STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225305	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary Health Care Center	39 Queen Street Worcester, MA 01610

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide appropriate assistance for one Resident (#3) out of a total sample of 23 residents, to maintain left-hand range of motion (ROM) when the Resident had a left-hand contracture.Specifically, the facility failed to adequately identify and treat Resident #3's left-hand contracture in a timely manner, when the severity of the Resident's left-hand contracture changed, increasing the Resident's risk for further decrease in ROM and skin breakdown. Findings include:Review of the facility policy titled Resident Mobility and ROM, last revised July 2017, indicated:-Residents with limited ROM will receive treatment and services to increase and/or prevent further decrease in ROM.-The care plan will be developed by the interdisciplinary team (IDT) based on the comprehensive assessment and will be revised as needed. Resident #3 was admitted to the facility in January 2022 with diagnoses including symptoms and signs involving cognitive functions and awareness and need for assistance with personal care. Review of Resident #3's clinical record indicated the Resident was diagnosed with a left-hand contracture on 9/18/25. Review of Resident #3's ADL Care Plan intervention, revised on 11/17/25, indicated: [name of rolled gauze] to be applied to left hand for contracture management.Further review of Resident #3's comprehensive care plan indicated the Resident was at risk for impaired skin integrity and had potential for pressure ulcer development. Review of Resident #3's Minimum Data Set (MDS) Assessment, dated 12/30/25, indicated:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) of one out of 15 total possible points.-was dependent on staff for activities of daily living (ADLs).-has impaired upper extremity ROM on one side.-has received occupational therapy services within the previous seven days. Review of the Occupational Therapy Evaluation, dated 12/10/25, indicated for Resident #3:-was referred to occupational therapy services for his/her left-hand contracture and the Resident's left upper extremity ROM was impaired.-left hand was extremely tight due to spasticity.-The Occupational Therapist (OT) was barely able to get the Resident's fingers off of the palm of his/her hand .-would yell with attempts to move his/her left hand open due to it was tightly fisted.-was at high risk for skin breakdown as his/her fingernails are making contact with his/her skin. Review of Resident #3's Physician Orders, dated 12/14/25, indicated:-Tx (treatment) for left hand: wash with warm soapy water, pat dry with a gauze and apply hand cone with Velcro strap to keep the finger off the palm of the hand.-Nursing, please place hand cone to left hand with Velcro strap daily and keep on at all times except for removal for skin care twice a day. Call OT for any issues. Review of Resident #3's Occupational Therapy Treatment Encounter Note (TEN), dated 1/28/26, indicated:-required max (maximum) effort from the OT to get the Resident's left hand open enough to place a clean gauze roll.-has not made any progress despite increased doses of Baclofen (prescription muscle relaxant used to treat severe, chronic muscle spasms, stiffness, and rigidity).-was . poorly conscious and would only scream when his/her hand was being opened.-plan was to discontinue occupational therapy services on 1/30/26.-Nursing staff were changing the Resident's rolled gauze daily. Review of Resident #3's Occupational Therapy Discharge summary, dated [DATE], indicated:-required the use of rolled gauze in his/her left (continued on next page)

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

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand.-Use of the rolled gauze was keeping the skin in the Resident's left hand dry and without pressure from his/her fingernails.-Nursing staff were to continue applying rolled gauze in the Resident's left hand daily, to keep the Resident's skin dry and intact. On 4/8/26 at 9:17 A.M., the surveyor observed Resident #3 positioned in bed with his/her hands on top of the covers. The Resident's left hand was observed in a fisted position without a hand cone in the Resident's left hand. On 4/9/26 at 10:30 A.M., the surveyor observed Resident #3 seated in the hallway at the nurses' station. The Resident's left hand was observed in a fisted position and laying on the Resident's lap without a hand cone in the Resident's left hand. Review of Resident #3's April 2026 Treatment Administration Record (TAR) indicated the following treatments were signed off as completed daily from 4/1/26 through 4/9/26:-Nursing, please place hand cone to left hand with Velcro strap daily and keep on all times except for removal for skin care twice a day. Call OT for any issues.-Tx for left hand: wash with warm soapy water, pat dry with a gauze and apply hand cone with Velcro strap to keep the finger off the palm of the hand. During an interview on 4/9/26 at 12:45 P.M., the OT said she provided occupational therapy services to Resident #3 in December 2025 and January 2026 to address the Resident's left-hand contracture. The OT said the Resident was discharged from occupational therapy services on 1/30/26 and that the discharge plan was for nursing staff to clean the Resident's hand and place rolled gauze into the Resident's hand daily. The OT said the rolled gauze kept the Resident's hand dry and kept his/her fingers away from his/her palm so that the Resident's skin did not break down. The OT said the treatment for cleaning the Resident's hand and placing the rolled gauze was challenging and that nursing staff had not alerted her that they were unable to perform the treatment. The OT said the Resident was unable to tolerate the use of a hand