STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225315	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands, The	335 Nichols Road Fitchburg, MA 01420

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide food and drink at a safe and appetizing temperature for residents on Three (Unit Two, Unit Three and Unit Five) of Four units observed and for one Resident (#11) out of a total sample of 31 residents. Specifically, the facility failed to: 1. Ensure that residents on Unit Two, Unit Three and Unit Five received food that was served at safe and appetizing temperatures.2. Ensure that Resident #11's meal preferences were honored when the meals tickets identified the Residents' choices of meal. Findings include: 1. Review of the facility policy titled Food Temperature Control, revised 4/28/25, included but was not limited to: -Food temperatures are maintained during mealtimes to ensure residents receive safe food served at acceptable temperatures.>Food prepared by methods that conserve nutritive value, flavor and appearance.>Food and drink that is palatable, attractive, and at a safe and appetizing temperature. >Food attractiveness - refers to the appearance of the food when served to residents.>Food palatability - refers to the taste and/or flavor of the food.>Proper (safe and appetizing) temperature - means both appetizing to the resident and minimizing the risk for scalding and burns.>Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) Food - means food that requires time/temperature control for safety to limit the growth of pathogens (i.e., bacteria or viral organisms capable of causing a disease or toxin formation). -Food temperatures are checked at the completion of the cooking process and before food is placed on the serving line; if issues are identified, they are corrected, or the food is discarded. >Food temperatures are recorded prior to meal services on the Food Temperature Record Log.>If the food temperatures are unsatisfactory, the problem areas are corrected before serving the food item(s).>Hot foods are held at a minimum of 135 degrees Fahrenheit (F) or per state requirements.>Cold foods are held at or below 41 degrees Fahrenheit per Centers for Medicaid and Medicare Services (CMS) guidelines, unless state requirements are more stringent.>Food should not be placed on the steam table more than 30 minutes before meal services begin. >Maximum length of time food is held on the steam table is four hours. Review of the facility policy titled Food Preparation, revised 4/29/25, included but was not limited to: -Food is prepared by methods that conserve nutritive value, flavor and appearance. The food that is served to the residents is palatable, attractive and served at the appropriate temperature. The food is prepared in a manner in which the nutritive value is not compromised and destroyed because of prolonged food storage, light and air exposure, cooking in large volumes of water, or being held on the steam table. >Food is seasoned appropriately and acceptable to the residents.>Food is prepared in a manner and form that meets each resident's needs.>Food is prepared by methods that conserve nutritive value, flavor and appearance.>Food and drinks are palatable, attractive, and served at a safe and appetizing temperature while minimizing the risk for scalding and burns. Review of the facility policy titled Resident Dining Services, revised 4/29/25, included but was not limited to: -The facility has an established process to ensure food is served in accordance with professional standards for food service safety and in a safe, clean, home environment. Dining services will include food served timely, at proper temperatures, diets served according to physician orders and appropriate assistance provided to meet the individual needs of the residents to create a pleasant experience.>Food that (continued on next page)

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accommodates resident allergies, intolerance, and preferences.>Food distribution - means the processes involved in getting food to the residents. This may include holding foods hot on the steam table or under refrigeration for cold temperature control, dispensing food portions for individual residents, family style and dining room service, or delivering meals to resident's rooms or dining areas, etc. When meals are assembled in the kitchen and then delivered to resident's rooms or dining areas to be distributed, covering food is appropriate, either individually or in a mobile food cart. Review of the facility policy titled Nutrition Assessment, revised 4/29/25, included but was not limited to: -A representative from the Food and Nutrition Services department visits all residents upon admission and routinely thereafter. Food preferences are obtained, and a nutritional history and visual assessment are completed and documented.>The Director of Food and Nutrition Services/Registered Dietician (RD) or designee completes appropriate sections of the electronic nutrition assessment and obtain food and beverages preferences. >During the initial visit, food and beverage preferences, intolerances, food allergies, weight history, percent of food intake, eating patterns and cultural/ethnic/religious food restrictions are discussed. If the resident cannot respond appropriately, a family member or representative for the resident is contacted, if possible. >Nutrition assessment also includes information such as route of intake, any special food formulation, meal and snack patterns, supplements, dislike and preferences. Review of the facility policy titled Resident Satisfaction with Food and Dining, revised 3/26/25, included but was not limited to: -Facility will have a process in place to monitor the quality of food and beverages delivered to the residents. >The Director of Food and Nutrition Services monitors the quality of food served and the level of resident satisfaction in regard to overall dining.>Delivered temperatures, palatability, appearance and accuracy of meals served are monitored by conducting test trays per facility guidelines.>The Director of Food and Nutrition Services will address concerns noted with food, dining, and meal service in a timely manner and record per facility guidelines. On 11/19/25 at 8:18 A.M., during the initial observation on Unit Two, multiple residents reported the following concerns to surveyor #4:-Hot food was always cold. -Hot food was never hot, food was always cold by the time it was served. -Hot food was tasteless and was always cold.-Staff would offer to warm food in the microwave when the hot food was cold. -Some residents mentioned that the hot food would come out of the meal cart lukewarm.