STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report a potential allegation of abuse for one Resident (#7) out of a total sample of 22 residents. Findings include: Review of the facility policy titled, Investigation of Resident Abuse, Neglect, Mistreatment, Misappropriation of Resident Property Complaints/Allegations, dated as last revised 6/2022, indicated the following: -Any complaint, observation, or suspicion of resident abuse, neglect, mistreatment, exploitation, or misappropriation of resident property is thoroughly investigated and reported to the Massachusetts Department of Public Health, Division of Health Care Quality and any other appropriate agency has deemed appropriate in accordance with state and federal law. -One abuse, neglect, mistreatment, exploitation, or misappropriation of resident property is observed, suspected, or reported to any facility employee, the employee will immediately notify the unit manager/supervisor, and they will immediately report the issue to the Administrator or DON in his/her absence. -The Administrator and Director of Nursing will be notified immediately, upon receipt of an allegation of resident abuse, neglect, mistreatment, or misappropriation of resident property. Review of the facility policy titled, Resident Protection During Abuse Investigation Policy and Procedure, dated revised 6/22, indicated the following: -Any employee who is accused of resident abuse, neglect, mistreatment, exploitation, or misappropriation of resident property will be suspended without pay pending further investigation. The status of his/her employment will be determined by the outcome of the internal investigation by the facility and the external final investigation by the Department of Public Health. -An incident of abuse, neglect, mistreatment, or misappropriation of resident property must be reported to the unit manager/supervisor who will examine the resident and document findings in the medical record and internal abuse reporting form. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The results of the investigation are reported to the administrator within three days and officials in accordance with state law within 5 days of the incident if the alleged violation is verified. -The Administrator or designee will inform the resident and or the resident's representative of the results of the investigation and corrective actions. Resident #7 was admitted to the facility in June 2021 with diagnoses including acute pain due to trauma, osteoporosis with pathological fracture of vertebra(e) (back bone) and muscle weakness. Review of Resident #7's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status score of 15 out of a possible 15 which indicated the Resident is cognitively intact. The MDS also indicated Resident #7 requires supervision for functional tasks. Review of Resident #7's MDS, dated [DATE], indicated the Resident is on scheduled pain medication. Review of a grievance form, dated 10/24/24, indicated the following grievance written by a staff member: Concern: -(The Resident) asked the 11-7 nurse (name) at 12 am if (he/she) could have Tylenol for pain in (his/her) shoulders, hips and back. (The nurse) told (him/her) no because she didn't think (the Resident) was in pain. (The nurse) did not offer anything else to (the Resident) instead of the Tylenol. (The Resident) waited for the 7-3 shift to come in so (he/she) could ask again for something and at this point was in tears due to (his/her) pain. Action taken: -DON (Director of Nursing) spoke to nurse in question who reports that she gave Tylenol to (the Resident). Follow-up: -F/u (follow-up) when resident return from MLOA on 11/12/24. Resident didn't remember receiving dose/situation but reports enough time has passed that (he/she) is indifferent with resolution. Lyrica (pain medication) started upon readmission. At the time of this incident, Resident #7 had the following physician orders: -Pain evaluation: Document verbal/nonverbal signs of pain every shift, initiated on 3/29/23. -Meloxicam oral tablet (a nonsteroidal anti-inflammatory drug (NSAID) used to relieve pain, inflammation, and stiffness) 15 MG (milligrams). Give one tablet at bedtime for supplement, initiated on 5/20/24. -Tylenol tablet 325 MG give two tablets by mouth every 6 hours as needed for fever or pain, initiated 6/16/21. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-May apply generic muscle rub to lower back and bilateral shoulders as needed for pain, initiated on 10/18/24. Review of the Medication Administration Report (MAR) for October 2024 indicated the following: -Resident #7 was assessed for pain on the shift the incident occurred by the nurse mentioned in the grievance, however there was no number scale used/reported for the pain and no nursing note. -Resident #7 did not receive any pain medication from the nurse listed in the grievance throughout the shift. -Resident #7 received Tylenol at 7:45 A.M., when the next nurse started the new shift and at this time the Resident's pain was assessed to be an 8 out of 10 on the pain assessment scale. The Nurse mentioned in the grievance form is no longer an employee of the facility and was unavailable for interview. During an interview 5/19/25 at approximately 8:30 A.M., Resident #7 said he/she did not remember this incident from October. Resident #7 said he/she does have pain at times and when he/she receives pain medication it helps. During an interview on 5/28/25 at 12:33 P.M., the Director of Nursing said if a resident is voicing pain, he would expect the nursing staff to assess the resident's pain level and if the resident has an order in place for an as needed pain medication he would expect the nursing staff to provide that medication. The Director of Nursing said if the pain medication is provided, this would be documented on the MAR and if not on the MAR he could not assume the medication was provided. The Director of Nursing said he does not fully remember the incident in October and reviewed the grievance form and the MAR with the surveyor. After review, the Director of Nursing said he could not recall ever seeing that the medication was never given and did not feel that the nurse adequately managed Resident #7's pain. The Director of Nursing said that if a nurse does not address the pain of a resident and another staff member brings it to the attention of management that is a concern for him. The Director of Nursing said not addressing a resident's pain is considered to be neglect and this would need to be investigated and reported, not just written up as a grievance. The Director of Nursing said this incident was not reported to the state agency secondary to a full investigation not having been completed.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to fully investigate a potential allegation of neglect for one Resident (#7) out of a total sample of 22 residents. Findings include: Review of the facility policy titled, Investigation of Resident Abuse, Neglect, Mistreatment, Misappropriation of Resident Property Complaints/Allegations, dated as last revised 6/2022, indicated the following: -any complaint, observation, or suspicion of resident abuse, neglect, mistreatment, exploitation, or misappropriation of resident property is thoroughly investigated and reported to the Massachusetts Department of Public Health, Division of Health Care Quality and any other appropriate agency has deemed appropriate in accordance with state and federal law. -One abuse, neglect, mistreatment, exploitation, or misappropriation of resident property is observed, suspected, or reported to any facility employee, the employee will immediately notify the unit manager/supervisor, and they will immediately report the issue to the Administrator or DON in his/her absence. -Investigation of the allegation will begin immediately. The Unit Manager supervisor will notify the Director of Nursing and the Administrator immediately upon the allegation if there is abuse or bodily harm and within 24 hours if the allegation does not include abuse and does not result in bodily injury. -The resident is interviewed. The interview is documented, dated, signs nurse, nurse manager, or designee. -The staff member/resident implicated is interviewed. The staff member must document their knowledge version of the incident in written narrative, including the date, their signature, and the telephone number where they can be reached. -If a staff member has been implicated in an incident involving resident abuse, neglect, mistreatment, exploitation, or misappropriation of resident property the associate is suspended immediately pending investigation. Suspension may continue pending further investigation and a determination by the Department of Public health, division of healthcare quality. Interview all witnesses to the incident. Witnesses must document their knowledge, independently or with assistance, in written narrative, including the date, their signature, and a telephone number where they may be contacted. -The Administrator and Director of Nursing will be notified immediately, upon receipt of an allegation of resident abuse, neglect, mistreatment, or misappropriation of resident property. Review of the facility policy titled, Resident Protection During Abuse Investigation Policy and Procedure, dated revised 6/22, indicated the following: (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-any employee who is accused of resident abuse, neglect, mistreatment, exploitation, or misappropriation of resident property will be suspended without pay pending further investigation. The status of his/her employment will be determined by the outcome of the internal investigation by the facility and the external final investigation by the Department of Public Health. -All alleged or suspected abuse, neglect, mistreatment, or misappropriation of resident property will be caused for a thorough investigation conducted immediately by the management of (the facility). -staff must report such allegations without fear of retaliation from the facility or staff. -An incident of abuse, neglect, mistreatment, or misappropriation of resident property must be reported to the unit manager/supervisor who will examine the resident and document findings in the medical record and internal abuse reporting form. -The unit manager/supervisor, and/or the director of nursing will complete the investigation form with