cone due to the severity of the Resident's left-hand contracture and pain and that the treatment that was supposed to be in place was for the Licensed Nurses to clean the Resident's hand and place the rolled gauze between the Resident's fingers and palm on his/her left hand. During an interview on 4/9/26 at 1:00 P.M., Nurse #1 said she was responsible for Resident #3's care that day and that she attempted to place the rolled gauze in the Resident's left hand a few minutes prior to speaking with the surveyor. Nurse #1 said the Resident's left hand was too contracted to place the rolled gauze between the Resident's fingers and palm and that the Resident had been like this since Nurse #1 began providing care to the Resident about one month prior. Nurse #1 said she was only able to place the rolled gauze between the Resident's thumb and index finger. Nurse #1 then lifted the Resident's left arm and rolled gauze was observed in the Resident's lap where his/her left hand was laying prior to Nurse #1 lifting it up. Nurse #1 picked up the rolled gauze and placed the rolled gauze between the Resident's left thumb and index finger. Nurse #1 then attempted to move the Resident's middle, ring, and pinky fingers away from the Resident's palm and the Resident winced and called out don't! Nurse #1 said she could not move the Resident's fingers away from his/her palm to put the rolled gauze in place. During an interview on 4/9/26 at 1:24 P.M., the OT said the Resident was able to tolerate placement of rolled gauze into his/her left palm, between his/her index, middle, ring, and pinky fingers and his/her palm when occupation therapy services were discontinued in January 2026. The OT said if nursing staff were not able to place the rolled gauze anymore due to the Resident's contracture, nursing staff should have completed a referral to occupational therapy so that OT could have reassessed the Resident. The OT said it was a problem for the Resident if the nursing staff could not keep the Resident's fingers off his/her palm. During an interview on 4/9/26 at 2:35 P.M., Nurse #1 said she signed off on the treatment ordered for the Resident to have a hand cone placed in the left hand daily even though Resident #3 did not have a hand cone. Nurse #1 said she provided rolled gauze instead of the hand cone because the Resident did not have a hand cone and the Resident's hand was too contracted for a hand cone. Nurse #1 said using the rolled gauze was better than using nothing. Nurse #1 assisted Resident #3 to his/her room and turned the Resident's left forearm so that the palm side of the Resident's left hand could be observed. The Resident's left index and pinky fingers were observed bent and pressed against the Resident's palm, and the Resident's index and pinky (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fingernails, which were long, brown, and thick, pressed into the Resident's palm, making an indentation. The Resident's left middle and ring fingers were also bent with their fingertips laying against the Resident's palm. Nurse #1 tried and was unable to move the Resident's fingers away from his/her palm. During an interview on 4/9/26 at 3:49 P.M., the Director of Nursing (DON) said Resident #3's order for the use of a hand cone in the left hand should have been discontinued when it was determined that the Resident could not tolerate the hand cone. The DON said an order should have been obtained for the rolled gauze to be placed in the Resident's hand when the Resident was discontinued from occupational therapy services and the rolled gauze was identified as the appropriate treatment for the Resident's left-hand contracture. The DON said nursing staff should have notified the OT when they were no longer able to place the rolled gauze effectively in the Resident's left hand so that the Resident could be reassessed. During an interview on 4/10/26 at 1:53 P.M., the OT said she reassessed Resident #3's left hand contracture on 4/9/26, following the surveyor's inquiries. The OT said she was able to cleanse inside the Resident's palm, under the Resident's fingers, using a tongue depressor and some gauze, and that the Resident's palm could be visualized. The OT said she cleaned dead skin from the Resident's left palm and that the Resident's joint at the base of his/her left pinky finger on the palm side was macerated (softening and breaking down of skin due to prolonged exposure to moisture, appearing white, wrinkled, or soggy), and the Resident's left palm had a strong odor. The OT said the Resident is at risk for skin breakdown and that she was glad that the Resident did not develop a wound in his/her palm due to his/her contracture and pressure.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure that competency and skills necessary to provide the level and type of care needed for one Resident (#12) were demonstrated by one Licensed Nurse (Nurse #3). Specifically, the facility failed to ensure that Nurse #3 completed the necessary training and competencies relative to gastrointestinal feeding tube management prior to providing tube feeding care and services for Resident #12. Findings include:Review of the Facility Assessment Tool (self-completed assessment that indicated what types of care a facility provided as well as what their staffing and educational plans to meet the Resident's needs), dated 10/1/25, included but was not limited to:*Nursing facilities will conduct, document, and review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. The assessment will be reviewed annually and updated as needed. >The purpose of the assessment is to evaluate the resident population and determine what resources are necessary to care for the residents competently during day-to-day operations (including nights and weekends) and emergencies. Use this assessment to make decisions about your direct care staff needs (including those who provide services under contract and volunteers), as well as your capabilities to provide services to the residents in your facility, at least annually and as necessary, per the above requirement. Using evidence-based, date driven methods focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychological well-being. -Consider the following competencies (this is not an inclusive list).