-The residents mentioned that it did not matter whether it was breakfast, lunch or supper, the food was always cold. Review of the facility's Mealtime Schedule, last revised 3/18/19, indicated the following: >The lunch tray line started in the kitchen at 11:30 A.M. >The first lunch meal cart for Unit two was scheduled to be delivered to the Unit at 11:37 A.M. >The second lunch meal cart for Unit two was scheduled to be delivered to the Unit at 11:51 A.M. >The first lunch meal cart for Unit three was scheduled to be delivered to the Unit at 11:44 A.M. >The second lunch meal cart for Unit three was scheduled to be delivered to the Unit at 11:58 A.M.>The first lunch meal cart for Unit five was scheduled to be delivered to the Unit at 12:12 P.M. >The second lunch meal cart for Unit five was scheduled to be delivered to the Unit at 12:26 A.M. Review of the facility's Resident Council meeting minutes, dated 8/28/25, indicated: >Food was cold and needed to be microwaved. >Eggs are served hard again. >Seasoning and cooking pork differently.>Some chicken is served hard. Review of the Resident Council Concern Follow-Up, dated 8/28/25, indicated the New Food Service Director (FSD) attended the resident council meeting. The FSD educated staff on proper cooking. The FSD would also take food temperatures before the food left the kitchen. Review of the facility's Resident Council Meeting minutes, dated 10/7/25, indicated: >Training for kitchen staff.>Salty gravy. >Toast should be crispier. >Some residents want eggs over easy. Review of the Resident Council Concern Follow-Up dated 10/7/25, indicated the FSD would be spending more time training with kitchen staff. Review of the facility's Resident Council Meeting minutes, dated 10/30/25 indicated:>Chilli to be added to the alternative menu.>Some residents want over easy eggs. >Some residents reported cold food. Review of the Resident Council Concern Follow-Up dated 10/30/25, indicated the FSD attended the resident council meeting and took notes. The FSD said food temperatures were being monitored and were (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	within acceptable temperature range. During the Resident Group Meeting on 11/20/25 at 10:25 A.M. with eleven residents present primarily from Units Two and Four, the following concern was shared with surveyor #1:>Hot food served at the facility was often served cold. On 11/20/25 at 11:35 A.M., surveyor #4 observed the following in the facility's Main Kitchen: -The lunch food had been prepared and was stored, covered with foil, in metal bins on the steam table. -The Food Temperature Log had been completed as follows for food items on the steam table: >Soup 182*F (Degrees Fahrenheit [F]) >Pork Roast 179*F >Chicken [NAME] 162*F >Green Beans 184*F >Mashed Potato 186*F >Gravy 190*F >Pureed Meat 187*F >Pureed vegetable 190*F >Ground Meat 174*F >Pureed Pork Roast 179*F >Dessert 35*F >Pureed Dessert 35*F >Diet Dessert 35*F >Milk and Thickened Milk 35*F -There was one [NAME] and four Dietary Aides in the Main Kitchen. >The [NAME] was removing food items from the oven and placing the items into metal bins on the steam table. >Two Dietary Aides were moving trays and assembling food carts in the kitchen. >One Dietary Aide was moving cold beverages from inside of the stand-up refrigerator to a cart in the food services area of the Kitchen. >One Dietary Aide was in the dish room, placing pots and pans into the dish machine.During an interview at the time, the [NAME] said the food items for lunch had been cooked, placed on the steam table, and the food temperatures had been recorded. The [NAME] said the tray line would start soon. On 11/20/25, at 11:49 A.M., surveyor #4 observed the following in the facility's Main Kitchen: >The tray line began at 11:49 A.M. (19 minutes after the facility scheduled time) >One Dietary Aide prepared trays with utensils and drinks. >One Dietary Aide called resident diets off to the [NAME] who plated the residents' food. -Meal carts for the units were prepared and dispatched from the kitchen at the following times:>Unit Two: 1st cart - 12:00 P.M. (23 minutes later than facility scheduled time).>Unit Three: 1st cart - 12:12 P.M. (28 minutes later than scheduled).>Unit Two: 2nd cart - 12:25 P.M. (34 minutes later than scheduled).>Unit Four: 1st cart - 12:48 P.M. (33 minutes later than scheduled).>Unit Four: 2nd cart - 1:01 P.M. (41 minutes later than scheduled). >Unit Five: 1st cart - 1:10 P.M. (48 minutes later than scheduled). >Unit Five: 2nd cart - 1:21 P.M. (55 minutes later than scheduled). On 11/20/25 at 11:52 A.M., surveyor #1 observed the following on Unit Two: >1st cart arrived on the unit at 12:01 P.M.>2nd cart arrived on the unit at 12:26 P.M. -Test Tray was completed with surveyor #1 and CNA #2 at 12:38 P.M., after the residents had received their lunch meal trays on Unit Two. The test tray results were as follows:>Mashed potatoes: 125.9*F, tasted like mashed potato, but not flavorful and was lukewarm. >Sweet potato: 112.4*F, flavor was good and tasted like sweet potato, caramel, not warm but not cold.>Green beans: 120.9*F, tasted like green beans. Cool to room temperature. >Chicken: 111.9*F, surveyor #1 was unable to taste the chicken due to dietary restrictions. CNA #2 declined to taste.>Pork Roast: 126.5*F, surveyor #1 was unable to taste the pork due to dietary restrictions. CNA #2 declined to taste.>Dinner Roll: 106.3*F, Room temperature and tasted like a dinner roll.>Cola: 51.6*F, Cold. >Whole milk: 45.3*F, cool, tasted like milk.>Apple juice: 54.1*F, cool to room temperature. >Dessert: 48.9*F, tasted like cheesecake, no whipped topping and cool. On 11/20/25 at 12:12 P.M., surveyor #2 observed the following on Unit Three: >1st meal cart arrived on the unit at 12:12 P.M. >2nd cart arrived on the unit at 12:30 P.M. -Test Tray was completed by surveyor #2 after the residents had received their lunch meal trays on Unit Three. The test tray results were as follows:>Roast Pork: 96.0*F, slightly warmer than room temperature but palatable>Chicken: 96.0*F, slightly warmer than room temperature but palatable>Mashed Potatoes: 100.0*F, slightly warmer than room temperature, did not taste like mashed potatoes.>Carrots: 102.0*F, slightly warmer than room temperature, did not taste like carrots. On 11/20/25 at 1:24 P.M., surveyor #3 observed the following on Unit Five: >1st meal cart was already on the unit.