed. There was no communication board visible in the room. During an observation on 2/12/25 at 8:01 A.M., Resident #15 was observed sitting up in bed. There was no communication board visible in the room. During an observation on 2/13/25 at 12:30 P.M., Resident #15 was observed sitting up in bed. Certified Nursing Assistant #1 entered the room and was observed placing the lunch tray on the overbed table and removed the hot plate cover and began speaking to Resident #15 in English. Resident #15 did not answer. CNA #1 then walked out of the room. The staff member did not knock on the door, introduce herself, or speak to Resident #15 in his/her language during the observation. There was no communication board visible in the room and interpreter services were not utilized. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/24 at 12:41 P.M., Certified Nurse Assistant (CNA) #1 said Resident #15 can hear and understand very little English but can only communicate in Bosnian. During an interview on 2/13/24 at 1:15 P.M., Nurse #10 said Resident #15 has communication issues with staff because he/she did not speak English and that Resident #15 gets frustrated when he/she can't communicate with staff. Nurse #10 said she has never seen or used a communication board or interpreter services with the Resident and said she will guess or point to things when trying to communicate with the Resident. During an observation on 2/14/25 at 7:05 A.M., Resident #15 was observed lying in bed. CNA # 3 was observed speaking to Resident #15 in English, asking if he/she was hungry, as she was providing morning care. Resident #15 could be heard speaking in a different language and CNA #3 continued to provide care to Resident #15. There was no communication board visible in the room and interpreter services were not utilized. During an interview on 2/14/24 at 7:10 A.M., Certified Nurse Assistant (CNA) #3 said she will point to the bathroom or to objects when trying to communicate with the Resident but is not always able to understand what the Resident wants. CNA #3 said she has never seen or used a communication board with the Resident and said she has never used the interpreter line with Residents. During an interview on 2/14/24 at 9:29 A.M., the Director of Nurses (DON) said she expected staff to communicate in the Residents preferred language by utilizing the interpreter line or a communication board. The DON said she expected all staff to follow the care plan and Kardex, and said a communication binder should be utilized and accessible in the Residents room.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41105 Based on observation, record review and interview the facility failed to ensure interventions to treat contracture management were implemented for one Resident (#26) out of a total sample of 30 residents. Specifically, the facility failed to ensure palm protectors were in place. Findings include; The facility policy titled titled Resident Mobility and Range of Motion, dated July 2017, indicated the following: 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM (range of motion). 5. The care plan will include specific interventions, exercises and therapies to maintain, \prevent avoidable decline in, and/or improve mobility and range of motion. Resident #26 was admitted to the facility in August 2021 and has diagnoses that include Alzheimer's disease and unspecified lack of coordination. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/27/24, indicated Resident #26 was dependent on staff for all Activities of Daily Living (ADLs). Review of the Occupational Therapy (OT) treatment note, dated 12/19/24, indicated the following: -Re-educated unit manager and charge nurse regarding use of palm protectors during the day as tolerated to minimize the risk of skin breakdown. Palm protectors not in place at the time of therapist visit. Provided new palm protector and labeled left and right. Nursing demonstrates good understanding, orders entered into PCC (electronic medical record). Confirm carry-over next visit and discharge from OT service. Review of the record failed to indicate an order was entered into the medical record, as indicated in the 12/19/24 OT note. Further review failed to indicate nursing notified the physician of the recommendation. Review of the current physician's orders indicates an order, with a start date of 2/11/25, Palm guard to bilateral hands daily as tolerated. [NAME] with AM care, doff with PM care. Monitor for s/sx (symptoms) skin breakdown. Review of the current behavior care plan for Resident #26 indicated the following failed to indicate Resident #26 refused to wear palm protectors. On 2/11/25 at 8:32 A.M., Resident #26 was observed in bed and there were no palm protectors in place. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 7:35 A.M., and 8:29 A.M., Resident #26 was observed in bed and no palm protectors were in place. During an interview on 2/12/25 at 8:31 A.M., with the Assistant Director of Nursing (ADON) and Director of Rehabilitation (DOR) the DOR said some time ago she recommended palm guards for Resident #26 due to hand contractures and to subsequently prevent skin breakdown. The DOR said at that time she did education with all the staff and communicated to nursing the recommendation for the palm guards with the understanding that nursing would put the order in the record. Further, she said that her boss was in yesterday (2/11/25) cleaning up the records and put the order in place because it was noted to not be in. During a follow-up interview on 2/12/25 at 8:37 A.M., the DOR provided the surveyor with the OT treatment note dated 12/19/24 and said that after re-reading her note she recalls educating nurse management with the understanding the order would be put in by the nurse unit manager. During an interview on 2/12/25 t 11:09 A.M., with the Director of Nursing she said that if OT documented that the unit manager and charge nurse were made aware of the recommendation in December 2024 then the order probably should have been in the record. The DON said that she relies on receiving a copy of the Functional Maintenance Plan (FMP), where it is documented that education with the staff was completed, but in this case she does not have a copy of it and therefore does not wish to answer as to whether Resident #26 should have an order in place.