>Specialized care - tube feedings. Review of the facility policy titled, Competency Evaluation, undated, included but was not limited to: *It is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job.>Competency - is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual need to perform work roles or occupational functions successfully. -The knowledge and skills required among staff to meet resident's needs are determined through the facility assessment process.-Evaluating competency of staff is accomplished through the facility's training program.-Initial competency is evaluated during the orientation process. An employee remains on orientation until all competencies are verified.-Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations. -A variety of methods may be used to evaluate learning and/or skills competency. Examples include, but are not limited to:>Lecture or demonstration with return by the employee.>Direct observation of the employee's ability to demonstrate use of tools, devices, or equipment.>Direct observation of the employee's ability to perform specific tasks.>Review of the employee's documentation.>Peer review or interviews with other staff, residents, and/or families.>Review of adverse events or other data.-Checklists are used to document training and competency evaluations.-Only designated individuals may verify competency.>Staff Development Coordinator.>Orientation preceptor.>Department Head/Administrator.>Higher level employee/professional who has demonstrated competency.>Consultant expert.>Physician.-Employee competency forms are maintained in the Staff Development Coordinator's offices for current training year, then forwarded to the Human Resources Director for placing into employee's personnel file. Review of the completed Matrix for Providers (listing of all residents in the facility and their pertinent care categories) provided to the survey team on 4/8/26 indicated the following:-Census: 114 residents.-1 resident receiving tube feeding. Review of the facility assessment failed to indicate nursing competencies and skills set necessary to provide the level and type of care needed for facility residents with tube feeding. Review of Nurse #3's facility education records failed to indicate evidence that any competencies relative to tube feeding was completed by the Nurse. Resident #12 was admitted to the facility in September 2020 with diagnoses including Multiple Sclerosis, encounter (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for surgical aftercare following surgery on the digestive system, Gastrostomy Status, Dysphagia, oral phase feeding difficulties, and Obstructive Sleep Apnea (OSA). Review of the Minimum Data Set (MDS) Assessment, dated 1/6/26, indicated Resident #12:-has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of seven out of a possible 15 points. -received nutrition and hydration via a feeding tube. -received over 51 percent (%) of their calories via tube feed. -received fluid intake via a feeding tube and received over 501 cc (cubic centimeters) of fluid for hydration per day. Review of Resident #12's April 2026 Physician's orders indicated:-Free water flush via G-Tube 350 milliliters (ml) every 4 hours for Hydration related to GASTROSTOMY STATUS, initiated 2/18/26.-Enteral Nutrition via pump: Jevity 1.5 at 120 cc/ml from 6:00 P.M.- 6:00 A.M., initiated 12/15/25. On 4/9/26 at 8:28 A.M., the surveyor observed Resident #12 lying in bed with the head of the bed elevated and Nurse #3 providing enteral tube feeding care for the Resident. Nurse #3 assessed the feeding tube for gastric residual volume and attached a 60 ml catheter tipped syringe to the open enteral tube, removed the syringe plunger and poured the entire amount of water (refilling the syringe barrel thirteen consecutive times without use of the syringe plunger) from a large styrofoam cup into the syringe barrel attached to the enteral tube, allowing water to flow through the tube and into the Resident's stomach. Resident #12 was observed saying to Nurse #3 that the Nurse was making him/her heavy with all that water. During an interview at the time, Nurse #3 said that the large styrofoam cup held 350 ml of water and that the Resident had a Physician order in place for a 350 ml water flush every 4 hours. During a follow-up interview on 4/9/26 at 9:18 A.M., when the surveyor asked about the measurement of the large styrofoam cup, Nurse #3 used a 207 ml clear plastic cup to fill the total amount of water that was administered to Resident #12 into the large styrofoam cup, and the actual total measured was 828 ml. Nurse #3 said that Resident #12 was ordered for 350 ml water flush and not the 828 ml water flush that was given. Nurse #3 said that she administered an extra 478 ml of fluids without a Physician order and that it was important for her to follow the Physician orders as indicated. During an interview on 4/9/26 at 9:48 A.M., the Staff Development Coordinator (SDC) said that there was no Licensed Nurse competency related to tube feeding care and services for Nurse #3. The SDC said that he will check Nurse #3's personnel educational file and get back to the surveyor. During an interview on 4/9/26 at 3:45 P.M., the SDC said that there was no nursing competency conducted in the facility relative to tube feeding care and services. During an interview on 4/10/26 at 11:02 A.M., Nurse #3 said she completed general orientation when she started working in the facility in August 2024. Nurse #3 said that the orientation