>2nd cart arrived at 1:24 P.M. 11/20/25 at 1:24 P.M., surveyor #3 observed the lunch meal delivery on Unit Five. Tray pass began immediately. All residents meal trays were served from both carts by 1:40 P.M. On 11/20/25 at 1:41 P.M., the test tray was completed by surveyor #3 and findings were as follows:>Pork Roast: 120.0*F, warm, tasty, meat looked like beef, brown in color. Pork Roast tasted good but did not realize it was pork roast, and facility staff were not able to identify what kind of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review, and interview, the facility failed to adhere to infection control practices and standards for two (Unit Two and Unit Five) out of four resident units and for one Resident (#69) out of a total sample of 31 residents, increasing the risk of contamination and spread of infection for residents in the facility.Specifically, the facility failed to:1. conduct testing of residents and staff for COVID-19 infections, every forty-eight hours as required, when Unit Two and Unit Five were experiencing an outbreak of COVID-19 infections.2. for Resident #69, ensure that staff wore the required Personal Protective Equipment (PPE: items such as gown, N95 respirator, eye protection worn by the staff to decrease the spread of infection) while in the Resident's room when the Resident was on Isolation Precautions (interventions including use of PPE to prevent the spread of a communicable diseases).Findings include: 1. Review of Centers for Disease Control and Prevention (CDC) Infection Control Guideline: SARS-CoV-2, revised 6/24/24, retrieved from, https://www.cdc.gov/covid/hcp/infection-control/index.html, indicated: >Nursing Homes -The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. -Perform testing for all residents and health care personnel (HCP) identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. -Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at Day 1 (where day of exposure is day 0), Day 3, and Day 5. Review of the Facility Assessment, last reviewed 7/17/25, indicated but was not limited to: >Services provided: -infection prevention and control -identification and containment of infections -prevention of infections Review of the facility policy for COVID-19 Outbreak Investigation, last reviewed 8/7/25, indicated: -the facility will perform COVID-19 outbreak investigations in accordance with local, state, and federal regulations to mitigate the spread of COVID-19 within the facility. -an outbreak investigation is initiated when a new single case of COVID-19 occurs among residents or staff to determine if others have been exposed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-in an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. -upon identification of a single new case of COVID-19 infection in any associate (staff member) or resident, testing should begin immediately. Review of the facility's Long Term Care Respiratory Surveillance Line listing, undated, for COVID-19 positive residents and staff indicated the following: >the first COVID-19 positive resident tested positive on 11/16/25 on Unit Five >the second COVID-19 positive resident tested positive on 11/18/25 on Unit Two >the third COVID-19 positive resident tested positive on 11/20/25 on the Unit Five >seven more residents and one staff member tested positive for COVID-19 on 11/23/25 on Unit Five >two more staff members tested positive for COVID-19 on 11/24/25 on Unit Five Review of the documentation provided by the facility titled Outbreak Testing, undated, failed to indicate that all residents and staff on Units Two and Five had been tested for COVID-19 until 11/23/25 and 11/24/25, which is greater than 24 to 48 hours after the first residents tested COVID-19 positive on each unit. During an interview on 11/24/25 at 2:12 P.M., the Regional Director of Clinical Services said that all residents and staff on Units Two and Five should have been tested for COVID-19 after the first residents had tested positive and they were not. The Regional Director of Clinical Services also said that the outbreak testing for residents and staff had not started until 11/23/25 and that residents and staff should have been tested after the first positive case had been identified. 2. Review of the facility's policy titled Transmission-Based Precaution and Isolation Procedure, revised 8/19/25, included but was not limited to: The facility will implement and utilize transmission-based precaution to ensure the mitigation of infection spread and to ensure standards of infection prevention and control are followed. -Transmission-based precautions must be used when a resident develops signs and symptoms of a transmissible infection, arrives at a nursing home with symptoms of an infection (pending laboratory confirmation), or has a laboratory confirmed infection and is at risk of transmitting the infection to other residents. <Contact Precautions are intended to prevent transmission of pathogens that are spread by direct (e.g., person to person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves before or upon entering (i.e., before making contact with the resident or the resident's environment) the room or cubicle. Prior to leaving the resident's room or cubicle, the PPE is removed, and hand hygiene is performed. <Droplet Precautions, the use of droplet precautions applies when respiratory droplets contain pathogens which may be spread to another susceptible individual. Respiratory pathogens can enter (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-STOP! ISOLATION IN ADDITION TO STANDARD PRECAUTIONS >STAFF AND PROVIDERS MUST: -clean hands: when entering & exiting -Gown: change between each resident -N95 Respirator (facemask acceptable if N95 not available; fit tested N-95 or higher required for Aerosol Generating Procedure (AGPs) -Eye protection (googles or face shield) -Gloves: change between each resident >KEEP DOOR CLOSED (Unless safety concern or not on physically separate unit) >Use patient dedicated or disposable equipment. -Clean and disinfect shared equipment -wear gloves and a gown for the following high contact resident care activities: >transferring >changing linens On 11/19/25 at 9:37 A.M., the surveyor observed CNA #1 put on (don) a gown, N95 mask, gloves, and entered Resident #69's room and closed the door behind her. During an interview on 11/19/25 at 9:57 A.M., the surveyor and CNA #1 reviewed the sign posted outside Resident #69's room. CNA #1 said Resident #69 was on isolation for COVID-19 infection. CNA #1 said she assisted Resident #69 to the bathroom and provided activities of daily living (ADL) care. CNA #1 said she was supposed to wear a gown, gloves, N95 and eye protection but when she looked inside the bin located outside of the Resident's room there was no eye protection or face shields. CNA #1 also said she should have had an eye protector on prior to caring for the Resident. CNA #1 said it was important that she covered her eyes using a face shield to prevent the transmission of infection to other residents. On 11/20/25 at 7:48 A.M., the surveyor observed from the hallway, Resident #69 was seated in his/her room. The surveyor observed Resident #69 sneeze and used the sleeve of his/her right hand to clean his/her nose. On 11/20/25 at 7:51 A.M. through 7:56 A.M., the surveyor observed from the hallway that CNA #2 was making Resident #69's bed. CNA #2 was observed to not be wearing a gown, N95 mask or eye protection. CNA #2 was observed removing dirty linen from the Resident's bed and placing the linen in a linen cart located outside Resident #69's room. The surveyor did not observe hand hygiene being completed by CNA #2 before exited Resident #69's room. During an interview immediately following (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the observation, the surveyor and CNA #2 reviewed the isolation sign posted outside Resident #69's room, and CNA #2 said she was only making