a written, dated, signed statement from all persons involved. -The investigation form and written statements from all persons involved will be forwarded to the Administrator immediately. Both the Director of Nursing and the Administrator will conduct an immediate investigation. -If abuse, neglect, mistreatment, or misappropriation is suspected or substantiated, the employee will immediately be sent home in full disciplinary action will be enforced including suspension and or termination of employment pending outcome of the investigation. -The accused employee will not be permitted to enter the facility unless otherwise directed by the administrator, until the investigation has been completed, and final resolution has been given. -The Administrator or designee will inform the resident and or the resident's representative of the results of the investigation and corrective actions. Resident #7 was admitted to the facility in June 2021 with diagnoses including acute pain due to trauma, osteoporosis with pathological fracture of vertebra(e) (back bone) and muscle weakness. Review of Resident #7's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status score of 15 out of a possible 15 which indicated the Resident is cognitively intact. The MDS also indicated Resident #7 requires supervision for functional tasks. Review of Resident #7's MDS dated [DATE] indicated the Resident is on scheduled pain medication. Review of a grievance form dated 10/24/24, indicated the following grievance written by a staff member: Concern: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-(The Resident) asked the 11-7 nurse (name) at 12 am if (he/she) could have Tylenol for pain in (his/her) shoulders, hips and back. (The nurse) told (him/her) no because she didn't think (the Resident) was in pain. (The nurse) did not offer anything else to (the Resident) instead of the Tylenol. (The Resident) waited for the 7-3 shift to come in so (he/she) could ask again for something and at this point was in tears due to (his/her) pain. Action taken: -DON (Director of Nursing) spoke to nurse in question who reports that she gave Tylenol to (the Resident). Follow-up: -F/u (follow-up) when resident return from MLOA on 11/12/24. Resident didn't remember receiving dose/situation but reports enough time has passed that (he/she) is indifferent with resolution. Lyrica (pain medication) started upon readmission. -The attached statement from the nurse in question was dated 11/7/24, 2 weeks after the incident. -The grievance also failed to indicate the staff member who made the grievance was interviewed. Review of Resident #7's medical record indicated the Resident was sent out to the hospital on [DATE], a week after this incident. At the time of this incident, Resident #7 had the following physician orders: -Pain evaluation: Document verbal/nonverbal signs of pain every shift, initiated on 3/29/23. -Meloxicam oral tablet (a nonsteroidal anti-inflammatory drug (NSAID) used to relieve pain, inflammation, and stiffness) 15 MG (milligrams). Give one tablet at bedtime for supplement, initiated on 5/20/24. -Tylenol tablet 325 MG give two tablets by mouth every 6 hours as needed for fever or pain, initiated 6/16/21. -May apply generic muscle rub to lower back and bilateral shoulders as needed for pain, initiated on 10/18/24. Review of the Medication Administration Report (MAR) for October 2024 indicated the following: -Resident #7 was assessed for pain on the shift the incident occurred by the nurse mentioned in the grievance, however there was no number scale used/reported for the pain and no nursing note. -Resident #7 did not receive any pain medication from the nurse listed in the grievance throughout the shift. -Resident #7 received Tylenol at 7:45 A.M., when the next nurse started the new shift and at this time the Resident's pain was assessed to be an 8 out of 10 on the pain assessment scale. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse mentioned in the grievance form is no longer an employee of the facility and was unavailable for interview. During an interview 5/19/25 at approximately 8:30 A.M., Resident #7 said he/she did not remember this incident from October. Resident #7 said he/she does have pain at times and when he/she receives pain medication it helps. During an interview on 5/28/25 at 12:33 P.M., the Director of Nursing said if a resident is voicing pain, he would expect the nursing staff to assess the resident's pain level and if the resident has an order in place for an as needed pain medication he would expect the nursing staff to provide that medication. The Director of Nursing said if the pain medication is provided, this would be documented on the MAR and if not on the MAR he could not assume the medication was provided. The Director of Nursing said he does not fully remember the incident in October and reviewed the grievance form and the MAR with the surveyor. After review, the Director of Nursing said he could not recall ever seeing that the medication was never given and did not feel that the nurse adequately managed Resident #7's pain. The Director of Nursing said that if a nurse does not address the pain of a resident and another staff member brings it to the attention of management that is a concern for him. The Director of Nursing said not addressing a resident's pain is considered to be neglect and this would need to be investigated, not just written up as a grievance. The Director of Nursing said the nurse's interview was not done timely and a full investigation into this neglect was not completed by the facility.

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to ensure that Minimum Data Set (MDS) assessments were transmitted within 14 days after a resident assessment was completed for three Residents (#65, #11 and #6), out of a total sample of 22 residents. Findings include: Review of Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, Version 3.0, indicated assessments must be completed no later than 14 calendar days after the assessment reference date (ARD) and transmitted and encoded within 7 days of assessment completion. 1a. Resident #65 was admitted to the facility in June 2024 with diagnoses that included post traumatic stress disorder and depression. Review of Resident #65's most recent Minimum Data Set (MDS) Assessment, dated 3/21/25, indicated a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 indicating that the Resident has severe cognitive impairment. Further review of the MDS Assessment, with an ARD of 3/21/25, indicated that it was completed on 4/14/25 and submitted on 4/16/25, 26 days after the ARD date. 1b. Resident #11 was admitted to the facility in September 2019 with diagnoses that include anoxic brain damage, aphasia following cerebral infarction and dysphagia (difficulty swallowing). Review of the most recent Minimum Data Set (MDS) Assessment, dated 3/19/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicating that the Resident was cognitively intact. Further review of the MDS Assessment, with an ARD of 3/19/25, indicated that it was completed on 4/14/25 and submitted on 4/16/25, 28 days after the ARD. 1c. Resident #6 was admitted to the facility in November 2011 with diagnoses including dementia and type 2 diabetes mellitus. Review of the most recent MDS Assessment, dated 4/2/25 indicated a BIMS score of 3 out of a possible 15, indicating that the Resident had severe cognitive impairment. Further review of the MDS, with an ARD date of 4/2/25 indicated that it was completed on 4/22/25, 20 days after the ARD. During an interview on 5/29/25 at 8:18 A.M., the MDS Nurse said that MDS assessments should be completed based on the instructions in the RAI manual. She said that quarterly MDS assessments should be submitted within 14 days of the ARD but for Resident's #65, #11 and #6, they were not. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/29/25 at 10:03 A.M., the Director of Nurses said that he would expect that MDS assessments are completed as per the RAI manual, and that MDS assessments are submitted within 14 days of the ARD.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for six Residents (#14, #36, #65, #5, #29 and #62), out of 22 sampled residents. Specifically: 1. For Resident #14 the facility failed to ensure the MDS assessment was accurately coded for skin conditions (section M). 2. For Resident #36 the facility failed to ensure the MDS assessment was accurately coded for the use of restraints. 3. For Residents #65, #5 and #29, the facility failed to ensure the MDS assessment was accurately coded related to pneumococcal vaccination status. 4. For Resident #62, the facility failed to ensure the MDS assessment was accurately coded for a resident who had been discharged . Findings include: 1. Resident #14 was admitted to the facility in December 2024 with diagnoses of necrotizing fasciitis, septicemia and diabetes mellitus. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/7/25, indicated that Resident #14 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating the Resident was cognitively intact. Review of section M of the discharge return anticipated assessment, dated 12/23/25, indicated Resident #14 had four stage four pressure ulcers. Review of section M of the OBRA (Omnibus Budget Reconciliation Act) admission assessment, dated 1/14/25, indicated Resident #14 had a stage four pressure ulcer. Review of section M of the discharge return anticipated assessment, dated 1/23/25, indicated Resident #14 had a stage four pressure ulcer. Review of section M of the OBRA (Omnibus Budget Reconciliation Act) admission assessment, dated 2/7/25, indicated Resident #14 had a stage four pressure ulcer. Review of Resident #14's medical record failed to indicate the Resident ever had pressure ulcers during his/her admission. During an interview on 5/29/25 at 11:15 A.M. the MDS nurse said she was not aware of Resident #14 having pressure ulcers and that she would consider any MDS submissions indicating the Resident had stage four pressure injuries inaccurate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 10:44 A.M. the Director of Nursing (DON) said Resident #14 did not have pressure ulcers during his/her admission and that any MDS assessments indicating the Resident did have pressure ulcers were inaccurate. 