process included medication administration, resident assessment and wound care and services. Nurse #3 said that there were no competencies and/or return demonstration related to tube feeding care and services during the orientation process. Nurse #3 said that there had not been any performance evaluation completed when she completed her orientation process and she did not have any annual training since August 2024. Nurse #3 also said that she was not competent in care and services related to enteral tube feeding or had any prior competency or training related to tube feeding care and services for residents in the facility, and her prior experience and training related to tube feeding was when she was in nursing school. Nurse #3 said that she has knowledge on the basic steps in administering medications through the feeding tube which she learned from nursing school but did not learn this in the facility. During an interview on 4/10/26 at 2:20 P.M., the Director of Nursing (DON) said that there was no personnel education on file for Nurse #3 relative to tube feeding competency prior to the Nurse working with Resident #12. The DON also said that there was no tube feeding competency completed for licensed nursing staff prior to the start of the new SDC and there has not been any education and or staff competencies relative to tube feeding. During an interview on 4/14/26 at 2:15 P.M., the Administrator said that the facility assessment included a list of staff competencies, but the list was not an exclusive list. The Administrator said that the facility assessment should not be exclusive because he does not need to update the assessment frequently unless something happens. The Administrator said that the facility assessment includes the tool but (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not the process for staff to evaluate staff competencies. The Administrator said that he will need time to review the facility assessment and get back to the surveyor. During an interview on 4/14/26 at 3:03 P.M., the Administrator said that there was no competency for licensed nursing staff on tube feeding and there should have been to address the needs of the residents in the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed, the facility failed to ensure that three Residents (#96, #1 and #5) out of a total sample of 23 residents were provided the right to participate in the care plan process.Specifically, the facility failed to: 1. For Resident #96, ensure that the Resident was provided with the required information for participation in the care planning process when he/she was not informed of where the care meetings were held and the facility did not provide rationale why the Resident's participation in the care planning process was not practicable when the Resident's Healthcare Proxy declined to attend.2. For Resident #1, the facility failed to ensure the Resident was invited to participate in and attended his/her care plan meetings and provide facility rationale as to why the participation of the Resident was determined to be not practicable for the development of his/her care plan.3. For Resident #5, the facility failed to ensure that the Resident was invited to participate in and attended his/her care plan meetings and rationale was provided as to why the Resident's participation was determined to be not practicable for the development of his/her care plan.Findings include: Review of the facility policy titled Care Plans, – Comprehensive Person-Centered, last revised March 2022 indicated: -the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -the resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. -if the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were to taken to include the resident or representative in the process. -the resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. 1. Resident #96 was admitted to the facility in August 2022, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Schizophrenia. Review of the MDS (Minimum Data Set) assessment dated [DATE], indicated Resident #96: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. -was English speaking. -makes himself/herself understood. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-usually understands others. -did not refuse care in the look back period. During an interview on 4/8/26 at 9:46 A.M., Resident #96 said that he/she had been invited to her care plan meetings with an invitation, however he/she did not know where the care plan meetings were held in the facility so he/she could attend, which he/she would like to do. Review of Resident #96's clinical record failed to indicate any documented evidence that the Resident participated in the care planning process with the interdisciplinary team (IDT) during the Resident's care plan meeting reviews held on 2/27/25, 5/29/25, 8/28/25, 12/2/25, and 3/3/26. Further review of Resident #96's clinical record: -failed to indicate the rationale for why the Resident did not or could not participate in any care plan meetings, or refusals to participate in the meetings in 2025 and 2026. -indicated that the Resident's Healthcare Proxy (HCP- a legal document that designates a trusted person to make medical decisions on your behalf if you are unable to do so) had been invited to attend the Resident's care plan meeting and declined to attend on 2/27/25, 8/28/25, 12/2/25 and 3/9/26. -the care plan meeting invitations did not indicate the location of the care plan meeting and that the Resident's need to call the Social Worker by telephone to confirm their attendance. During an interview on 4/13/26 at 11:01 A.M., the Social Worker (SW) said that Resident #96's decision to not attend their care plan meeting should have been documented in the Resident's clinical record and it had not been. The SW said that Resident #96 had not expressed an interest in attending his/her care plan meetings. The SW also said that there was no documented evidence in the progress notes that Resident #96 declined to attend his/her care plan meetings and there should have been. During an interview on 4/13/26 at 11:44 A.M., the Director of Nursing (DON) said that it is important to invite Resident #96 to his/her care plan meetings because the meetings are about the Resident and he/she deserve a voice in their plan of care and to know that their voice matters. 