Resident #69's bed and thought a gown, N95 mask and eye protection were not needed. CNA #2 said she was not providing ADL care for Resident #69 and did not think she needed to wear a gown, N95 mask and eye protection. When the surveyor asked CNA #2 why Resident #69 was on isolation precautions, CNA #2 said Resident #69 has COVID-19 infection and it was important that she wear a gown, N95 mask and eye protection to prevent the transmission of infection to other residents. During an interview on 11/20/25 at 9:00 A.M., the DON said Resident #69 was on isolation for Covid-19 infection and all staff entering the Resident's room to provide all forms of close contact care such as ADL care and changing bed linens needed to wear a gown, gloves, N95 respirator and eye protection to prevent the spread of infection to other residents. The DON said she had put out an alert yesterday (11/19/25) reminding all staff about the facility protocol and policy for residents who were on isolation precautions to ensure that the staff abide by the protocol. On 11/20/25 at 9:35 A.M., the surveyor observed CNA #3 enter Resident #69's room without donning eye protection. During an interview on 11/20/25 at 9:47 A.M., CNA #3 said she had assisted Resident #69 to the bathroom and did not wear eye protection when she entered the Resident's room. CNA #3 said she should have used eye protection when entering the room to prevent particles and pathogens from getting into her eyes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement a person-centered care plan relative to meal assistance for one Resident (#125) out of a total sample of 31 residents. Specifically, for Resident #125, the facility failed to implement care plan interventions of cutting up larger meal items to bite sized pieces, getting the Resident out of bed and in the dining room for meals, and staff supervision to eat as identified on Resident #125's person-centered care plan to address nutritional interventions for significant weight loss over a one-month period of time. Findings include:Review of the facility policy titled Nutrition Assessment, revised 4/29/25, included but was not limited to: -A representative from the Food and Nutrition Services department visits all residents upon admission and routinely thereafter. Food preferences are obtained, and a nutritional history and visual assessment are completed and documented. Each resident receives a comprehensive nutrition assessment to determine nutritional needs on admission, annually, and when the resident becomes at risk for compromised nutritional status. <Is offered a therapeutic diet when there is a nutritional problem, and the health provider orders a therapeutic diet. Review of the facility policy titled Nursing Documentation, revised 8/29/25, included but was not limited to: -Nursing Services<Providing care includes, but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident needs. Resident #125 was admitted to the facility in July 2025 with diagnoses including Dysphagia oropharyngeal phase and dysarthria following other nontraumatic intracranial hemorrhage. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #125:-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of 15. -required set up or clean up assistance with eating. Review of Resident #125's November 2025 Physician's orders, indicated:-House Shakes two times a day for supplement. Give 4 ounce (oz). Document % (percent) taken, initiated 11/11/25. Review of Resident #125's Care Card, dated 11/25/25, included but was not limited to:<Supervision by staff to eat. Review of Resident #125's Weight Summary from 7/8/25 through 11/24/25, indicated the following:-7/8/25: 168.1 pounds (lbs.)-8/14/25: 166.7 lbs.-9/4/25: 168.6 lbs.-10/9/25: 165.0 lbs.-11/13/25: 145.3 lbs. (-19.7 in one month)-11/24/25: 148.0 lbs. Review of Resident #125's Nutrition Care Plan, revised 11/19/25, indicated:-at risk for alteration in nutrition related to acute on chronic medical conditions. Resident at risk for malnutrition as evidenced by Mini Nutritional Assessment (MNA) 7/9/25, 11/13 - significant weight loss. <assist to fully set up meal tray, cut larger items to bite size.<out of bed and in dining room for all meals and supervised. Review of Resident #125's Activity of Daily Living (ADL) Care Plan, revised 11/25/25, indicated:-the Resident has an ADL self-care performance deficit related to Activity Intolerance, Fatigue.<eating: the Resident requires intermittent supervision by staff to eat. Encourage out of bed (OOB) and to dining room for meals. Review of Resident #125's Speech Evaluation Summary of Daily Skilled Services dated 11/20/25, indicated:-initiated staff education-care plan update-positioning OOB for meals-assist to set up (s/u) tray On 11/20/25 at 8:25 A.M., the surveyor observed Resident #125 in his/her bedroom seated at the edge of the bed with a bedside table located in front of him/her and a breakfast tray on the bedside table. The surveyor observed the breakfast meal items included two French toast slices with syrup, cold cereal, a cup of milk, orange juice and tea and no staff members were present in the Resident's room. During an interview at the time, Resident #125 said that the meal tasted the same as always. On 11/20/25 at 8:30 A.M., the surveyor observed the Speech Therapist (ST) enter Resident #125's room and let the Resident know she had been asked to evaluate him/her to determine if he/she needed regular textured meals. The ST was observed asking the Resident if she could cut his/her meal into bite size pieces and the Resident agreed. The ST was observed to cut the French toast into bite size pieces, and the Resident began independently eating the bite size pieces. During (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 11/20/25 at 8:44 A.M., the ST said that she had been following Resident #125 for a while and is very familiar with the Resident. The ST said she evaluated Resident #125 to determine if the Resident's diet could be advanced to regular texture meals. The ST also said that upon entering the Resident's room, she observed Resident #125's breakfast tray, and the French toast was not cut into bite size pieces. The ST said she assisted and cut the food into bite size pieces and immediately observed the Resident independently began to eat his/her breakfast meal. The ST further said Resident #125 has weight loss and she would update the care plan to ensure that Resident #125's meal plan matches the Resident presentation. On 11/20/25 at 8:54 A.M., the surveyor observed Resident #125 eat a few bites of the French toast on his/her tray, and the cold cereal and milk were untouched by the Resident. On 11/21/25 at 8:42 A.M., the surveyor observed Resident #125 seated on his/her bed with the head of the bed elevated and a breakfast tray located on the bedside table placed in front of the Resident. The surveyor observed the breakfast meal items were scrambled eggs, muffin, a cup of orange juice, milk, tea, and cold cereal and the breakfast meal