2. Resident #36 was admitted to the facility in December 2019 with diagnoses that included Alzheimer's disease, failure to thrive and pain. Review of the most recent MDS, dated [DATE] indicated that the Resident was unable to participate in the Brief Interview for Mental Status and was assessed by staff as having severe cognitive impairment. Further review of the MDS indicated bedrails are used daily as physical restraints. On 5/27/25 at 7:51 A.M., the surveyor observed Resident #26 sleeping in bed. Resident #36's bed did not have any bedrails on it. On 5/28/25 at 7:36 A.M., the surveyor observed Resident #26 sleeping in bed. Resident #36's bed did not have any bedrails on it. Review of Resident #36's active care plan failed to indicate the use of restraints or bedrails. Review of the most recent Siderail/Position Device/Restraint Screen, dated 12/12/24, indicated No side rails used and failed to indicate the use of any restraints. During an interview on 5/29/25 at 7:53 A.M., Unit Manager #1 said that the use of bedrails is determined by the bedrail assessment. She said Resident #36 does not use bedrails. Unit Manager #36 said that bedrails are not used as a restraint in the facility, they are used only for mobility. She said the MDS assessment is inaccurate, to code the use of bedrails daily used as a restraint for Resident #36. During an interview on 5/29/25 at 8:18 A.M., the Minimum Data Set (MDS) Nurse said that bedrails are not used as a restraint in the facility. She also said that part of completing the MDS Assessment would be assessing the resident and observing their environment. She said if the resident does not use bedrails, then it should not be coded on the MDS, she said the MDS was inaccurate, to code the use of bedrails as a restraint for Resident #36. During an interview on 5/29/25 at 10:03 A.M., the Director of Nurses said that bedrails are not used as a restraint on any residents in the facility, only as a mobility enabler to support independence. He said that bedrails coded as a restraint on the MDS would be inaccurate for Resident #36. 3a. Resident #65 was admitted to the facility in June 2024 with diagnoses that included post-traumatic stress disorder and depression. Review of Resident #65's most recent Minimum Data Set (MDS) Assessment, dated 3/21/25, indicated a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 indicating that the Resident has severe cognitive impairment. The MDS assessment further indicated that the Resident was not up to date with the pneumonia vaccine, and that the vaccine had not been offered to the Resident. Review of Resident #65's medical record indicated a consent to receive the pneumococcal vaccine signed and dated 10/7/24, indicating that the vaccine was offered to the Resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 9:36 A.M., the Infection Preventionist said that Resident #65 was offered the pneumonia vaccine but had not received it. During an interview on 5/29/25 at 10:01 A.M., the Director of Nurses said that the MDS documented as not offered would be inaccurate and that if the Resident signed consent to receive the vaccine, then they should have received it. 3b. Resident #5 was admitted to the facility in April 2023 with diagnoses that included anemia and dementia. Review of Resident #5's most recent MDS, dated [DATE], indicated a BIMS score of 5 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated that the Resident's pneumonia vaccine is up to date. Review of Resident #5's medical record indicated a consent to receive the pneumococcal vaccine signed and dated 9/20/24. Further review of the medical record failed to indicate that the Resident received the pneumococcal vaccine. During an interview on 5/29/25 at 9:36 A.M., the Infection Preventionist said that she is aware that Resident #5 has a signed consent to receive the pneumococcal vaccine, but that he/she has not received it yet. The Infection Preventionist said that the facility has been unable to obtain the vaccines from the pharmacy. During an interview on 5/29/25 at 10:01 A.M., the Director of Nurses said that he was not aware that the facility was unable to obtain the pneumococcal vaccine from the pharmacy. He said that if the Resident has consented to the vaccine, then it should be administered. The Director of Nurses further said that the MDS coding of up to date would not be accurate since the Resident had not received the vaccine. 3c. Resident #29 was admitted to the facility in in November 2023 with diagnoses that included parkinsonism and dementia. Review of Resident #29's most recent MDS Assessment, dated 4/30/25, indicated a BIMS score of 6 out of a possible 15, indicating that the Resident had severe cognitive impairment. Further review of the MDS indicated that the Resident's pneumococcal vaccine is up to date. Review of Resident #29's medical record indicated a consent to receive the pneumococcal vaccine signed and dated 9/21/24. Further review of the medical record failed to indicate that the Resident received the pneumococcal vaccine. During an interview on 5/29/25 at 9:36 A.M., the Infection Preventionist said that she is aware that Resident #29 has a signed consent to receive the pneumococcal vaccine, but that he/she has not received it yet. The Infection Preventionist said that the facility has been unable to obtain the vaccines from the pharmacy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 10:01 A.M., the Director of Nurses said that he was not aware that the facility was unable to obtain the pneumococcal vaccine from the pharmacy. He said that if the Resident has consented to the vaccine, then it should be administered. The Director of Nurses further said that coding the vaccine as up to date would be inaccurate since the Resident had not received the vaccine. 4. Resident #62 was admitted to the facility in October 2023 with diagnoses that included dementia, depression and adult failure to thrive. Review of the most recent Minimum Data Set (MDS) Assessment, dated 12/1/24, indicated that the Resident could not participate in the Brief Interview for Mental Status (BIMS) assessment and was assessed by staff to have modified independence for cognitive skills of daily decision making. This assessment indicated that the Resident was able to recall the current season, and the location of their own room. Review of the medical record indicated that Resident #62 was transferred out of the facility to the hospital on [DATE], and Discharge, return anticipated MDS Assessment was completed. Further review of the medical record failed to indicate that the Resident returned to the facility after the hospital transfer on 11/20/24. During an interview on 5/29/25 at 8:18 A.M., the MDS nurse said that the 12/1/24 MDS Assessment for Resident #62 would be inaccurate because he/she did not return to the facility, therefore staff could not perform a staff assessment of cognition. During an interview on 5/29/25 at 10:03 A.M., the Director of Nurses said that Resident #62 did not return to the facility following hospitalization and went to a different facility. He said that a staff assessment of cognition could not be completed if the Resident was not in the facility and the MDS would be inaccurate.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2b. Resident #2 was admitted to the facility in April 2021 with diagnoses including stroke resulting in hemiplegia, diabetes and unspecified protein-calorie malnutrition. Review of Resident #2's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) and the staff assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #2 is dependent for all functional tasks. Review of Resident #2's physician orders indicated the following order initiated on 8/12/24: -Weekly skin check every day shift, every Mon (Monday). Review of Resident #2's potential for skin alteration care plan last revised 3/19/25, indicated the following intervention: - weekly comprehensive skin assessment, observe skin daily during care and report any concerns to MD (physician). Review of the latest Norton Scale Assessment (a tool used to assess the risk of pressure ulcers in patients), dated 3/4/25, indicated Resident #2 had a risk score of 6 which indicated a high risk for pressure ulcer development. The Norton Scale also indicates that for a score of 10 or less weekly skin checks are recommended. Review of Resident #2's weekly skin checks indicated nursing had not completed a skin check for the past four weeks, since 5/1/25. During an interview on 5/29/25 at 8:23 A.M., Unit Manager #1 said all residents are expected to have weekly skin checks and there would not be a reason for anyone to not having a skin check. Unit Manager #1 said there was recently an upgrade to the electronic medical record system and the scheduling for assessments was somehow erased and that may be the reason for skin assessments not being completed as ordered. During an interview on 5/29/25 at 10:09 A.M., the Director of Nurses said that skin checks should be completed weekly, as indicated in the physician's orders. The Director of Nurses further said that the Electronic Medical Record just had an update, and some assessments were not retriggered, but that the physician's orders should have reminded the nurses to complete them. 2c. Resident #21 was admitted to the facility in July 2017 with diagnoses including Alzheimer's Disease, diabetes, heart failure and muscle weakness. Review of Resident #21's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated the Resident is cognitively intact. Review of Resident #21's physician orders indicated the following order initiated on 8/11/24: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Weekly Skin Check, every day shift every Sat (Saturday). Review of Resident #21's potential for skin alteration care plan last revised 5/27/25, indicated the following intervention: -Complete Skin Condition check weekly. Review of the latest Norton Scale Assessment (a tool used to assess the risk of pressure ulcers in patients), dated 5/22/25, indicated the Resident had a risk score of 10 which indicated a high risk for pressure ulcer development. The Norton Scale also indicates that for a score of 10 or less weekly skin checks are recommended. Review of Resident #21's weekly skin checks for the past two months indicated the nursing staff had failed to complete the skin check on 4/28/25, 5/10/25 and 5/17/25. During an interview on 5/29/25 at 8:23 A.M., Unit Manager #1 said all residents are expected to have weekly skin checks and there would not be a reason