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41105 Based on observation, record review and interview the facility failed to implement a physician ordered intervention to mitigate injury from an accident for one Resident (#110) out of a total sample of 30 residents. Specifically, the facility failed to ensure a fall mat was in place when Resident #110 was in bed. Findings include: The facility policy titled Falls-Clinical Protocol, dated as revised September 2012, indicated the following: -Treatment/Management: 1. Based on preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The facility policy titled Care Plans, Comprehensive Person-Centered, dated as revised March 2022, indicated the following: 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Resident #110 was admitted to the facility in February 2024 and has diagnoses that include Alzheimer's disease, history of falling and hemiplegia affecting right dominant side. Review of the most recent Minimum Data Se (MDS) assessment, dated 12/18/24, indicated that on the Brief Interview for Mental Status exam Resident #110 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #110 had no behavior of rejecting care and was dependent on staff for all Activities of Daily Living (ADLs). Review of the falls report for Resident #110, dated 8/11/24, indicated the following: -On 8/11/24 Resident #110 had an unwitnessed fall from bed. -Immediate actions taken to prevent recurrence: Floor mat (window side) Review of the active Physician's orders for Resident #110 indicated the following order: -floor mat (window side) when in bed, start date 8/11/24. Review of the current care plan for Resident #110 indicates the following; -Focus: Resident is at risk for falls: cognitive loss, lack of safety awareness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions include: fall on 8/11/24-floor mat (window side) when in bed, initiated 8/11/24. -Focus: Resident is at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing eating, bed mobility, transfer, locomotion, toileting related to: recent illness, fall hospitalization , etc, resulting in fatigue, activity intolerance, confusion, etc. Interventions include: mechanical lift for all transfers with total assist of two using medium sling with divided legs. Review of the Functional Abilities and Goals Assessment, dated 12/18/24, indicated Resident #110: -Is dependent on staff for all ADLs; -Is impaired on both sides of his/her lower extremities. Review of the February 2025 Treatment Administration Record indicated nursing staff documented that Resident #110's fall mat was in place daily on all three shifts on 2/11/25, 2/12/25 and 2/13/25, contrary to observations during survey. On 2/11/25 at 8:22 A.M., Resident #110 was observed in bed. There was no fall mat in place. There was no fall mat observed in the room. On 2/13/25 at 8:25 A.M., and 9:10 A.M., Resident #110 was observed in bed. There was no fall mat in place. There was no fall mat observed in the room. On 2/14/25 at 7:22 A.M.,Resident # 110 was observed in bed. There was no fall mat in place. There was no fall mat observed in the room. During an interview on 2/14/25 at 7:26 A.M., with Resident #110's Nurse #5 she said Resident #110 should have a fall mat in place on the window side of the bed as ordered by the MD. During an interview on 2/14/25 at 7:29 A.M., with the ADON she said that if there is a doctors order for a fall mat to be in place it should be in place. The ADON observed Resident #110 in bed, without a fall mat in place, and left the unit to obtain one.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44095 Based on observation, record review and interview the facility failed to ensure professional standards of practice for Foley catheter care for two residents (#38 and #133) out of a total sample of 30 residents. Specifically: 1. For Resident #38, the facility failed to ensure they obtained physician's orders for the correct indwelling catheter size. 2. For Resident #133, the facility failed to ensure Nurse #8 inserted the correct size suprapubic tube (SPT) into his/her bladder. Finding include: Review of the facility policy titled Catheter Care, Urinary, dated as revised August 2022, indicated that the purpose of this procedure is to prevent urinary catheter- associated complications, including urinary tract infections. Changing Catheters 2. Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. 1.) Resident #38 was admitted to the facility in September 2024 with diagnoses including atrial fibrillation, low back pain, and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/18/24, indicated that Resident #38 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. On 2/11/25 at 8:43 A.M., the surveyor observed Resident #38 in his/her bed. He/she had a urinary drainage bag at his/her bedside that was not in a privacy bag. Resident #38 said he/she just returned from the hospital with urinary retention and required a urinary catheter. Review of Resident #38's hospital discharge summary, dated 2/7/25, indicated that Resident had a 16 French 10 (mL) balloon. Review of Resident #38's plan of care related to urinary catheter, dated 2/7/25, indicated: -Provide urinary catheter care every shift and as needed. Review of Resident #38's physician's order, dated 2/7/25, indicated: -Foley catheter 18 French with 10cc balloon to bedside straight drainage for diagnosis/ history of need urinary retention while in the hospital. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #38's MQS: Admission/ Readmission Screener - V 15 assessment, dated 2/7/25, indicated: 1. Urinary Elimination: f. Foley Catheter 1c. Catheter Size: 16 French 1d. Balloon Volume: 10 milliliters During an interview on 2/12/25 at 4:14 P.M., Unit Manager #2 said that she obtained the physician's order for Resident #38's catheter based on the nursing assessment. On 2/12/25 at 4:12 P.M., the surveyor and the Director of Nursing (DON) observed Resident #38's urinary catheter. The catheter was sized 16 French and 10 mL balloon. The DON said that nursing should obtain orders indicating the correct size of the catheter. 2.) Resident #113 was admitted to the facility in April 2024 with diagnoses including neuromuscular dysfunction of the bladder, diabetes, and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated that Resident #113 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. This MDS indicated Resident #113 required an indwelling catheter. Review of Resident #113's plan of care related to suprapubic catheter due to neurogenic bladder and stage 3/4 pressure ulcer of the sacrum, dated 4/16/24, indicated: -Replace drainage system if disconnections or leakage occur. Review of Resident #113's physician's order, dated 4/5/24, indicated: -Change Foley Catheter when occluded or leaking, as needed. -Replace drainage system if disconnections or leakage occur, as needed. -SPT 16 French with 10 cc balloon to bedside straight drainage for diagnosis/ history of neurogenic bladder/ spinal cord injury. Review of Resident #113's physician's order, dated 6/24/24, indicated: -Change suprapubic catheter every 6 weeks, every day shift every 40 day(s). Review of Resident #113's eMar - Medication Administration Note, dated 2/5/25, indicated: -Change Foley Catheter when occluded or leaking as needed. Suprapubic catheter changed today due to leakage. On 2/11/25 at 8:17 A.M., the surveyor observed Resident #113 in his/her bed. There was a urinary drainage bag dated 1/17/25, the urinary drainage bag contained rose colored urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 11:43 A.M., the surveyor and Nurse #4 observed Resident #113's urinary catheter. The catheter was sized 18 French with a 10 mL balloon. Nurse #4 reviewed Resident #4's physician's order and said that Resident #113 did not have the correct size urinary catheter in his/her bladder. During an interview on 2/14/25 at 9:05 A.M., Nurse #8 said she changed Resident #113's SPT on 2/5/25. Nurse #8 said she should have verified the physician's order prior to changing the SPT. Nurse #113 said she inserted an 18 French 10 mL balloon. During an interview on 2/12/25 at 3:01 P.M., the Director of Nursing said nursing should follow the orders and insert the correct size SPT.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44095 Based on record review and interview for one Resident (#375) of a total sample of 30 residents, the facility failed to provide sufficient fluid intake as ordered by the physician. Specifically, for Resident #375 the facility failed to ensure nursing provided free water bolus' (FWB) consistently as ordered by the physician. Findings include: Review of the facility policy titled, Enteral Nutrition dated as revised November 2018, indicated that adequate nutritional support through enteral nutrition is provided to residents as ordered. 3. The dietitian, with input from the provider and nurse: d. calculates fluids to be provided (beyond free fluids in formula). Resident #375 was admitted to the facility in February 2025 with diagnoses including vascular dementia, diabetes, and chronic kidney disease. Review of Resident #375's hospital discharge summary, dated 2/10/25, indicated the following: - Nutrition following, Jevity 1.5 tube feeding rate of 100 milliliters (mL) per hour from 10:00 P.M., to 10:00 A.M. , with 175 mL free water bolus (FWB). Next FWB is due at 4:00 P.M., no residuals. Warm hand off given to the facility. Review of Resident #375's physician's order, dated 2/10/25, indicated: - Nothing by Mouth (NPO), all medications through the g-tube. - Flush tube with at least 15 mL of water after final medication, every shift. - Enteral Feed: Flush tube with 15 ml of water before each medication pass, every shift. Flush tube with at least 15 mL of water between each medication. - Flush tube with 175 mL of water every 4 hours, every shift. Further review indicated nursing scheduled this order to be administered every shift and not every 4 hours. Review of Resident #375's Medication Administration Record (MAR), dated 2/11/25 and 2/12/25, indicated that nursing provided Resident #375 with free water bolus of 175 mL every shift, total fluids on 2/11/25 were 525 mL and on 2/12/24 were 525 mL, not the 1050 mL of his/her daily needs as ordered by the physician. Review of Resident #375's Nutritional Risk Assessment - V 8, dated 2/13/25, indicated: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Continue current tube feed regimen: Jevity 1.5 @ 100 mL/hour nocturnally for 12 hours (up at 10pm, down at 10am), (provides 1800 kcals, 76g protein, 912 mL water). Continue 30 mL No Carb Prosource once daily, (provides 60kcals, 15g protein). Continue 175 mL free water flushes every 4 hours (provides 1050 mL free water) Total: 1860 kcals, 91g protein, 1962ml water Continue current plan of care. On 2/11/25 at 8:10 A.M. and on 2/12/25 at 7:06 A.M., the surveyor observed Resident #375 in bed. Resident #375 was observed receiving tube feeding, the tube feeding machine was set for feeding only and there was no secondary bag with the free water bolus (FWB). During an interview on 2/13/25 at 7:30 A.M., Nurse #3 said he routinely works the overnight shift, and he follows the orders for FWB. Nurse #3 said that he only did one 175 mL FWB during his eight-hour shift, but he could not remember what time. Nurse #3 said that the orders for FWB are timed and documented on in the MAR when completed. Nurse #3 said that he must do the FWB manually because the facility does not have the supplies to provide the FWB bag automatically scheduled with the tube feeding pump. During an interview on 2/13/25 at 11:23 A.M., Nurse #5 said she routinely works the day shift, and she provides FWB based on the physician's orders. Nurse #5 