was untouched by the Resident. The surveyor further observed that no staff member was present in the Resident's room. On 11/21/25 at 1:17 P.M., through 1:25 P.M., the surveyor observed Resident #125 seated on his/her bed with his/her eyes closed, the lunch meal placed in front of him/her was untouched and no staff members were in the Resident's room. The surveyor observed the lunch meal items included rice, spinach, ground meat, a bowl of chocolate dessert, soup, a cup of water and ginger ale. The surveyor observed two staff members walking by Resident #125's room and picking up meal trays from other resident rooms. During an interview on 11/21/25 at 1:35 P.M., Unit Manager (UM) #1 said Resident #125 had been working with ST and required assistance to set up his/her meals. When the surveyor asked UM #1 what is required for a meal set up for residents, UM #1 said staff were expected to cut the Resident's meal into bite size pieces and set him/her up in a seated position during meals. UM #1 said Resident #125 should be out of bed for meals. UM #1 further said that Resident #125 typically sleeps through his/her meals when served if she/he was in his/her bed. UM #1 said that she met with the team on 11/20/25 and had in-services for 3:00 P.M.- 11:00 P.M. shift to ensure that nursing staff gets Resident #125 out of bed for meals. UM #1 further said that she failed to communicate the information to the other staff members that Resident #125 needed to be out of bed for meals, and it should have been done. During an interview of 11/21/25 3:09 P.M., the Director of Nursing (DON) said the expectation for all the Unit Managers was to identify weight loss and follow up with the necessary interventions, but they had not. The DON further said that Unit Managers were responsible for implementing and educating nursing staff on changes made to Residents #125's care plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and records review, the facility failed to provide necessary care and services to ensure that abilities in activities of daily living (ADL's) did not diminish for two Residents (#12 and #16), out of a total sample of 31 residents.Specifically,For Resident #12, the facility staff failed to assist Resident #12 with applying his/her hearing aid during ADL care when the Resident had documented hearing deficits and required assistance with personal care, resulting in Resident #12 being unable to hear and communicate with others as required. For Resident #16, the facility failed to initiate the Restorative Nursing Program timely for upper extremity strengthening to maintain and increase bilateral upper extremity strength and independence with Activities of Daily Living (ADL's) for the Resident. Findings include: 1.Review of the facility policy titled, Vision and Hearing Devices, dated 9/18/25, included but was not limited to the following: >It is the facility policy to ensure residents receive proper treatment and assistive devices to maintain .hearing abilities. -Assess the residents use of assistive devices to maintain hearing upon admission. -Document use of assistive device in electronic health record and/or on care plan/care directive. Review of the facility policy titled, Activities of Daily Living, dated 9/4/25, included but was not limited to: -The resident will receive assistance as needed to complete ADLs. Resident #12 was admitted to the facility in September 2005 with diagnoses including Age Related Cognitive Decline, Hearing Loss, and Need for Assistance with Personal Care. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #12: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a total possible score of 15. -hearing was adequate with a hearing device in place. Review of Resident #12's Person-Centered Care Plan included but was not limited to: >Focus- Activity of Daily Living (ADL) deficit, updated 9/4/25. >Goal- Resident will maintain highest level of ADL function possible through next review, updated 9/4/25. >Interventions - Resident requires extensive assist of another person to complete personal hygiene, dress, bathe and use the toilet, updated 9/4/25. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #12's Person-Centered Care Plan failed to indicate any intervention or direction to provide a hearing device. On 11/19/25 at 9:23 A.M., the surveyor observed Resident #12 sitting in the dining room, dressed for the day and eating breakfast. When the surveyor introduced herself to Resident #12 and began to ask questions, Resident #12 touched his/her right ear and said, I can't hear you, I need my hearing aid. I wish they would remember to help me with my hearing aid; I need them to hear. At the same time, a staff member left the unit dining room and returned with Resident #12's hearing aid. With the hearing aid in place, Resident #12 said he/she could then hear the surveyor's questions. On 11/20/25 at 7:48 A.M., the surveyor observed Resident #12 seated in the hallway dressed for the day. The surveyor began to speak to Resident #12 and the Resident said that he/she was unable to hear the surveyor and pointed to his/her right ear. During an interview at the time, Certified Nurse Aide (CNA) #5 said that she was the CNA assigned to Resident #12 today and that he/she had been provided with all morning care and dressed for the day. CNA #5 said Resident #12 needed assistance with personal care like washing and dressing, was hard of hearing and sometimes forgetful. CNA #5 said that she was not aware that Resident #12 had a hearing aid and that if Resident #12 needed a hearing aid, the hearing aid should have been listed in the Resident's Care Kardex so that CNA #5 would know to put the hearing aid in place for him/her. CNA #5 then provided Resident #12 with his/her hearing aid and the Resident said, that's better; now I can hear you both. CNA #5 further said if the Resident's hearing aid had been listed on the Resident's Care Kardex she would have known to assist the Resident to wear the hearing aid. During an interview on 11/24/25 at 12:41 P.M., UM #2 said Resident #12 required assistance for personal care, was hard of hearing, required a hearing aid and that the assigned CNA should put the hearing aid in place for the Resident during morning care. At the same time the surveyor and UM #2 reviewed Resident #12's medical record which failed to provide evidence that the Resident's care plan indicated a need for a hearing device. UM #2 said that Resident #12 should have a care plan in place for hearing deficit and a linked Kardex entry for the hearing device needed. UM #2 said that the nursing department was responsible to develop a person-centered care plan and care Kardex when Resident #12 was admitted . UM #2 further said that a hearing loss care plan and care Kardex would be important for Resident #12 so that the facility staff would know what services were needed. UM #2 said that Resident #12 could misinterpret conversations or misunderstand what was being said to him/her when the hearing device was not in place. 