for anyone to not having a skin check. Unit Manager #1 said there was recently an upgrade to the electronic medical record system and the scheduling for assessments was somehow erased and that may be the reason for skin assessments not being completed as ordered. During an interview on 5/29/25 at 10:09 A.M., the Director of Nurses said that skin checks should be completed weekly, as indicated in the physician's orders. The Director of Nurses further said that the Electronic Medical Record just had an update, and some assessments were not retriggered, but that the physician's orders should have reminded the nurses to complete them. 2d. Resident #28 was admitted to the facility in April 2025 with diagnoses including dementia and delusion orders. Review of Resident #28's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #28 requires maximal assistance from staff for all functional tasks. Review of Resident #28's physician orders failed to indicate and order for weekly skin checks. Review of the latest Norton Scale Assessment (a tool used to assess the risk of pressure ulcers in patients), dated 4/28/25, indicated the Resident had a risk score of 11 which indicated a moderate risk for pressure ulcer development. The Norton Scale also indicates that for a score of 11-15 weekly skin checks are recommended. Review of Resident #28's weekly skin checks for the past two months indicated the nursing staff had failed to complete the skin check on 5/8/25 and 5/22/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 8:23 A.M., Unit Manager #1 said all residents should have orders for weekly skin checks and are expected to have weekly skin checks and there would not be a reason for anyone not having a skin check. Unit Manager #1 said there was recently an upgrade to the electronic medical record system and that could be the reason why Resident #28's skin check order was deleted. During an interview on 5/29/25 at 10:09 A.M., the Director of Nursing said every resident should have weekly skin checks. 3. Resident #28 was admitted to the facility in April 2025 with diagnoses including dementia and delusion orders. Review of Resident #28's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #28 requires maximal assistance from staff for all functional tasks. Review of Resident #28's physician orders indicated the following order: -Seroquel Oral Tablet (an antipsychotic medication) 25 MG (milligrams). Give 1 tablet by mouth two times a day for Dementia with delusions, agitation, initiated on 4/22/25. Review of the pharmacy recommendation dated 5/8/25 indicated: -Please consider performing the AIMS testing now and every six months to monitor for tardive dyskinesia. Review of Resident #28's medical record failed to indicate an AIMS assessment was completed prior to the initiation of Seroquel, after the pharmacy recommendation or subsequently after. During an interview on 5/28/25 at 2:37 P.M., Unit Manager #1 said the AIMS assessment is typically done by the psychiatric nurse practitioner. Review of Resident #28's behavioral health notes from the psychiatric nurse practitioner failed to indicate an AIMS assessment had been completed. During a follow up interview on 5/29/25 at 8:23 A.M., Unit Manager #1 said she clarified the timing of the AIMS assessment with the Director of Nursing, and he said the AIMS assessment should be completed upon admission if a resident is admitted on an antipsychotic or upon starting the antipsychotic. Unit Manager #1 said the nursing staff missed this assessment for Resident #28. During an interview on 5/28/25 at 10:06 A.M., the Director of Nursing said nursing should complete an AIMS assessment upon admission or upon the initiation of an antipsychotic medication to get a baseline status of the resident. Based on observations, interviews, and record review, the facility to ensure that services provided met professional standards for five Residents (#11, #36, #2, #21, #28), out of 22 total sampled residents. Specifically, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. For Resident #11, the facility failed ensure that the air mattress was functioning. 2. For Residents #36, #2, #21, #28 the facility failed to ensure weekly skin checks were completed as indicated in the physician's orders. 3. For Resident #28, the facility failed to complete a baseline AIMS (Abnormal Involuntary Movement Scale) assessment upon admission and at the initiation of an antipsychotic medication. Findings include: 1. Resident #11 was admitted to the facility in September 2019 with diagnoses that include anoxic brain damage, aphasia following cerebral infarction and dysphagia (difficulty swallowing). Review of the most recent Minimum Data Set (MDS) Assessment, dated 3/19/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicating that the resident is cognitively intact. Further review of the MDS indicated that the Resident requires supervision or touching assistance with meals and is dependent on staff for Activities of Daily Living. The MDS also indicated that the Resident is at risk for developing pressure ulcers, but did not currently have any pressure ulcers. On 5/27/25 at 7:52 A.M., the surveyor observed Resident #11 sleeping in bed. Resident #11 had an air mattress on his/her bed. The air mattress was deflated and was not functioning. On 5/27/25 at 8:06 A.M., the surveyor observed Resident #11 eating breakfast in his/her bed. The air mattress on the bed was deflated and was not functioning. On 5/27/25 at 8:20 A.M., staff removed Resident #11's breakfast tray and left the room. The air mattress on the bed was deflated and was not functioning. Resident #11 said that he/she was not comfortable in the bed and had pain. On 5/27/25 at 9:02 A.M., two staff members were providing care to Resident #11. The air mattress on the bed remained deflated and not functioning during this time. On 5/28/25 at 7:37 A.M., Resident #11 was awake in bed. The air mattress was set to max inflation (>400 pounds). There was a handwritten note on the air mattress pump that said 5/28 7 am air mattress deflated, on max to refill. Resident #11 said, please help me, I am so uncomfortable. Review of most recent Norton Assessment (An assessment to determine a resident's risk for skin breakdown), dated 3/27/25, indicated a score of 8, which indicates high risk for skin breakdown. Review of Resident #11's active physician orders failed to indicate an order for an air mattress. Review of Resident #11's active care plan failed to indicate the use of an air mattress or air mattress settings. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/28/25 at 12:16 P.M., Nurse #6 said that she worked with Resident #11 on 5/27/25. She said that after the Certified Nurse's Aides provided care to Resident #11, they informed her that the air mattress was not functioning. Nurse #6 said this has been happening as the plug easily gets pulled out of the wall. Nurse #6 said that she would have expected the staff who provided and cleared Resident #11's breakfast the previous day to notice the air mattress was deflated and not functioning. Nurse #6 reviewed Resident #11's medical record and said that Resident #11 did not have a physician's order for the air mattress, but he/she should have. Nurse #6 said that an order would instruct nursing to check the settings and function of the mattress every shift. Nurse #6 said that Resident #11 did not have any open skin areas, but did have a fragile area to his/her buttock which is why he/she utilizes an air mattress. During an interview on 5/28/25 at 12:20 P.M., Unit Manger #1 said that she found Resident #11's air mattress unplugged and not functioning this morning, and she had placed the note on the pump. She said that staff should have noticed the mattress was not functioning. Unit Manager #1 said any resident who utilizes an air mattress should have a physician's order indicating the appropriate setting, and to check the function of the mattress. She said if Resident #11 had an order, it would have triggered staff to check the function. She said a non-functioning air mattress places the resident at risk for skin breakdown. During an interview on 5/29/25 at 10:14 A.M., The Director of Nurses said that all residents on an air mattress should have a physician's order, otherwise the nurses would not know the settings to maintain. He said the order would also call for checking the function every shift. The Director of Nurses said that he would expect any staff who enter the room to notice if the air mattress is not functioning. The Director of Nurses further said that a non-functioning air mattress places the resident at risk for skin breakdown. 2a. Review of the facility policy, titled Skin Care Program and Protocols, revised in June 2022, indicated, but was not limited to, the following: - Designated nurses are to provide direct surveillance of the skin problems weekly and they must monitor the ordered treatments and preventative measures are being carried out appropriately. Resident #36 was admitted to the facility in December 2019 with diagnoses that included Alzheimer's disease, failure to thrive and pain. Review of Resident #36's most recent Minimum Data Set (MDS) Assessment, dated 3/13/25, indicated that the Resident was not able to participate in the Brief Interview for Mental Status Exam, and was assessed by staff as having severe cognitive impairment. Review of Resident #36's active skin care plan, dated as revised 7/4/23, indicated, The Resident is at risk for skin breakdown due to decreased mobility, refusal of care, B&B (bowel and bladder) incontinence and protein calorie malnutrition Norton Score less than 15, with interventions that included comprehensive skin assessment weekly. Review of physician's orders indicated the following: - Weekly Skin Check every day shift every Wed, dated 8/16/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the assessments tab in the Electronic Medical Record indicated that the most recently completed skin check was completed on 5/1/25, and skin checks were missed, as ordered on 5/7/25, 5/14/25, 5/21/25 and 5/28/25. Further review of the assessment tab indicated a skin assessment that had been opened on 5/14/25 but left blank and was not signed as completed. Review of the most recent Norton Assessment (an assessment to determine a resident's risk for skin breakdown), dated 12/12/24 indicated a score of 7, indicating high risk for skin breakdown Review of May 2025 Treatment Administration Record (TAR) indicated that the weekly skin check was completed as ordered on 5/7, 5/14 and 5/21 and 5/28. Review of Progress notes from 5/1- 5/28 failed to indicate refusal of skin checks or that any skin checks were completed. During an interview on 5/29/25 at 7:56 A.M., Unit Manager #1 said that there should be a physician's order for weekly skin checks. She said that if a nurse is signing them off as completed on the TAR, then they should be completing the assessment. The surveyor and Unit Manager #1 reviewed Resident # 36's medical record and she said that skin checks were not completed on 5/7, 5/14, 5/21 or 5/28 as indicated in physician's orders. During an interview on 5/29/25 at 10:09 A.M., the Director of Nurses said that skin checks should be completed weekly, as indicated in the physician's orders. The Director of Nurses further said that the Electronic Medical Record just had an update, and some assessments were not retriggered, but that the physician's orders should have reminded the nurses to complete them.