2.Resident #1 was admitted to the facility in December 2025, with diagnoses including Alzheimer's disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #1: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of two out of 15. -required assistance with activities of daily living (ADLs). Review of the MDS Schedule for Resident #1 indicated that the Resident had care plan meetings scheduled for 12/14/25, and 3/17/26. Review of the attendance sheets for the care plan meetings on 12/14/25 and 3/17/26 did not indicate (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #1 attended the meetings. Review of Resident #1's clinical record failed to indicate documented evidence that the Resident was invited to participate in and attended the care plan meetings on 12/14/25 and 3/17/26. Further review of the clinical record failed to indicate any refusal by Resident #1 to participate in the meetings. The clinical record did not indicate documentation of why the Resident was not present for the care plan meetings or that the participation of Resident #1 in their care plan meetings was not practicable. 3. Resident #5 was admitted to the facility in December 2020 with diagnoses including Alzheimer's disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] Section C, indicated that Resident #5 was severely cognitively impaired. Review of the MDS Schedule for Resident #5 indicated that the Resident had care plan meetings scheduled for 10/14/25, 1/5/26, and 4/4/26. Further review of the attendance sheets for the care plan meetings on 10/14/25, 1/5/26, and 4/4/26 did not indicate that Resident #5 attended the meetings. Review of Resident #5's clinical record failed to indicate documented evidence that the Resident was invited to participate in the care plan meetings held on 10/14/25, 1/5/26, and 4/2/26. Further review of the clinical record failed to indicate any refusal by Resident #5 to participate in the care plan meetings and documented rationale to indicate that the participation of Resident #5 in their care plan meetings was not practicable. During an interview on 4/14/26 at 1:35 PM the SW said there was no evidence that Resident's #1 and #5 were invited to participate in their care plan meetings. During an interview on 4/14/26 at 2:10 P.M., the DON said that the facility could not provide any documentation of Resident #1 and Resident #5's invitation to participate in their care plan meetings or any documentation showing refusal by Resident #1 and Resident #5 to participate. The DON said that there was no documentation Resident #1 and Resident #5's participation in and attending their care plan meeting was determined to not be practicable.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services relative to enteral feeding (delivery of nutrients through a feeding tube into the stomach/intestines), for one Resident (#12) out of a total sample of 23 residents. Specifically, for Resident #12, the facility failed to ensure that the accurate amount of water flushes as ordered by the Physician, and the appropriate tube feed flush procedure was being administered via the Resident's enteral feeding tube, when more than the ordered amount of water flushes was administered, placing the Resident at risk for gastrointestinal complications. Findings include:Review of the facility's policy titled, flushing a Feeding Tube, undated, included but limited to:*It is the policy of this facility to ensure that staff providing care and services to the residents via a feeding tube are aware of, competent in, and utilize facility protocols regarding feeding nutrition and care. Feeding tube care and services will be provided in accordance with resident needs and professional standards of practice.-Verify physician orders for tube feeding flush amount.-After tube placement has been verified, flush the tube utilizing the 60 milliliters (ML) catheter tip syringe (legacy feeding tubes) or 60 ml ENFit (a specialized, standardized syringe [ISO] designed specifically for enteral feeding) syringe (feeding tube with ENFit connector) with the prescribed amount of water every four (4) hours, before and after feedings and medications or as directed by the physician.-Notify physician of any abnormalities noted. Review of the facility's policy titled, Care and Treatment of Feeding Tubes, undated, included but limited to:*It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.-Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush. -The facility will utilize the Registered Dietitian in estimating and calculating a resident's daily nutritional and hydration needs. *Directions for staff on how to provide the following care will be provided:-Frequency and volume used for flushing, including flushing for medication administration, and what to do when a prescriber's orders does not specify. Review of the facility's policy titled, Appropriate Use of Feeding Tubes, undated, included but limited to:*It is a policy of this facility to ensure that a resident maintains acceptable parameters of nutritional and hydration status. Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident's clinical deems this intervention medically necessary. -A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal pharyngeal ulcers. -Feeding tubes (naso-gastric, gastrostomy, jejunostomy) will be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Review of the facility's policy titled, Documentation in Medical Record, undated, included but limited to:*Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.-Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. -Documentation shall be completed at the time of services, but no later than the shift in which the assessment, observation, or care services occurred.-Principles of documentation include, but are not limited to:>Documentation shall be factual, objective, and resident centered.>False information shall not be documented.>Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. >Documentation shall be timely and in chronological order.>Avoid generalizations and vague phrases or expressions. -When documentation occurs after the fact, (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside acceptable time limits, the entry shall be clearly indicated as late entry. Resident #12 was admitted to the facility in September 2020 with diagnoses including Multiple Sclerosis, encounter for surgical aftercare following surgery on the digestive system, Gastrostomy Status, Dysphagia, oral phase feeding difficulties, and Obstructive Sleep Apnea (OSA). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #12:-has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of seven out of a possible 15 points. -has received nutrition and hydration via a feeding tube. -has received over 51 percent (%) of calories via tube feed. -has received fluid intake via a feeding tube and received over 501 cc (cubic centimeters) of fluid for hydration per day. Review of Resident #12's April 2026 Physician's orders indicated:-Free water flush via G-tube 350 milliliters (ml) every 4 hours for hydration related to GASTROSTOMY STATUS, initiated 2/18/26.-Enteral Nutrition via pump:Jevity 1.5 at 120 cc/ml from 6:00 P.M.- 6:00 A.M., initiated 12/15/25.Review of Resident #12's April 2026 Medication Administration Record (MAR) indicated 350 ml of free water flush via G-tube was administered on 4/9/26, with a check mark and Nurse #3's initials. On 4/9/26 at 8:28 A.M., the surveyor observed Resident #12 lying in bed with the head of the bed elevated and Nurse #3 accessed Resident #12's enteral feeding tube and assessed for gastric residual volume. Nurse #3 then attached a 60 ml catheter tipped syringe to the open enteral tube, removed the syringe plunger and poured the entire amount of water (refilling the syringe barrel thirteen consecutive times without use of the syringe plunger) from a large styrofoam cup into the syringe barrel attached to the enteral tube, allowing water to flow through the tube and into the Resident's stomach. Resident #12 was observed saying to Nurse #3, you are making me heavy with all that water. Nurse #3 said that the large styrofoam cup held 350 ml of water and that the Resident had a Physician order in place for a 350 ml water flush every 4 hours. On 4/9/26 at 9:18 A.M., when the surveyor asked about the measurement of the large styrofoam cup, Nurse #3 used a 207 ml clear plastic cup to fill the total amount of water in the large styrofoam cup that was administered to Resident #12, and the actual total was 828 ml. Nurse #3 said that Resident #12 was ordered for 350 ml water flush and not the 828 ml water flush given. Nurse #3 said that she administered an extra 478 ml of fluids without a Physician order and the risk of administering extra fluids to Resident #12 would be aspiration, fluid overload, and pneumonia. Nurse #3 also said that it was important for her to follow the Physician orders as indicated. During an interview on 4/9/26 at 3:45 P.M., the Staff Development Coordinator (SDC) said that there were no licensed nursing competencies relative to tube feeding care and services. The SDC also said that the risk to Resident #12 receiving an extra 478 ml of fluids not ordered by the Physician, was fluid overload due to Resident #12's prior history of congestive heart failure. The SDC also said Resident #12 was at an increased risk for discomfort leading to bloating, pressure and discomfort in his/her abdomen. During an interview on 4/10/26 at 11:02 A.M., Nurse #3 said she went through regular orientation when she began working in the facility. Nurse #3 said that the orientation process included medication administration, resident assessment, wound care and learning the electronic medical record (EMR). Nurse #3 said that she had basic steps in administering medication through the feeding tube during her nursing education training in school but has not had any training or education relative to care of an enteral feeding tube prior to working with Resident #12. Nurse #3 also said she should not have documented 350 ml water flushes on Resident #12's (MAR) as the water flush information entered was inaccurate. During an interview on 4/10/26 at 2:20 P.M., the Director of Nursing (DON) said that there were no trainings and/or staff competencies related to tube feedings for the Licensed Nurses prior to Nurse #3 working with Resident #12. The DON also said that no tube feeding education and staff competencies were completed by licensed nursing staff prior to the current SDC starting at the facility. Please Refer to F726