2. Review of the facility policy titled Restorative Nursing, effective 5/16/19 and revised 8/20/24, indicated but was not limited to the following: -Policy: To promote the resident's optimum function, a restorative program may be developed by proactively identifying, care planning and monitoring of a resident's assessments and indicators. -Definitions:.Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. -Procedure:.Accurate and thorough assessment of the patient is fundamental in determining the patient's need for restorative services.The trained CNA will document provided techniques per the restorative care plan in the medical record. Resident #16 was admitted to the facility in July 2025, with diagnoses including fracture of the left (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	humerus (upper arm bone), lack of coordination, difficulty in walking, muscle weakness, history of falling, chronic pain, and polyneuropathy. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #16 was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15 points. Review of Resident #16's Restorative Nursing Communication Tool, signed and dated 10/28/25 by an Occupational Therapist Practitioner, indicated but was not limited to the following: -Diagnosis: Falls; Left upper extremity shoulder fracture. -Focus Area: Ambulation; Upper extremity strengthening. -Frequency: Three days per week for 6 weeks. -Goals: 1) To maintain current function by ambulating in room/hallway with rolling walker, standby assist. 2)To maintain and increase bilateral upper extremity strength (especially left upper extremity shoulder flexion) to increase independence with Activities of Daily Living and self-propulsion with the wheelchair. Review of Resident #16's Physical Therapy Treatment Encounter Note, date of service 10/30/25, indicated discussion with the Resident regarding the Resident's discharge from Physical Therapy services, and the Resident agreed with the Restorative Program. Review of Resident #16's Physical Therapy Discharge Summary, signed and dated 10/31/25, indicated the Restorative Program was established for the Resident, and the Resident was on the Restorative Program for ambulation. Review of Resident #16's Restorative Nursing Communication Tool signed and dated on 11/13/25 by the Restorative Nurse, indicated but was not limited to the following: -Problem: Decreased range of motion (ROM) of left upper extremity related to fracture; Decreased mobility and activity tolerance. -Goal: Ambulate 50 feet (ft.) with rolling walker and one assist. Self-propel wheelchair 150 ft. -Six days per week, 15 minutes (min.) per day. -Individual program -Functional: -Upper extremity active ROM: Ball toss, bean bag toss, Wii games, Parachute games, etc. Three repetitions of six per exercise. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lower extremity active ROM: Marching, leg stretches, ankle flexion. Self-propel in the wheelchair 150 ft. -Walking 50 ft with rolling walker and one assist. Review of Resident #16's Limited Physical Mobility Care Plan, initiated on 11/13/25, indicated but was not limited to the following: -Goals: -The Resident would increase level of mobility by ambulating 50 ft. with the rolling walker, one assist. -The Resident would increase strength and endurance of the upper extremities, self-propelling in the wheelchair 150 ft. -Interventions: -Nursing Restorative Program: Active ROM of the lower extremities. (Exercises: Three repetitions of six for 15 min., six days per week for 12 weeks). -Nursing Restorative Program: Active ROM of the upper extremities. (Exercises: Three repetitions of six, self-propel in wheelchair 150 ft. for 15 min., six days per week for 12 weeks.) -Nursing Restorative Program: Walking Program. (Ambulate with rolling walker, one assist, 50 ft. for 15 min. per day for six days weekly for 12 weeks.) -Frequency: As needed. -Target Date: 2/2/26. During an interview on 11/19/25 at 9:16 A.M., Resident #16 said he/she was supposed to be receiving Rehabilitation Services, but had not received services since the Resident had moved to this unit from another unit in the facility. During an interview on 11/21/25 at 3:17 P.M., Unit Manager (UM) #1 said Resident #16 was due to begin the Restorative Nursing Program on 11/13/25, with goals including increased ROM, increased upper extremity strength, and ambulation with assistance. UM #1 said there was no evidence that the Resident had received any Restorative Nursing Program services. During a follow-up interview with Resident #16 on 11/21/25 at 3:40 P.M., the Resident said he/she continued to question when Rehabilitation Services would begin, and said he/she did not feel like he/she had been getting exercise. The Resident said it made him/her feel weak and did not make him/her feel good. During an interview on 11/25/25 at 10:49 A.M., the Director of Nursing (DON) said the expectation was for Resident #16 to have received Restorative Nursing Program services according to his/her plan of care. During an interview on 11/25/25 at 1:13 P.M., Occupational Therapist (OT) #2 said Resident #16 was (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharged from Rehabilitation Services at the end of October 2025. OT #2 said the purpose of the Restorative Nursing Program was for the Resident to maintain his/her functional status at the level at which he/she was discharged from Rehabilitation Services. OT #2 said she performed an evaluation of Resident #16 on 11/22/25 to determine whether the Resident had a decline in function from the time of the Resident's discharge from Rehabilitation Services, due to the lapse in time between the services. OT #2 said this evaluation occurred because a facility staff informed her that the Resident's Restorative Nursing Program services had not yet been initiated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate indwelling urinary catheter (also referred to as Foley catheter) care and services for one Resident (#10) of four applicable residents, out of a total sample of 31 residents.Specifically, for Resident #10, the facility failed to obtain Physician orders for the placement and size of an indwelling urinary catheter when the Resident had a functioning urinary catheter in place. Findings include:Review of the facility policy titled Physician Orders, reviewed 2/27/25, indicated:-A physician, physician assistant (PA) or nurse practitioner (NP) must provide orders for the resident's immediate care and ongoing care of the resident. The facility is obliged to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines.-Medications, diets, therapy and any treatment may not be administered to the resident without a written order from the attending physician. Resident #10 was admitted to the facility in October 2025 with diagnoses including Congestive Heart Failure and dislocation of the right hip. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #10:-had mild cognitive and memory impairment.