said she administers the FWB (once a shift) when the order shows up on the MAR. During an interview on 2/14/25 at 8:48 A.M., Nurse #11 said she routinely works the evening shift, Nurse #11 said that she provides the FWB when the order shows up on the MAR. Nurse #11 said that she must provide the FWB manually because the facility does not have the supplies to provide the FWB bags automatically scheduled with the tube feeding pump. During an interview on 2/13/25 at 12:34 P.M., Unit Manager #2 said that Resident #375 should receive FWB according to the physician's orders. Unit Manager #2 reviewed the physician's order, and she said that the order was not transcribed correctly, and the order is only scheduled once a shift, and the documentation supports Resident #375 has not received FWB according to the physician's order. Unit Manager #2 said the order should be scheduled every 4 hours with specific times on the MAR to ensure Resident #375 is receiving adequate fluids/hydration. During an interview on 2/13/25 at 3:42 P.M., the Dietitian said that fluid flushes during the medication pass are not calculated into Resident #375's daily hydration needs (1050 mL), the FWB of 175 mL to be provided separately. The Dietitian said it is important for Resident #375 to receive the FWB based on the calculations to maintain adequate hydration. During an interview on 2/13/25 at 3:07 P.M., the Director of Nursing said that Resident #375 should receive flushes as ordered by the provider to maintain hydration.

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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. 44095 Based on observation, interview, and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#38), out of a total sample of 30 residents. Specifically, for Resident #38, the facility failed to ensure that nursing changed Resident #38's oxygen tubing as ordered by the physician. Findings include: Review of the facility policy titled, Oxygen Administration, dated as revised October 2010, indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review physician's orders or facility protocol for oxygen administration. Resident #38 was admitted to the facility in September 2024 with diagnoses including atrial fibrillation, low back pain, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment, dated 12/18/24, indicated that Resident #38 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #38 required oxygen therapy. On 2/11/25 the surveyor observed an oxygen concentrator in Resident #38's room. There was also a portable oxygen tank next to the oxygen concentrator with the oxygen tubing dated 12/12/24. Resident #38 said that he/she wears oxygen continuously at 3 liters per minute. On 2/11/25 at 4:17 P.M. and on 2/12/25 at 11:53 A.M., the surveyor observed Resident #38 receiving oxygen via the portable oxygen tank, the tubing was dated 12/12/24. Review of Resident #38's plan of care related to supplemental oxygen, dated 2/7/25, indicated: - Change tubing as per facility protocol. Review of Resident #38's physician's order, dated 2/11/25, indicated: - Oxygen at 3 liters per minute via nasal cannula continuously. Review of Resident #38's physician's order, dated 9/8/24, indicated: - Oxygen tubing change weekly. Label each component with date and initials, every night shift every Sunday label each component with date and initials. Review of Resident #38's Treatment Administration Record (TAR), dated February 2025, indicated nursing (Nurse #6) changed the oxygen tubing as ordered on 2/9/25. However based on the surveyors observation on 2/11/25 and 2/12/25 the tubing was not changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 11:54 A.M., Nurse #7 said the oxygen tubing should be changed weekly. Nurse #7 observed Resident #38 using his/her portable oxygen tank and she said that tubing dated 12/12/24 should have been changed. During an interview on 2/12/25 at 3:58 P.M., Nurse #6 said that oxygen should be changed according to the physician's order. Nurse #6 said if there are multiple oxygen delivery devices for the residents each device's oxygen tubing should be changed. During an interview on 2/12/25 at 11:55 A.M. Resident #38 said that the facility does not always have the correct length oxygen tubing and he/she would like longer tubing. Resident #38 said that he/she is unable to change tubing on his/her own. During an interview on 2/12/25 at 2:58 P.M., the Director of Nursing said that nursing should change oxygen in accordance with the physician's orders.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44095 Based on observation, record review, and interview, the facility failed to ensure nursing was competent and had the required skill set to provide necessary care for residents' needs. Specifically, for Resident #60, the facility failed to ensure that nursing prepared medications in a safe manner. Findings include: Review of the facility policy titled, Administering Medications, dated as revised April 2019, indicated that medications are administered in a safe and timely manner, and as prescribed. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 22. The individual administering the medication initials the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones. Resident #60 was admitted to the facility in June 2023 with diagnosis including epilepsy, diabetes, and heart failure. On 2/12/25 at 9:39 A.M. until 9:40 A.M., the surveyor observed Nurse #2 preparing medications at her medication cart. Nurse #2's computer screen was black, and she was observed preparing medications from multiple cards of prescription medications and placing them into a medication cup. At 9:40 A.M., the surveyor asked Nurse #2 what she was doing, and she replied, I am getting medications ready for Resident #60, Nurse #2 then tried to leave her medication cart with a cup of medications and Nurse #2 said she was going to administer medications to Resident #60. The surveyor requested Unit Manager #3 to intervene because Nurse #2 was not verifying and referencing the Medication Administration Record while preparing medications (unsafe and not following the policy). At 9:41 A.M., the surveyor requested Nurse #2 along with Unit Manager #3 to complete a medication reconciliation of the medications that were present in the medication cup (the same medications that she attempted to administer to Resident #60, before she was stopped by the surveyor). Nurse #3 turned on the black computer screen, she logged into the computer, and then she logged into the electronic health record. The following medications were already signed off/ documented as administered on the MAR: - Protonix 40 milligrams (mg), medication for acid reflux. - Dilantin 100 mg (4 capsules), medication used for seizures. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Rivaroxaban 2.5mg, medication for peripheral artery disease. - Metformin 500 mg (2 tablets), medication for diabetes. - Metoprolol succinate extended release 25 mg, medication for hypertension. The following medications were documented as administered but were not present in the medication cup: - Zoloft 25 mg, medication for depression. - Farxiga 5 mg, medication for diabetes. - aspirin delayed release 81 mg, medication for blood clot prevention. Review of Resident #60's Medication Administration Audit Report on 2/13/25 indicated Nurse #2 signed off as administered Resident #60's medication on 2/12/25 at 8:36 A.M., 1 hour and 4 minutes before the surveyor's observations. During an interview on 2/12/25 at 9:42 A.M., Nurse #2 said she did not review the MAR while preparing medications and was preparing medications from memory. During an interview on 2/12/25 at 9:45 A.M., Unit Manager #3 said that Nurse #2 did not prepare medications in a safe manner. Unit Manager #3 said that Nurse #2 should have followed the facility policy and administered medications by verifying the order. During an interview on 2/12/25 at 9:47 A.M., the Assistant Director of Nursing said that Nurse #2 should have had her MAR open while preparing medication to verify the correct medications and doses. During an interview on 2/12/25 at 10:10 A.M., the Director of Nursing said that Nurse #2 did prepare medications in a safe manner. The DON said that Nurse #2 should have followed the facility policy and administered medications by verifying the order.

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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. 44095 Based on observations, interviews, and record reviews for three Residents (#22, #376 and #70) out of four residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. Three out of four nurses observed made 3 errors out of 33 opportunities resulting in a medication error rate of 9.09%. Specifically, 1.) For Resident #22, Nurse #1 administered the incorrect dose of a medication spray (Fluticasone, medication used for allergies) 2.) For Resident #376, Nurse #4 did not follow manufacture's recommendations and crushed a medication (metoprolol extended-release tablet, cardiac medication that once crushed becomes immediate release) which indicated do not crush. 3.) For Resident #70, Nurse #5 administered the incorrect medication (calcium with vitamin D) that was also expired. Findings include: Review of the facility policy titled, Administering Medications, dated as revised April 2019, indicated that medications are administered in a safe and timely manner, and as prescribed. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. 1.) Resident #22 was admitted to the facility in August 2022 with diagnoses including end stage renal disease, heart failure, and peripheral vascular disease. Review of the most recent Minimum Data Set assessment, dated 1/29/25, indicated that Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 2/12/25 at 8:01 A.M., the surveyor observed Nurse #1 administered medications to Resident #22 including: - Fluticasone, spray one in each nare. Review of Resident #22's physician's order, dated 11/5/22, indicated: - Fluticasone 50 micrograms, 2 sprays in each nostril one time a day for allergy/nasal congestion. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/25 at 8:15 A.M., Resident #22 said that he/she takes one spray each nose. 2. Resident #376 was admitted to the facility in February 2025 with diagnoses including atrial fibrillation, hypertension, and metabolic encephalopathy. On 2/12/25 at 8:43 A.M., the surveyor observed Nurse #4 administered medications for Resident #376. Nurse #4 crushed and administered Resident #376's metoprolol extended-release tablet. Review of Resident #376's physician's order, dated 2/4/25, indicated: - May crush, open, and combine medications as per manufacturer guideline and pharmacy recommendations. Review of Resident #376's physician's order, dated 2/5/25, indicated: - Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligrams, give 0.5 tablet by mouth one time a day for hypertension. Review of Resident #376's metoprolol medication card included the following manufacturer's instructions: do not crush, swallow whole. During an interview on 2/12/25 at 2:00 P.M., Nurse #4 said she should not have crushed Resident #376's extended-release medication. 3.) Resident #70 was admitted to the facility in April 2023 with diagnosis including dementia and diabetes. On 2/12/25 at 9:28 A.M., the surveyor observed Nurse #5 administer medications to Resident #70. Nurse #5 administered one tablet of calcium with vitamin D. Review of the manufacture's guidelines indicated the serving size is two tablets which is equal to calcium 400 milligrams and vitamin d 12.5 micrograms. Further review of the medication bottle indicated the medication expired in November 2024. Review of Resident #70's physician's order, dated 4/13/23, indicated: - Calcium Carbonate Tablet 600 milligrams (mg), give one tablet by mouth two times a day for supplementation. During an interview on 2/12/25 at 2:22 P.M., Nurse #5 said she should have administered the correct form and dose of calcium, and she said she should have verified the expiration date prior to administering medications. During an interview on 2/12/25 at 3:13 P.M., the Director of Nursing said nursing should verify the correct dose prior to administering medications, nursing should follow manufacture's guidelines and not crush medications that are do not crush, and she said that nursing should verify the correct medication and expiration date prior to administering medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 41105 Based on observations and interviews the facility failed to ensure drugs and biologicals were stored in accordance with acceptable professional standards of practice. Specifically: 1. Nursing failed to secure the medication carts on 2 of 3 units. 