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals were stored in accordance with professional requirements on one unit's (Dementia Unit -Third Floor Side A) medication cart, out of a total of three units reviewed. Specifically, the facility failed to ensure that a medication cart on the Third floor Side A was locked, and prepared medications were secured when the medication cart were left unattended, to prevent unauthorized personnel and residents' access to medications on and in the medication cart. Findings include:Review of the facility policy titled, Medication Storage, Storage of Medications, dated 1/2025, included but was not limited to:*Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.-The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements, including those established by the United States Pharmacopeia (USP). Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medications rooms, medication cabinets, or other suitable containers. -In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended to by persons with authorized access. During an observation on 4/10/26 from 8:19 A.M. to 9:00 A.M., the surveyor observed Nurse #1 on the Third Floor (Dementia Unit) with the following:-Nurse #1 prepared the following medications:>Lisinopril 10 milligrams (mg) tablet>Azathioprine 50 mg tablet>Vitamin D 25 micrograms (mcg) tablet>Aspirin 81 mg tablet>Folic Acid 1 mg tablet>Furosemide 40 mg tablet>Mesalamine DR 40 mg capsule>Trazodone 25 mg tablets>Albuterol HFA (hydrofluoroalkane) 90 mcg inhaler>Cyclosporine ophthalmic emulsion 0.05 percentage (%)>Serevent Diskus Salmeterol 50 mcg>Artificial tears eye drop-Nurse #1 crushed the medications, placed them in a clear plastic cup and added apple sauce to the medications.-Nurse #1 walked away from the medication cart and entered the Unit dining room leaving the cup of crushed medications, eye drops, and inhalers on the cart, the medication cart unlocked and the computer screen with private resident information open and visible for anyone to read.-The surveyor observed staff members escorting residents into the dining room, and staff and residents were walking by the area where the unsecured medication cart was positioned in the hallway. -Nurse #1 returned to the medication cart positioned in the hallway and pushed the medication cart to the other side of the hallway. The surveyor observed that the eye drops and inhaler medications remained on top of the medication cart, the cart was left unattended again, with the medication cart unsecured and the computer screen unlocked. During an interview on 4/10/26 at 9:00 A.M., Nurse #1 said that medication carts should be locked and medications put away for safety when the medication cart was unattended. Nurse #1 said that the risk of leaving crushed medications, prescription inhalers and eye drops, on top of the medication cart was that other staff members and residents would have access to medications left on the top of the cart and inside the medication cart if the cart was unlocked. Nurse #1 also said that she should have secured the computer screen when she stepped away from the computer to ensure that resident's information was protected. During an interview on 4/10/26 at 2:20 P.M., the Director of Nursing (DON) said that his expectation for nursing staff during medication administration was that Nurses place medications inside the medication cart and secure the medication cart when they walked away from the cart to prevent unauthorized personnel access to the medications on the top and inside the medication cart especially if the medication cart was (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positioned in the hallway on the Dementia Unit where residents and other staff members would have easy access to the unlocked medication cart. The DON further said that the Dementia Unit had residents that wander on the unit who might have access to the medication cart if the medication cart was left unattended with medications on top of the cart. The DON said that nursing staff should secure the computer screen when the Nurse walked away to protect resident information from unauthorized persons as leaving the computer screen up and unsecured was a HIPAA violation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to ensure that food was stored in a safe and sanitary manner, in accordance with professional standards for food service safety to prevent the spread of foodborne illness. Specifically, the facility's dietary staff failed to: -ensure food items were properly labeled and dated in the main kitchen refrigerators placing residents at risk for food borne illness. -discard left over food within 72 hours that had been clearly labeled and dated, placing residents at risk for foodborne illness. -maintain a clean and sanitary food storage freezer, stove, and blender used for the storage or preparation of resident food placing residents at risk for food borne illness. -store chemicals away from the drink station, placing residents at risk for receiving contaminated beverages. Findings include: Review of the Food and Drug Administration (FDA) Food Code 2017 included the following: Nonfood Contact Surfaces: The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. Storage of Equipment, Utensils: The improper storage of clean and sanitized equipment, utensils.may allow contamination before their intended use. Contamination can be caused by moisture from absorption, flooding, drippage, or splash. It can also be caused by food debris, toxic materials, litter, dust, and other materials. Review of the facility policy titled Food Storage, undated, included but was not limited to: -Sufficient storage facilities will be provided to keep foods safe. Food will be stored in an area that is clean., and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. >All freezer units will be kept clean.at all times. >Leftover food will be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 72 hours or discarded. On 4/8/26 at 7:45 A.M., the surveyor and [NAME] #1 observed the following in the facility's main kitchen: -In the walk-in refrigerator: >a soft meat-like product wrapped in plastic wrap, unlabeled and undated. >a clear plastic container with a clear plastic lid which contained a soft white substance, unlabeled and undated. >one silver steam table pan containing an unlabeled white substance, partially covered with plastic wrap, dated 4/3/26. >one silver steam table pan containing an unlabeled yellow substance covered with plastic wrap, dated 4/1/26. During an interview at the time, [NAME] #1 said the soft meat-like product was shredded chicken breast and the soft white substance was cottage cheese. [NAME] #1 