-had an indwelling urinary catheter in place. On 11/24/25 at 9:24 A.M., the surveyor observed Resident #10 lying in bed with an indwelling urinary catheter drainage bag hanging from the bed frame. The surveyor further observed that the indwelling urinary catheter tubing contained clear yellow urine, and the drainage bag was protected with a privacy cover. On 11/25/25 at 9:39 A.M., the surveyor observed Resident #10 reclining in bed with an indwelling urinary catheter drainage bag in place, that was protected with a privacy cover and hooked to the Resident's bed frame. Review of Resident #10's Physician orders dated 11/25/25, failed to indicate any orders for the placement or size of an indwelling urinary catheter. During an interview on 11/25/25 at 9:49 A.M., the surveyor and Nurse #1 reviewed Resident #10's Physician orders. Nurse #1 said that there was no Physician order in place for the Resident's indwelling urinary catheter and that all medications, treatments and procedures required a physician's order. Nurse #1 also said that she didn't know what size catheter Resident #10 had in place because there was no physician order indicating the size of the catheter that should have been inserted for Resident #10. During an interview on 11/25/25 at 9:58 A.M., the Director of Nurses (DON) said that Resident #10 should have had a Physician's order in place for the indwelling urinary catheter, but the Resident did not have an order in place for the urinary catheter.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review, and interviews, the facility failed to ensure that laboratory services were completed as ordered for one Resident (#88) out of a total sample size of 31 residents. Specifically, for Resident #88, the facility failed to obtain laboratory testing as ordered by the Provider on 10/29/25, placing the Resident at risk for delayed assessment, management, and diagnosis of his/her medical symptoms based on the laboratory testing results. Findings Include:Review of the facility policy titled Laboratory Services dated 9/23/25 included but was not limited to the following: -The facility will ensure that laboratory services meet the needs of a resident, that the results are reported promptly to the ordering provider to address potential concerns and for disease prevention, for resident assessment, diagnosis, and treatment, and the facility is responsible for the quality and timeliness of services whether services are provided by the facility or an outside source. -The facility will be responsible for the timeliness of the laboratory services. Resident #88 was admitted to the facility in May 2025, with diagnoses including Malignant Neoplasm of the Brain, Hypothyroidism and Anemia. Review of Resident #88's Person-Centered Care Plan indicated: >Focus- Resident was at risk for re-hospitalization, with interventions that included to obtain labs as ordered, initiated 5/14/25. >Focus- Resident had increased nutrient needs, with interventions that included to obtain labs/diagnostic work as ordered, initiated 5/14/25. Review of Resident #88's Physician Assistant (PA) Progress Note, dated 10/29/25 indicated: -Will order blood work to assess for iron deficiency anemia and consider supplementation. Review of Resident #88's November 2025 Physician's orders indicated:-Bloodwork: TSH (Thyroid-Stimulating Hormone test), free T3 (Thyroid Hormone Test), T4 (Thyroxine), B12 (measures B12 vitamin blood levels) and folate (Vitamin B9) levels, Ferritin, Serum Iron and TIBC (Total Iron-Binding Capacity), effective 10/29/25. Review of Resident #88's medical record failed to indicate any evidence of laboratory results for the TSH, Free T3, T4, B12, Folate levels, Ferritin, Serum Iron and TIBC laboratory tests ordered on 10/29/25. During an interview on 11/25/25 at 9:14 A.M., Unit Manager (UM) #2 said Resident #88 was ordered for bloodwork of TSH, Free T3, T4, B12, Folate levels, Ferritin, Serum Iron and TIBC on 10/29/25. UM #2 said that the blood work should have been drawn the next day on 10/30/25. UM #2 said the Resident's bloodwork had not been drawn as ordered. UM #2 said Resident #88's labs ordered on 10/29/25 were important because those labs were specific to the Resident's diagnosis and disease monitoring. During an interview on 11/25/25 at 12:24 P.M., Physician Assistant (PA) #1 said she was unaware that the labs ordered on 10/29/25 for Resident #88 had not been obtained. PA #1 said that the labs ordered were important because supplementation would have been based on the results of the ordered labs. During an interview on 11/25/25 at 12:47 P.M., the Regional Director of Clinical Services said that laboratory services had been in the facility for lab services several times since 10/30/25 and therefore Resident #88's labs should have been drawn the next day following the order given for the Resident's bloodwork on 10/29/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225315	A. Building B. Wing	11/25/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that medical records were complete and accurate for two Residents (#7 and #61), out of a total sample of 31 residents.Specifically,For Resident #7, the facility failed to ensure the Physician orders obtained on 11/18/25 for wound care treatment to the Resident's right lower extremity were transcribed into the Resident's medical record, resulting in the potential risk for the Resident's right lower extremity wounds to worsen or become infected without timely and appropriate treatment and monitoring. 2. For Resident #61, the facility failed to ensure that the use of a physical restraint device (Enclosed Walker) was documented as required to determine the Resident's response and provide ongoing evaluation of the use of the physical restraint. Findings include:1.Review of the facility policy titled Physician Orders, effective August 2003 and revised 2/26/24, indicated but was not limited to the following:-Policy: .The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines.-Procedure:-All physician/practitioner orders, including verbal/telephone orders, are recorded on the Physician's Order Form.-The receiving nurse.immediately enters telephone or verbal orders into the clinical software.-Physician orders include the following:.Medications and Treatments. Resident #7 was admitted to the facility in April 2024, with diagnoses including Type 2 Diabetes Mellitus with diabetic neuropathic arthropathy, congestive heart failure (CHF), venous insufficiency, and peripheral vascular disease (PVD). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #7 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15. Review of the active Care Plan Report, reviewed on 10/30/25, indicated Resident #7:-had potential for impaired skin integrity related to edema and history of vascular ulcers (initiated on 2/4/25, revised on 2/4/25)-had a diabetic ulcer of the left plantar foot.