2. Nursing failed to ensure medication was stored in the packaging containers or other dispensing system in which it was received. 3. Nursing failed to ensure medications were dated once opened, and stored according to manufacturer's guidelines, in two of three medication carts observed. Findings include: The facility policy titled Medication Labeling and Storage, undated, indicated the following: -The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light control. Only authorized personnel have access to keys -Medication and biologicals are stored in the packaging containers or other dispensing system in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 1. On 2/11/25 at 6:55 A.M., the surveyor observed an unlocked and unattended medication cart on the 1st floor unit. The surveyor was able to open and access the cart and the nurse was unaware. During an interview on 2/11/25 at 7:09 A.M., with Nurse #1 she said that when she came in to her shift that morning the medication cart was already unlocked and that it should always be locked when unattended. On 2/11/25 at 8:34 A.M., the surveyor observed an unlocked and unattended med cart able on the 3rd floor unit. The surveyor was able to open and access the cart and the nurse was unaware. During an interview on 2/11/25 at 8:36 A.M., Nurse #2 said that the medication cart should always be locked when unattended. During an interview on 2/12/25 at 10:57 A.M., with the Director of Nursing she said that the medication carts should be locked when unattended. 2. On 2/11/25 at 6:55 A.M., the surveyor observed an unlocked and unattended medication cart on the 1st floor unit. The surveyor was able to open and access the cart and observe that in the top drawer of the cart there were three unlabeled cups filled with pills. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/11/25 at 7:09 A.M., with Nurse #1 she said that she had arrived on shift a short while earlier and found the medication cart unlocked so she decided to start preparing morning medication. Nurse #1 struggled to remember who 2 of the 3 cups were for and identified them by room number. Nurse #1 said that the night nurse still had the key to the medication cart and that they had not yet counted out the medication cart. She said that medication should not be pre-poured. During an interview on 2/12/25 at 10:57 A.M., with the Director of Nursing (DON) the surveyor shared the observations and information reported by Nurse #1 the previous morning, The DON said that's not okay. 44095 3. Review of the facility policy titled, Medication Labeling and Storage, undated, indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Medication Storage: 6. Medications requiring refrigeration are stored in the refrigerator. Medication Labeling: 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. 6. Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date. a. On 2/11/25 at 7:17 A.M., the Surveyor and the Nursing Supervisor observed on the second-floor 'long hall' medication cart: - one bottle of brinzolamide ophthalmic suspension drops, opened and undated - one bottle of latanoprost eye drops, opened and undated - one bottle of brimonidine 0.2% ophthalmic drops, opened and undated - one fluticasone furoate/ vilanterol inhaler, opened and undated - one fluticasone propionate/ salmeterol inhaler, opened and undated - one insulin glargine pan, opened and undated During an interview on 2/11/25 at 7:20 A.M., the Nursing Supervisor said that nursing is responsible for dating eye drops, inhalers, and insulin pens based on manufacture's recommendations. b. On 2/11/25 at 7:31 A.M., the Surveyor and Nurse #1 observed on the first-floor 'long hall' medication cart: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- one bottle of liquid protein, opened and undated. Manufacture's guidelines indicated good for 3 months once opened. - one fluticasone furoate/ vilanterol inhaler, opened and undated - one umeclidinium and vilanterol inhaler, opened and undated. - one insulin aspart, unopened. Manufacture's guidelines indicated refrigerate until opened. During an interview on 2/11/25 at 7:36 A.M., Nurse #1 said that nursing is responsible for dating liquid protein, dating inhalers once opened, and nursing should ensure insulins are stored in the refrigerator until it is opened. During an interview on 2/13/24 at 3:17 P.M., the Director of Nursing said that nursing should store medications according to manufactures guidelines.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45763 Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure that staff dated resident food and drinks in three of three unit kitchenette refrigerators. Findings include: Review of the facility's undated policy titled Food Brought by Family/Visitors indicated, but was not limited to, the following: - Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. - Family members and visitors are asked to inform nursing staff when foods are brought for a resident. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. o Perishable foods are stored in re-sealable containers with tight-fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. - The nursing staff will discard perishable foods on or before the use-by date. - The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul order, past due package expiration dates). On 2/11/25 at 7:24 A.M., the surveyor made the following observations in the first floor kitchenette refrigerator: - One bottle of a nutritionally fortified supplemental shake, opened but undated - One white plastic bag containing an open package of hot dogs and a plastic container of baked beans, undated. - One pitcher of apple juice dated 2/4, use by 2/10. - One container of spreadable cheese, open but undated. On 2/11/25 at 7:31 A.M., the surveyor made the following observations in the second floor kitchenette refrigerator: - One pitcher filled with apple juice, undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One single-serve bottle of orange juice, open with a straw inside. The juice was separated and sediment had settled at the bottom of the bottle, there was an expiration date of 1/24/25. - One slice of pizza wrapped in tin foil labeled with a resident room number but undated - One container of resident food dated 2/7 and 2/9. - One package of sharp white cheddar cheese, opened, labeled with resident room number but undated. On 2/11/25 at 7:38 A.M. the surveyor made the following observations in the third floor kitchenette refrigerator: - One pitcher filled with orange juice dated 2/4 with a use-by date of 2/10. - One resealable bag containing hard boiled eggs, undated. - One pitcher filled with apple juice, undated. During an interview on 2/13/25 at 10:16 A.M., the Food Service Director (FSD) said kitchenette refrigerators should be checked at least daily for label dates/expiration dates. The FSD said food should be labeled, dated and discarded after three days and that juice should be dated and discarded after five days; the FSD said that unlabeled food or juice should be discarded.

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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. 41105 Based on observation, record review and interview the facility failed to ensure accuracy of the medical record for two Residents (#110 and #13) out of a total sample of 30 residents. Specifically: 1. For Resident #110 the staff inaccurately documented in the Treatment Administration Record (TAR) regarding a resident fall mat. 2. For Resident #13 staff inaccurately documented that blood pressure readings were taken using the Resident's left arm when they were not. Findings include: 1. Resident #110 was admitted to the facility in February 2024 and has diagnoses that include Alzheimer's disease, history of falling and hemiplegia affecting right dominant side. Review of the most recent Minimum Data Se (MDS) assessment, dated 12/18/24, indicated that on the Brief Interview for Mental Status exam Resident #110 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #110 had no behavior of rejecting care and was dependent on staff for all Activities of Daily Living (ADLs). Review of the falls report for Resident #110, dated 8/11/24, indicated the following: -On 8/11/24 Resident #110 had an unwitnessed fall from bed. -Immediate actions taken to prevent recurrence: Floor mat (window side) Review of the active Physician's orders for Resident #110 indicated the following order: -floor mat (window side) when in bed, start date 8/11/24. Review of the current care plan for Resident #110 indicates the following; -Focus: Resident is at risk for falls: cognitive loss, lack of safety awareness. Interventions include: fall on 8/11/24-floor mat (window side) when in bed, initiated 8/11/24. Review of the February 2025 Treatment Administration Record indicated indicated nursing staff documented that Resident #110's fall mat was in place daily, on all three shifts, on 2/11/25, 2/12/25 and 2/13/25, contrary to observations during survey. On 2/11/25 at 8:22 A.M., Resident #110 was observed in bed. There was no fall mat in place. There was no fall mat observed in the room. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 8:25 A.M., and 9:10 A.M., Resident #110 was observed in bed. There was no fall mat in place. There was no fall mat observed in the room. On 2/14/25 at 7:22 A.M.,Resident # 110 was observed in bed. There was no fall mat in place. There was no fall mat observed in the room. During an interview on 2/14/25 at 7:26 A.M., with Resident #110's Nurse #5, she said that it is the expectation that the documentation in the TAR be accurate. Nurse #5 reviewed the TAR and said that staff had documented that the fall mat was in place daily on all three shifts. During an interview on 2/14/25 at 7:29 A.M., with the ADON she observed Resident #110 in bed, without a fall mat in place. The ADON said that it is the expectation that the documentation in the TAR be accurate and if the staff documented that the fall mat was in place she would expect to see one in place. 45763 2) Resident #13 was admitted to the facility in August 2024 with a diagnosis of end stage renal disease. Review of the most recent MDS assessment, dated 1/8/25, indicated that Resident #13 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Review of Resident #13's active physician orders indicated the following orders: - Do not take B/P (blood pressure) in left arm every shift, initiated on 5/28/24. - (dialysis) Access Location: Left arm feel for thrill and auscultate for bruit every shift, and as clinically indicated, initiated 1/28/25. Review of Resident #13's care plans indicated the Resident required hemodialysis (a process for filtering the blood of a person whose kidneys were not working normally) related to renal failure. Review of Resident #13's vitals summary indicated Nurse #4 documented that she had measured the resident's blood pressure using his/her left arm 17 times since August 2024. During an interview on 2/13/25 at 11:29 A.M., Resident #13 said staff never use his/her left arm to measure his/her blood pressure. During an interview on 2/13/25 at 11:26 A.M., Nurse #4 said Resident #13 had a dialysis fistula (a surgical connection between an artery and a vein that is created to provide long-term access to the bloodstream for hemodialysis) in his/her left arm and that his/her left arm should not be used to measure his/her blood pressure as this would put the resident at risk for pain, inaccurate blood pressure readings and fistula malfunction. Nurse #4 said she has never measured Resident #13's blood pressure using his/her left arm, and that she had recorded that in error. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at approximately 12:00 P.M., Unit Manager #2 said staff should not be taking blood pressure measurement on Resident #13's left arm due to his/her fistula and that the documentation was a mistake. During an interview on 2/13/25 at approximately 2:00 P.M., the Director of Nursing (DON) said she would expect staff to document accurately.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Some	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 44095 Based on interviews and reviews of the Health Care Facility Reporting System (HCFRS-State Agency reporting system), the facility failed to provide written notice to the State Agency of a change in the Administrator as required. Findings include: Review of the Facility Administrator Contact Information from, dated 2/11/25, indicated the current Administrator start date of 11/1/24. Review of the Health Care Facility Reporting System (HCFRS) on 2/11/25, failed to include documentation to support the facility provided written notice to the State Agency of the change of the facility's Administrator. During an interview on 2/12/25 at 10:25 A.M., the Director of Nursing said that she thought that the State Agency was made aware of the change in Administrator. During an interview on 2/12/25 at 3:30 P.M., the Administrator said he was not aware that the State Agency was not made aware of the change in Administrator, but the state agency should have been made aware of the change.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41105 Based on record review and interview, the facility failed to electronically submit direct care staffing data to the Centers for Medicare and Medicaid Services (CMS) for the entire reporting period, Fiscal Year (FY) Quarter 4 2024 (July 1 - September 30), in accordance with the schedule specified by CMS. Findings include: During an interview on 2/11/25 at 2:58 P.M., with the facility Administrator he said that he started at the facility in November 2024 and was aware that the facility had not submitted the previous quarters staffing data to CMS. The Administrator said that at that time the facility was owned by another company. During an interview on 2/13/25 at 10:49 A.M., with the Regional Administrator she said that the facility was taken over by a new company in October 2024, but could not get the staffing data from the last company so they did not submit it.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41105 Based on staff interview and record review, the facility failed to ensure the Nursing staff completed the required 12 hours (no less than) of annual training, which at minimum includes dementia training for 4 out of 5 employee records reviewed. Findings include: The facility policy titled Staff Education and Competency, undated, indicated the following: -Education is a key component to ensuring that our residents receive quality care. Education is provided to staff in various formats. We use Relias(C) as an online training resource. In addition, we provide both individual and group training sessions. -Education begins at orientation which includes job specific training. All new staff receive a general orientation to core facility processes, policies, and procedures. Orientation training topics include, but are not limited to, hand hygiene, infection control, bloodborne pathogens, resident rights, abuse and neglect, HIPAA, dementia and behavior management, fire safety, disaster preparedness, emergency response, workplace safety, and additional topics as required by the State of Massachusetts. Competency evaluations are conducted as they may apply to the new employee. Department specific training and competencies are completed with staff throughout employment to ensure that they can safely and competently provide the levels and types of care required by our resident population. Education is provided to contracted staff and volunteers consistent with their expected roles. Annual education requirements are in place for all staff to ensure robust ongoing education and competency. In addition to the required annual education courses for all staff, supplemental annual training is also provided to direct care staff and certified nursing assistants. Annual competency evaluations are conducted for all staff with additional annual competencies for nurses and certified nursing assistants. -As part of ongoing education and training, mock drills are scheduled on a rotating shift and day schedule. This enables the facility to receive a wide variety and sampling of staff participation. The Staff Development Coordinator and the Director of Maintenance collaborate in the development of the Drill schedule for the facility. -In addition to the required annual education and competencies, the facility identifies educational opportunities based upon the specific resident population and care needs. Education specific to the individual employee is conducted as opportunities for individual staff growth are identified and as determined through performance reviews. The facility also implements additional staff education as a result of QAPI actions and those incorporated in plans of correction. Review of 5 employee records (2 nurses and 3 Certified Nursing Assistants) indicated that 5 of 5 had not completed the required annual training, including dementia training, for the past year. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/25 at 11:19 A.M., with the Director of Nursing (DON), she said that when the facility got taken over by a new company in the Fall they lost all access to the education system including proof of staff training and competency. The DON was able to verify that 4 of the 5 employee records reviewed did not have the required dementia training hours.