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and interview the facility failed to ensure assistance with Activities of Daily Living was provided for two Residents (#27 and #11) out of a total sample of 22 residents. Specifically: 1. For Resident #27 the facility failed to ensure supervision and cueing with meals was provided. 2. For Resident #11 the facility failed to ensure supervision with meals was provided. Findings include: The facility policy titled Activities of Daily Living (ADL) Support, dated 6/2022, indicated the following: 1. Residents will perform self-care with ADLs at the level on the CNA care plan of care card or assigned tasks. If the resident shows a change in the ADL function the nurse will be notified. 5. Assure adequate intake at each meal by encouraging, cueing, prompting and or feeding as needed. Notify nurses of changes in resident's normal intake. 1. Resident #27 was admitted to the facility in September 2018 and has diagnoses that include dementia without behavioral disturbance. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/26/25, indicated that Resident #27 was unable to participate in the Brief Interview for Mental Status exam and was assessed by staff to have severely impaired cognition. The MDS further indicated that Resident #27 required supervision or touching assistance for eating. Review of Resident #27's current Activities of Daily Living care plan, last updated 10/23/23, included the following intervention: -Eating: Continual Supervision ratio 1 no > [greater than] than 8 for verbal cues and encouragement to eat and drink. Review of Resident #27's current Nutrition care plan, last updated 3/24/25, indicated the Resident has chronic Mod (moderate) protein-cal (calorie) malnutrition (dx <diagnosis> in place) due to BMI (body mass index) < [less than]18, Inadequate oral intake at times, loss of muscle mass. Chewing/swallowing difficulty r/t (related to) dementia/dysphagia AEB (as evidenced by) diagnosis, diet order, SLP (speech and language pathologist). Review of Resident #27's current Kardex (care card with resident specific instructions to guide the nurses and Certified Nursing Assistants (CNAs) with care, indicated: -Eating: Continual Supervision ratio 1 no > than 8 for verbal cues and encouragement to eat and drink. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Nutrition Assessment, dated 3/24/25, indicated that Resident #27 is frail and underweight with little body mass. According to the assessment Resident #27's appetite: fair, best when presented one item at a time. On 5/27/25 at 8:04 A.M., Resident #27 was observed in bed, alone in his/her room with breakfast on the tray table directly in front of him/her. Resident #27 was attempting to self-feed, but the food was dropping on his/her chest. Resident #27 was laughing to him/herself and said, I keep dropping it and can't find it. The surveyor continued to make the following observation: -At 8:14 A.M., Resident #27 remained alone trying to clean the food off his/her chest. There were no staff present to supervise or to provide assistance or cues. On 5/28/25 at 7:56 A.M., Resident #27 was observed in bed, alone in his/her room with the curtain pulled around the bed, with breakfast on the tray table directly in front of him/her. The surveyor continued to make the following observations: -At 8:04 A.M., Resident #27 was observed scooping oatmeal out of the bowl, and placing it on his/her tray, saying aloud here you go, eat this, here you go repeatedly. -At 8:07 A.M., Resident #27 was observed as he/she attempted to take a sip of juice. Resident #27 accidentally spilled the juice on his/her chest., appeared to be distressed by the spill and said oh no as he/she grimaced and pulled the gown off his/her chest. -At 8:09 A.M., Resident #27 resumed scooping the oatmeal onto the tray and repeatedly said yes, that's good, eat that, mmm, good. -At 8:14 A.M., Resident #27 said aloud yes I am all wet now as he/she used his/her hands to pick up the food and feed him/herself the food that had fallen into his/her lap. -By 8:21 A.M., 25 minutes since the initial observation, Resident #27 remained alone, and no staff had supervised, cued or encouraged the Resident with the meal and most of the oatmeal was in two piles on the tray and minced eggs and meat in his/her lap. During an interview on 5/28/25 at 10:16 A.M., Certified Nursing Assistant (CNA) #1 said Resident #27 requires total assistance with ADL care and cannot do anything for him/herself because his/her dementia has worsened. CNA #1 said that Resident #27 will feed him/herself but needs a lot of cues and encouragement because the Resident thinks that he/she needs to feed his/her babies. CNA #1 said that Resident #27 is supposed to eat in the dining room so that staff can provide the supervision and cueing and that CNAs have access to the care card daily. During an interview on 5/28/25 at 10:23 A.M., Nurse #3 said Resident #27 requires supervision and cueing with his/her meals and should not be left alone in his/her room during meals. During an interview on 5/28/25 at 12:33 P.M., the Director of Nursing said that if a resident's care plan indicates that they require continual supervision and cues with eating then he would expect that staff be in the room to supervise the resident and provide cues as needed or that the resident eat in the main dining room where staff are able to provide the supervision and cueing as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #11 was admitted to the facility in September 2019 with diagnoses that include anoxic brain damage, aphasia following cerebral infarction and dysphagia (difficulty swallowing). Review of the most recent Minimum Data Set (MDS) Assessment, dated 3/19/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicating that the resident is cognitively intact. Further review of the MDS indicated that the Resident requires supervision or touching assistance with meals and is dependent on staff for Activities of Daily Living. On 5/27/25 at 8:06 A.M., the surveyor observed Resident #11 in bed eating breakfast. There were no staff in the Resident's room providing supervision. On 5/27/25 at 8:30 A.M., the surveyor observed Resident #11 in bed eating breakfast. Resident #11 had food on his/her face and large amounts of food spilled on his/her chest and abdomen. Resident #11 said that he/she was not in a comfortable position to eat. Resident #11 was observed coughing on fluids. On 5/28/25 at 7:53 A.M., the surveyor observed a staff member set up Resident #11's breakfast tray and leave the room. Resident #11 was in bed at an approximate 45- degree angle. Resident #11 was observed to be coughing when drinking liquids. The surveyor then observed Resident #11 spill oatmeal and hot chocolate on him/herself. The surveyor then alerted the Unit Manager of the food spill. Review of Resident #11's physician's orders indicated the following -Regular diet, Puree (level 4) texture, Nectar (Mildly Thick 2) consistency. May have soft finger foods and pasta cut up. Cold cereal with breakfast. Crustless Grilled cheese sandwich on the side with lunch and dinner. for nutrition, dated 2/19/25. (sic) Review of Resident #11's active activities of daily living care plan, dated as revised on 7/27/23, indicated the following intervention: -Eating- continual supervision of 1/ assist as needed. Assist with hot liquids. (sic) Review of Resident #11's active nutrition care plan, dated as revised on 3/17/25 indicated the following interventions: -Monitor s/sx (signs and symptoms) dysphagia (coughing, choking, runny nose). (sic) -Monitor/document/report prn (as needed) any s/sx of dysphagia. (sic) Review of Resident #11's Kardex (a document that tells staff how much assistance a resident requires) indicated: -Eating - continual supervision of 1/ assist as needed. (sic) Review of Resident #11's most recent Nutrition Assessment, dated 3/17/25, indicated the following: -Nutritional Diagnosis or Risk: Chewing difficulty r/t (related to) dysphagia AEB (as exhibited by) diet order, dx (diagnosis) of dysphagia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Self feeding difficulty at times r/t dementia AEB staff report. During an interview and observation on 5/28/25 at 8:01 A.M., Unit Manager #1 observed Resident #11 alone in his/her room with food and liquids spilled on him/herself. The surveyor and Unit Manager #1 reviewed the Resident's care plan and Unit Manager #1 said that Resident #11 needs supervision with his/her meals, and they were not getting it. Unit Manager #1 also said that the Resident was not in a high enough position to eat safely. During a follow up interview on 5/28/25 at 8:28 A.M., Unit Manager #1 said that the Certified Nurses Aide (CNA) who dropped off Resident #11's meal was not aware of the assistance needed. Unit Manager #1 said that the CNAs can access the resident Kardex through their charting system and it triggers from the care plan. During an interview on 5/29/25 at 10:11 A.M., The Director of Nurses said that he would expect that if Resident #11 was eating in his/her room, someone should be in the room supervising the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review and interviews, the facility failed to review and implement wound physician treatment recommendations for one Resident (#14) out of a total sample of 22 residents. Findings include: Review of the facility policy, titled Skin Care Program and Protocols, revised in June 2022, indicated, but was not limited to, the following: - Designated nurses are to provide direct surveillance of the skin problems weekly and they must monitor the ordered treatments, and preventative measures are being carried out appropriately. - All treatments require an MD (medical doctor) order, as well as appropriate documentation. - Treatment orders must include the type of dressing to be used, frequency of the dressing change (the dressing should be changed with the least frequency as possible). Resident #14 was admitted to the facility in December 2024 with diagnoses of necrotizing fasciitis, septicemia and diabetes mellitus. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/7/25, indicated that Resident #14 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating the Resident was cognitively intact. Review of Resident #14's care plans indicated the resident had potential/actual impairment to skin with the following interventions: - Follow the facility protocols for treatment of injury, initiated on 12/19/24. - Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, initiated on 12/19/24. Review of Resident #14's most recent wound evaluation and management summary, signed by the wound physician on 5/13/25, indicated the Resident had a post-surgical wound of the right buttock with the following treatment recommendation: -Gauze island with border apply twice daily for 23 days; hypochlorous acid solution (vashe) apply twice daily for 23 days. Further review of the wound evaluation and management summary indicated Resident #14 had an abdominal skin tear with the following treatment recommendation: -Gauze sponge non-sterile apply once daily for 23 days; change every four hours and as needed if saturated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's wound evaluation and management summaries, dated 12/10/24, 12/17/24, 12/23/24, 1/14/25, 1/21/25, 2/4/25, 2/11/25, 2/18/25, 3/4/25, 3/13/25, 3/20/25, 3/25/25, and 4/1/25, indicated the Resident had a post-surgical wound of the right buttock with the following treatment recommendation: -Foam with border (silicone-sacrum) apply twice daily; hypochlorous acid solution (vashe) apply twice daily. Review of Resident #14's wound evaluation and management summaries, dated 4/8/25, 4/15/25, 4/22/25, 4/30/25, and 5/6/25 indicated the Resident had a post-surgical wound of the right buttock with the following treatment recommendation: -Hypochlorous acid solution (vashe) apply twice daily; Gauze Island with border apply twice daily. Review of Resident #14's wound evaluation and management summaries, dated 4/8/25, 4/15/25, 4/22/25, and 4/30/25 indicated the Resident had an abdominal skin tear with the following treatment recommendation: -Gauze sponge non-sterile apply once daily; Bacitracin (a topical antibiotic ointment) apply once daily. Review of Resident #14's wound evaluation and management summary, dated 5/6/25 indicated the Resident had an abdominal skin tear with the following treatment recommendation: -Gauze sponge non-sterile apply once daily. Review of Resident #14's outpatient wound appointment summary, dated 4/28/25, indicated the following recommendation: -Lightly pack lower quadrant abdominal wound with dry gauze and cleanse twice daily. Review of Resident #14's physician orders indicated the following order: - Right buttock wound wet to dry dressing twice a day, and also if soaked. Place saline-soaked gauze over the wound followed by dry abdominal pad or dry gauze over the wet dressing. Then secure with large adhesive boarder gauze to keep intact, initiated on 12/17/24. - Wound care, apply dry gauze to right open area abdominal fold. Change twice daily, initiated on 5/28/25. Further review of the Residents physician orders failed to indicate that the facility ever implemented the buttocks wound treatment recommendations the wound physician made on 12/10/14, 12/17/24, 12/23/24, 1/14/25, 1/21/25, 2/4/25, 2/11/25, 2/18/25, 3/4/25, 3/13/25, 3/20/25, 3/25/25, 4/1/25, 4/8/25, 4/15/25, 4/22/25, 4/30/25, 5/6/25 and 5/13/25 or that the facility ever initiated bacitracin for the abdominal wound as recommended on 4/8/25, 4/15/25, 4/22/25 and 4/30/25. Review of the physician's orders indicated that the wound physician's recommendation to apply gauze to the abdominal wound was initiated 50 days after it was initially recommended by the wound physician and after the surveyor brought the concern to the attention of the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's physician orders, medication administrations records and treatment administration records failed to indicate that there was physician-ordered treatment in place for the Resident's abdominal wound, which was originally identified on 4/8/25, prior to 5/28/25. During an interview on 5/28/25 at 8:31 A.M., Nurse #3 said the wound physician rounds on residents once a week and that one of the facility nurses accompanied him. Nurse #3 said the wound physician would verbally communicate recommendations and document them in his notes which the unit manager would then review. Nurse #3 said he would expect wound physician recommendations to be implemented right away and would expect a physician order for a wound treatment to be in place for any wounds. Nurse #3 said Resident #14 had a wound on his/her buttocks and that the treatment for the buttocks wound should include vashe. During an interview and observation on 5/28/25 at 8:42 A.M., Unit Manager #1 said the wound physician came to the facility once a week and that she would typically accompany him during his rounds but that the wound physician did not round last week. Unit Manager #1 said that when the wound physician made a recommendation for an order for a treatment, it would be implemented on the same day the recommendation was made. The Unit Manager then checked Resident #14's abdominal fold and said there was an open area that should be packed with gauze and that she thought there was already an order for gauze; there was no gauze or wound treatment present on or around the wound at the time of the observation. During a follow-up interview on 5/29/25 at 11:51 A.M. Unit Manager #1 said pretty much everyone knew that the treatment for Resident #14's buttocks wound was vashe but that the current order needed to be updated to reflect the wound physician's recommendations as the Resident should be receiving vashe. Unit Manager #1 said some nurses could have been using normal saline for the treatment of the Resident's buttocks wound as that's what the order currently indicated to use. During an interview on 5/28/25 at 10:43 A.M. Nurse Practitioner (NP) #1 said the wound physician came to the facility every Tuesday morning and that Unit Manager #1 accompanied him. NP #1 said she would document if she disagreed with the wound physician recommendations but that she had not disagreed with any wound physician recommendations for Resident #14. NP #1 said she was not aware of the wound physician's recent recommendations for Resident #14's wounds. During interviews on 5/28/25 at 2:14 P.M. and 5/29/25 at 9:24 A.M., the Medical Director said she would expect the wound physician's recommendations to be implemented right away and that she had not disagreed with any wound physician recommendations for Resident #14. The Medical Director said she was under the impression that the Resident was receiving vashe and that the nurses had told her the bacitracin was in place for the Resident's abdominal wound. The Medical Director said she would expect the treatments to be in place for Resident #14's wounds. The Medical Director said that she would have expected the wound treatment order for Resident #14's buttocks wound to be changed from normal saline to vashe as recommended by the wound physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/28/25 at 10:02 A.M. the Wound Physician said he came to the facility once a week and that Unit Manager #1 would usually accompany him during his rounds. The Wound Physician said he would verbally relay recommendations and document the recommendations in his notes which were made available to the facility on the same day. He said he would expect an order for a wound treatment but that he didn't know if there was an order for Resident #14's wound treatments. The Wound Physician said he would assume there was an order for vashe and that he would have expected the recommendations for bacitracin and gauze for the abdominal wound to have been implemented. The Wound Physician said he was not aware that his recommendations were not implemented. During an interview on 5/28/25 at 2:54 P.M. the Director of Nursing said he would expect the wound physician's recommendations to be implemented as soon as possible and that he would expect a physician's order to be in place for any wound treatments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review, the facility failed to implement safe smoking for one Resident (#70), out of two sampled residents who smoked cigarettes. Specifically for Resident #70, the facility failed to ensure a smoking assessment was completed and a plan of care was developed prior to the Resident smoking at the facility. Findings include: Review of the facility policy titled Smoking, dated 11/22, indicated: -Smoking assessments are performed with residents who state their desire to smoke in order to monitor their ability to perform safe smoking function. This assessment is a rudimentary review of the resident's abilities both cognitive and physical functioning. These assessments are conducted on admission/readmission, with a change in the resident's status, and at least quarterly thereafter. The interdisciplinary team will review all completed smoking assessments to determine the safest smoking plan with the resident. Selected safety precautions will be reviewed with the resident and/or the resident's agent. Resident #70 was admitted to the facility in April 2025 with diagnoses that included opioid abuse, psychoactive substance abuse, post-traumatic stress disorder, and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/9/25, indicated Resident #70 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of Resident #70's medical record indicated on 4/3/25 Resident #70 signed the facility's smoking policy, however the record failed to indicate that a smoking assessment was completed or that a smoking care plan was developed. Review of Resident #70's at risk progress note, dated 5/1/25, indicated attends smoking groups. Review of Resident #70's respiratory therapist note, dated 5/25/25, indicated smoking cessation counseling done with patient. On 5/28/25 at 10:15 A.M., the surveyor observed Resident #70 outside the facility smoking a cigarette while staff were present. During an interview on 5/29/25 at 9:51 A.M., the Director of Nursing (DON) said he would expect a smoking assessment and care plan to be completed upon admission for a smoking resident. The DON said it is important to complete the assessment and the care plan to keep the resident safe.