(initiated on 7/11/24, revised on 9/10/25)-had a break in skin integrity.Vascular wound to the left lateral shin. (initiated 10/1/25)-had decreased nutrient needs .as evidenced by congestive heart failure.9/12/25 vascular wound to left lateral shin and diabetic ulcer to the plantar foot. (initiated on 4/23/24, revised on 10/16/25) Review of Resident #7's Wound Observation Tool-V4, effective 11/18/25 and signed 11/22/25, indicated the following:-On 11/18/25 the Resident had three unroofed blisters to the right medial shin.-The type of wound was identified as a venous ulcer.-The wound was identified to be partial thickness (extending into the first two layers of skin).-There was minimal, clear drainage present.-Wound measurements: -Right medial shin top: 4.0 centimeters (cm) by (x) 4.0 cm. -Right medical shin center: 2.0 cm x 1.75 cm. -Right medial shin bottom: 5.0 cm x 5.0 cm.-Treatment plan: Unna Boot (compression dressing made with guaze/ and zinc oxide paste, specifically designed to treat and manage venous ulcers) two times per week. Monitor weekly. Review of Resident #7's Weekly Skin Integrity Data Collection -V2 Tool, effective 11/19/25 and signed 11/19/25, indicated an open blister to Resident #7's lateral right lower extremity. Review of Resident #7's November 2025 Physician's orders failed to indicate any evidence of treatment orders for the right lower extremity wounds identified on 11/18/25 and 11/19/25. During an interview on 11/21/25 at 3:51 P.M., Resident #7 said he/she had an open area to the right shin and that an Unna Boot treatment was in place at that time. During an interview on 11/21/25 at 4:31 P.M., Unit Manager (UM) #1 said Resident #7 had a new open blister to the right lower leg, and that Resident #7 had an Unna Boot to the right lower extremity. UM #1 said that there was no evidence of a treatment order in the Resident's medical record for the right lower extremity wound at that time, but that there should have been. During an interview on 11/21/25 at 4:47 P.M., the Director of Nursing (DON) said that she had assessed Resident #7's lower extremities and performed wound care on 11/18/25. The DON said at that time the Resident had three superficial open blisters on the right shin related to edema, with weepy serous (continued on next page)

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	225315	A. Building B. Wing	11/25/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drainage. The DON said she obtained a Physician Order at that time to apply an Unna Boot to the right lower extremity wounds two times a week. The DON said that the Physician Order should have been entered into the Resident's Electronic Health Record at the time but had not been entered. During an interview on 11/25/25 at 10:37 A.M., the DON said that there was a risk to residents when Physician orders were not entered into the Electronic Health Records. The DON said that if a Physician order was not entered for a wound treatment, the nurses would not be able to follow the Physician order and would not know to perform the Physician ordered treatment or any appropriate monitoring of the treatment. 2. Review of the facility policy titled Physical Restraint Use, effective 11/1/17 and revised 9/3/25, indicated but was not limited to the following:-Policy: When a physical restraint is used, the facility must use the least restrictive restraint for the least amount of time and provide ongoing re-evaluation of the need for the physical restraint.-Procedure: A Physician Order is required for use of the specific type of restraint. The order should include the specific type of restraint, the condition and/or medical symptom that warrants restraint use, where and how the restraint is to be applied and used, and the time and frequency the restraint should be released.-Re-evaluation:-The need for the restraint is assessed quarterly and as indicated.-Documentation in clinical notes may include but is not limited to.Date and time of use, reason for use, resident tolerance, and the effectiveness of the restraint in treating the medical symptom(s). Resident #61 was admitted to the facility in March 2025, with diagnoses including metabolic encephalopathy, vascular dementia with anxiety, muscle weakness, and difficulty in walking. Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #61's cognition was severely impaired, as evidenced by a Brief Interview for Mental Status (BIMS) exam score of four out of a possible 15. Review of the active Care Plan Report, reviewed on 9/30/25, indicated Resident #61:-used an enclosed framed wheeled walker to promote safe ambulation and prevent injury related to falls (initiated on 11/10/25, revised on 11/10/25).-restraint use would be evaluated every two hours. The risks/benefits of the restraint would be evaluated/recorded, as well as alternatives to the restraint, the need for ongoing use of the restraint, and the reason for the use of the restraint. (initiated on 11/10/25, revised on 11/10/25).-the enclosed frame wheeled walker was to be utilized after meals, and the Resident checked for proper positioning every one hour and the restraint released every two hours. Restraint use was to be documented and released per facility policy (initiated on 11/10/25, revised on 11/14/25). Review of Resident #61's Physical Restraint Informed Consent Form indicated:-Type of restraining device: Enclosed walker.-Frequency and Duration: Daily for two hours at a time.-Medical reason(s) for restraining device: unsteady gait, poor safety awareness.-The Legal Representative signed consent for use of the restraint on 11/13/25. Review of Resident #61's November 2025 Physician Order Summary Report indicated:-May use enclosed framed wheeled walker in supervised area to promote safe ambulation. Check Resident for proper positioning every one hour and release every two hours. Every one hour as needed to promote safe ambulation. Check for proper positioning every one hour (start date 11/14/25).-May use enclosed framed [NAME] walker in supervised area to promote safe ambulation. Check Resident for proper positioning every one hour and release every two hours. Every two hours as needed to promote safe ambulation. Release every two hours (start date 11/14/25). The surveyor observed Resident #61 utilizing the Enclosed [NAME] on the following days and times:-11/19/25 at 12:08 P.M.-11/20/25 at 8:29 A.M.-11/21/25 at 9:25 A.M.-11/25/25 at 9:42 A.M. Review of Resident #61's November 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to indicate any documentation of the frequency of use of the Enclosed Walker, release of the restraint device, and positioning checks as required. During an interview on 11/25/25 at 9:54 A.M., UM #3 said there was no evidence that nursing staff recorded documentation in the MAR or in the TAR relative to Resident #61's Physician order for restraint use. During an interview on 11/25/25 at 10:52 A.M., the Director of Nursing (DON) said her expectation relative to restraint use for Resident #61 was that nursing staff was documenting the duration of the restraint use, the timing of the release of the restraint, and the timing of the positioning checks for Resident #61.