said that both items should have been labeled and dated before being put into the refrigerator. [NAME] #1 said the white substance was rice and should have been covered completely and discarded on 4/6/26 because prepared food was only kept for three days and the yellow substance was pasta and should have been discarded on 4/4/26 because prepared food should be discarded after three days. ˆ -In the reach-in refrigerator: >one clear plastic container with a green lid, labeled chunked pineapple, dated 3/26/26. >one clear plastic container with a red lid, labeled fruit cocktail, dated 4/3/26. > one clear plastic container with a clear lid labeled apple slices, dated 4/3/26. >one green bowl filled with a yellow substance, unlabeled and undated. >one box of muffins with ripped clear plastic wrap covering, undated. During an interview at the time, [NAME] #1 said the chunked pineapple should have been discarded on 3/29/26 and should not still be in the refrigerator. [NAME] #1 said the fruit cocktail should have been discarded on 4/6/26 and not still be in the refrigerator. [NAME] #1 said apples should have been discarded on 4/6/26 and not kept in the refrigerator. [NAME] #1 also said the yellow substance was apple sauce and should have been labeled and dated before putting it into the fridge and the muffins should have been covered completely and dated when opened, before being put back into the refrigerator. ˆ-In the silver reach-in freezer: >a large area of splattered white and brown substances to the outer doors, handles, inner walls and the floor of the inner compartment. >Green, red and brown debris was observed on the inner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	compartment walls and floor of the freezer.During an interview at the time, [NAME] #1 said she was unable to identify the splattered white and brown substance on the freezer. [NAME] #1 said the green, red and brown debris to the inner compartment was spilled food and should have been wiped up at the time of the spill. -On the Ninja blender: >dried, thick splatters of red, brown and white substances observed on the front control buttons, sides and rotation platform. The rotation platform was also observed to have dried solid, chunks of white matter. During an interview at the time, [NAME] #1 said the dried substances and chunks on the Ninja blender looked like old food and the blender should have been cleaned. -On the juice station: >two red buckets of cleaning solution with suds observed directly on top of the juice concentrate boxes used to prepare resident beverages.During an interview at the time, [NAME] #1 said that cleaning chemicals should not have been left on top of the juice concentrate boxes because the buckets could spill on the drinks.ˆ During an interview on 4/8/26 at 2:04 P.M., the Food Service Director (FSD) said the chemicals should not have been left on the juice station because the juice station could be contaminated. The FSD said the dirty kitchen equipment, undated food items, uncovered food items, and leftover foods, that were dated beyond 72 hours, presented a risk to the residents for foodborne illness.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that Pneumococcal Vaccination was offered as required to one Resident (#1), of five applicable residents reviewed for Pneumococcal immunization, out of a total sample of 23 residents. Specifically, for Resident #1, the facility failed to offer Pneumococcal Vaccination to the Resident when he/she was eligible for Pneumococcal Vaccination PCV20 or PCV21 (Pneumococcal Conjugate Vaccine: vaccine used to protect against 20 and 21 types of pneumococcal bacteria that commonly cause serious infections) at the time of admission to the facility. Findings include: Review of the CDC (Centers for Disease Control and Prevention) guidelines reviewed at www.cdc.gov indicated: >Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both: PCV13 (but not PCV15, PCV20, or PCV21) at any age PPSV23 at or after the age of [AGE] years old Review of the facility policy titled Resident Pneumococcal Immunization, dated 1/1/25, included but was not limited to: -Purpose - To minimize the risk of acquiring, transmitting, or experiencing complications from the pneumococcal virus and provide a safe environment for our residents. -Policy - All (company name) long term care facilities will offer the pneumococcal vaccine to each resident. -Procedure - Each resident is offered a pneumococcal immunization, unless medically contraindicated or the resident has already provided documentation of immunization. Resident #1 was admitted to the facility in December 2025 with diagnoses including Pneumonia, Asthma and Chronic Kidney Disease. Review of Resident #1's medical record indicated the following: >an invoked Health Care Proxy (HCP-person appointed to make healthcare decisions for someone when they are unable to do so themselves), effective 11/13/25. >had received PPSV23 (Pneumococcal Polysaccharide Vaccine 23-specific type of pneumococcal immunization) on 11/5/10. >had received PCV13 (a specific type of pneumococcal immunization) on 1/10/20. >No evidence that PCV 20 or PCV21 had been offered. During an interview on 4/9/26 at 10:30 A.M., the Infection Preventionist (IP) said the facility followed CDC guidance for Pneumococcal immunizations of residents living in the facility. The IP said he was responsible to ensure that Pneumococcal Consent Forms were completed correctly and reviewed for immunization eligibility. The IP said Resident #1 was at high risk for exposure to pneumonia due to the Resident's age and living in a nursing home. The IP said Resident #1 was eligible to receive PCV 20 or PCV 21 in November 2025. The IP said he should have approached the Resident's HCP to inform them that Resident #1's Pneumococcal immunization was not up to date at the time of admission and offer to immunize but did not.