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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** 2. Resident #2 was admitted to the facility in April 2021 with diagnoses including stroke resulting in hemiplegia, diabetes and unspecified protein-calorie malnutrition. Review of Resident #2's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) and the staff assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #2 is dependent on enteral feeding for nutrition. Review of Resident #2's physician orders indicated the following orders: -Glucerna with carbsteady (enteral feeding formula) 1.2 cal at 45ml/hr (milliliter per hour) via PEG tube (feeding tube) around the clock, every shift related to dysphagia. -Flush PEG tube with 200ml H20 (water) every 6 hours ATC (around the clock) for hydration. Programmed on pump for automatic flush, every shift related to dysphagia. On 5/27/25 at 7:52 A.M., Resident #2 was observed lying in bed. Next to the Resident was a pole consisting of a tube feeding pump, tube feeding formula in a gravity bag and a water bag. Both the formula and water bag were labeled 5/24/45, three days prior. On the Resident's bedside table was a half full bottle of formula not dated and warm to the touch. During an interview on 5/27/25 at 8:25 A.M., Nurse #3 observed Resident #2's feeding tube formula and water flush bags and the half full formula bottle. Nurse #3 said the open bottle of formula should have been dated and refrigerated after opening. Nurse #3 said the formula should not have been left on the Resident's side table due to the risk of it being used without knowing when it was open and not having been refrigerated. Nurse #3 also said all enteral feeding bags and water flush bags should be changed every 24 hours and these bags had not been changed for three days. On 5/28/25 at 12:17 P.M., Resident #2 was observed lying in bed and receiving enteral feeding. The formula bag and water flush bags were dated 5/27/25 at the time of 10:00 A.M. During an interview on 5/28/25 at 12:18 P.M., Unit Manager #1 and the surveyor observed Resident #2's enteral feeding formula together. The Unit Manager observed the bag dated for over 24 hours ago and said it should have been changed out. Unit Manager #1 said the formula bag and flush bag should be changed every 24 hours. Unit Manager #1 also said all open formula bottles need to be dated and refrigerated after opening. During an interview on 5/28/25 at 12:34 P.M., the Director of Nursing said the formula bag and flush bag should be changed every 24 hours. The Director of Nursing also said all open formula bottles need to be dated and refrigerated after opening. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review and interviews, the facility failed to ensure that services were provided in accordance with professional standards for two Residents (#17 and #2) with a gastrostomy tube (g-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition) out of two applicable residents, out of a total sample of 22 residents. Specifically, 1) For Resident #17 the facility failed to ensure tube feeding water flushes (intermittent boluses of water, stored in a separate bag, automatically dispensed during regular intervals in conjunction with enteral nutrition formula for purpose of hydration and maintenance of tube patency) was running at the correct setting as indicated in the physician's orders. 2) For Resident #2 the facility failed to properly label, date and store enteral feeding formula as well as change the enteral feeding formula and water flush bags every 24 hours. Findings Include: Review of the facility policy titled Enteral Nutrition Guidelines, dated and revised February 2007, indicated the following: 7. The nurse obtains a physician's order for placement of an enteral feeding tube. Feeding tube orders include the following information: -volume of water given as water flush. 13. The nurse irrigates the feeding tube with the prescribed amount of water every 4-8 hours to maintain or restore patency of the feeding tube and to provide free water to maintain adequate hydration of the resident. Resident #17 was admitted to the facility in September 2023, with diagnoses that included gastroparesis, severe protein-calorie malnutrition and unspecified psychosis. Review of Resident #17's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident scored a 15 out of possible 15 on the Brief Interview for Mental Status, indicating he/she was cognitively intact. Further review of the MDS indicated that Resident #17 required a feeding tube. On 05/27/25 at 09:25 A.M., the surveyor observed Resident #17 awake and lying in bed. Next to the Resident was a pole consisting of a tube feeding pump, tube feeding formula in a gravity bag and a water bag. The tube feeding pump was on and the tube feeding formula and water flush bag were connected to the Resident's abdomen. The tube feeding water flushes were set and running at 50 milliliters (ml) every four hours. On 05/27/25 at 11:50 A.M., the surveyor observed Resident #17 awake and lying in bed. Next to the Resident was a pole consisting of a tube feeding pump, tube feeding formula in a gravity bag and a water bag. The tube feeding pump was on and the tube feeding formula and water flush bag were connected to the Resident's abdomen. The tube feeding water flushes were set and running at 50 ml every four hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/25 08:12 A.M., the surveyor observed Resident #17 awake and lying in bed. Next to the Resident was a pole consisting of a tube feeding pump, tube feeding formula in a gravity bag and a water bag. The tube feeding pump was on and the tube feeding formula and water flush bag were connected to the Resident's abdomen. The tube feeding water flushes were set and running at 50 mml every four hours. Review of Resident #17's physician orders, dated 5/24/25, indicated the following: - H2O (water) flush both J (jejunostomy) and G (gastrostomy) tube ports with 60 mls of water each, every four hours for water. Review of Resident #17's tube feeding care plan indicated the following intervention revised and dated 5/12/25: -Nursing will provide care with tube feeding and water flushes. See MD (physician) orders for current feeding orders. Review of Resident #17's most recent Nutritional Assessment, dated 5/26/25 indicated the following: -Water Flush: 60ml via G and J tubes x 6/day =720ml. During an interview on 05/28/25 at 09:03 A.M., Nurse #5 said Resident #17's water flush setting was not correct and that the setting should be at 60 ml every 4 hours. During an interview on 5/28/25 at 10:27 A.M., the Dietitian said Resident #17 should receive 60 ml of water flushes every four hours. During an interview on 5/28/25 at 11:19 A.M., the Nurse Practitioner said nurses were expected to follow tube feeding and water flush orders as prescribed to prevent dehydration and lack of nutrition. During an interview on 5/28/25 at 12:57 P.M., the Director of Nursing said nurses were expected to follow physician orders as prescribed. Nurses should have checked the orders and called the dietitian to make sure Resident #17 was receiving the appropriate amount of water flushes.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC: a flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV]), consistent with professional standards of practice for one Residents (#71), out of one Resident with a PICC Line. Specifically, for Resident #71, the facility failed to ensure that when the PICC line dressing was lifting (compromised), it was changed, and that the insertion site was able to be visualized. Findings include: Review of the Lippincott Manual of Nursing Practice, 11th Edition, dated 2021, included the following for documentation relative to PICC line assessment: Assess the catheter insertion site daily by inspection and palpation through the transparent semipermeable dressing to discern tenderness. Look at the catheter and cannula pathway, and check for bleeding, redness, drainage, and swelling. Review of the facility titled Peripheral and Midline IV Maintenance, dated 2/24, indicated This purpose of this procedure is to prevent complications associated with intravenous therapy. including catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. 1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened). 3. Change the dressing if it becomes damp, loosened or visibly soiled and: b. immediately if the dressing or site appears compromised. Resident #71 was admitted to the facility in April 2025 with diagnoses that included osteomyelitis of vertebra, intraspinal abscess, and low back pain. Review of Resident #71's Minimum Data Set (MDS) assessment, dated 4/9/25, indicated he/she scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. The MDS further indicated the Resident was receiving IV medications. On 5/27/25 at 8:05 A.M., the surveyor observed Resident #71 in bed with a PICC line in his/her left arm. The PICC line dressing was peeling off the skin and the insertion site was covered with gauze. The Resident said he/she has been applying tape to the dressing because it has been peeling off for days. On 5/27/25 at 11:59 A.M., the surveyor observed Resident #71 in bed with a PICC line in his/her left arm with IV antibiotics infusing. The PICC line dressing was peeling off the skin and the insertion site was covered with gauze. Review of Resident #71's PICC line care plan, dated 4/3/25, indicated Change the dressing at insertion site weekly and as needed. Observe the site of my PICC line each shift for infiltration and S/S (signs and symptoms) of infection. Review of Resident #71's physician order, dated 4/10/25, indicated PICC Dressing - Change every 7 days and PRN (as needed). (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #71's nursing progress note, dated 5/28/25, indicated PICC dressing left arm needed to be changed due to dressing edges loosening. On 5/28/25 at 11:15 A.M., Nurse #1 and the surveyor observed Resident #71's PICC Line dressing lifting around the edges and the insertion site was covered by gauze. Nurse #1 said the PICC line dressing needs to be changed immediately because the edges are lifting, and you are unable to see the insertion site so the nurses would not know if it is infected. During an interview on 5/29/25 at 9:55 A.M., The Director of Nursing (DON) said his expectation of the nurses are that they observe the PICC line every time they go into the Resident's room. The DON said he would expect the dressing to be changed immediately if it starts to lift off the skin as it puts the Resident at risk for infection and the insertion site should always be able to be visualized so nursing knows if the site is becoming infected.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to assess and provide treatment for pain for one Resident (#7) with a diagnosis of acute pain due to trauma out of a total sample of 22 residents. Findings include: Review of the facility policy titled, Pain Assessment and Management, last revised 3/26/2009, indicated the following: -each resident has the right to expect a prompt, effective response to reports of pain. Therefore, it is the policy of this facility to: -To identify, assess and manage pain effectively and collaboratively with the interdisciplinary team. -To design a plan of care to achieve an optimal balance between pain relief and preservation of function, in accordance with the resident directed goals. Resident #7 was admitted to the facility in June 2021 with diagnoses including acute pain due to trauma, osteoporosis with pathological fracture of vertebra(e) (back bone) and muscle weakness. Review of Resident #7's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status score of 15 out of a possible 15 which indicated the Resident is cognitively intact. The MDS also indicated Resident #7 requires supervision for functional tasks. Review of Resident #7's MDS dated [DATE] indicated the Resident is on scheduled pain medication. Review of a grievance form dated 10/24/24, indicated the following grievance written by a staff member: Concern: -(The Resident) asked the 11-7 nurse (name) at 12am if (he/she) could have Tylenol for pain in (his/her) shoulders, hips and back. (The nurse) told (him/her) no because she didn't think (the Resident) was in pain. (The nurse) did not offer anything else to (the Resident) instead of the Tylenol. (The Resident) waited for the 7-3 shift to come in so (he/she) could ask again for something and at this point was in tears due to (his/her) pain. Action taken: -DON (Director of Nursing) spoke to nurse in question who reports that she gave Tylenol to (the Resident). Follow-up: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-F/u (follow-up) when resident return(sic) from MLOA on 11/12/24. Resident didn't remember receiving dose/situation but reports enough time has passed that (he/she) is indifferent with resolution. Lyrica (pain medication) started upon readmission. At the time of this incident, Resident #7 had the following physician orders: -Pain evaluation: Document verbal/nonverbal signs of pain every shift, initiated on 3/29/23. -Meloxicam oral tablet (a nonsteroidal anti-inflammatory drug (NSAID) used to relieve pain, inflammation, and stiffness) 15 MG (milligrams). Give one tablet at bedtime for supplement, initiated on 5/20/24. -Tylenol tablet 325 MG give two tablets by mouth every 6 hours as needed for fever or pain, initiated 6/16/21. -May apply generic muscle rub to lower back and bilateral shoulders as needed for pain, initiated on 10/18/24. Review of the Medication Administration Report (MAR) for October 2024 indicated the following: -Resident #7 was assessed for pain on the shift the incident occurred by the nurse mentioned in the grievance, however there was no number scale used/reported for the pain and no nursing note. -Resident #7 did not receive any pain medication from the nurse listed in the grievance throughout the shift. -Resident #7 received Tylenol at 7:45 A.M., when the next nurse started the new shift and at this time the Resident's pain was assessed to be an 8 out of 10 on the pain assessment scale. Review of Resident #7's care plans failed to indicate a care plan for pain at the time of survey. The Nurse mentioned in the grievance form is no longer an employee of the facility and was unavailable for interview. During an interview 5/19/25 at approximately 8:30 A.M., Resident #7 said he/she did not remember this incident from October. Resident #7 said he/she does have pain at times and when he/she receives pain medication it helps. During an interview on 5/28/25 at 12:33 P.M., the Director of Nursing said if a resident is voicing pain, he would expect the nursing staff to assess the resident's pain level and if the resident has an order in place for an as needed pain medication he would expect the nursing staff to provide that medication. The Director of Nursing said if the pain medication is provided, this would be documented on the MAR and if not on the MAR he could not assume the medication was provided. The Director of Nursing said he does not fully remember the incident in October and reviewed the grievance form and the MAR with the surveyor. After review, the Director of Nursing said he could not recall ever seeing that the medication was never given and did not feel that the nurse adequately managed Resident #7's pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 11:19 A.M., Nurse Practitioner #1 said she is the provider for Resident #7 now, however, was not here in October. Nurse Practitioner #1 said she would expect people who are in pain to be medicated per physician orders.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure behavioral health services, related to Substance Use Disorder (SUD), were provided to one Resident (#70) out of a total sample of 22 residents. Specifically, the facility failed to follow up with Resident #70 as indicated by providing psychiatric talk therapy; and, during the time behavioral health services failed to follow up with Resident #70, after he/she used an illicit substance (cocaine) which required hospitalization. Findings Include: Review of the facility policy titled, Treatment Options for Residents with Substance Use Disorder, dated 11/4/24, indicated The facility will offer appropriate and individualized treatment for all residents living with the disease of addiction or with a history of substance use disorder. Any resident admitted to the facility who is diagnosed with a substance use disorder, or is diagnosed with such while a resident, will be offered and supported with enrolling and attending appropriate, evidence based, and effective treatment from local Opioid Treatment Programs (OTP), Office Based Addiction Treatment (OBAT, or Office Based Opioid Treatment ([NAME]) programs. The facility is responsible for contacting and establishing a relationship with local treatment programs to off OTP/OBAT/[NAME] services to any resident Newly admitted residents with substance use disorders will be assessed by licensed substance use clinician, or designee, and offered appropriate referral to local OTP/[NAME]/OBAT if indicated, feasible, and warranted and agreed upon by resident. Substance use clinician, or designee, will provide resources to residents who request and/or accept referral to substance use treatment and will be supported/assisted with initiating treatment. Residents with substance use disorders and actively being treated as well as residents with a history of substance use disorder, will be offered behavioral health services and continued counseling. Residents with substance use disorders and actively being treated as well as residents with a history of substance use disorder, will have substance use disorder evaluations completed on admission and an individualized care plan completed by the IDT. Review of the facility policy titled, Acute Intoxication Due to Use of Opioids, dated 11/4/24, indicated Documentation and Post Intoxication Management: The Resident's care plan must be updated with information regarding substance used, and intervention to address the substance use. The resident's care team must be informed of the incident. Education about the dangers of intoxication and the dangers surrounding the use of psychoactive substances, e.g. effect of tolerance on use, must be given to the resident in a supportive manner. Resident #70 was admitted to the facility in April 2025 with diagnoses that included opioid abuse, psychoactive substance abuse, post-traumatic stress disorder (PTSD), and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/9/25, indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Further review indicated his/her PHQ 2-9 (resident mood interview) score was 18 indicating moderately severe depression. Review of Resident #70's admission substance abuse evaluation, dated 4/7/25, indicated he/she actively used substances within the last three months. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #70's substance use disorder care plan, dated 4/10/25, indicated the following interventions: - Assist me with my treatment program for substance use disorder which may include a Medication Assisted Treatment program. - I will be open to therapeutic discussions surrounding my substance use. - I will work towards developing coping strategies designed with me to support me in recovery. Review of Resident #70's physician order, dated 4/3/25, indicated May have Psych consult as needed. Review of Resident #70's psychiatric services and counseling consent indicated the Resident signed and consented to both medication management and talk therapy services on 4/3/25. Review of Resident #70's medical record failed to indicate he/she was ever seen by behavioral services for any service other than medication management. Review of Resident #70's social services admission note, dated 4/11/25, indicated Substance use being managed by methadone which is provided by [outside services]. He/she will be followed by substance use counselor & psych. He/she appears to be adjusting to the environment & attends smoking group. Care ongoing. Review of Resident #70's SUD counselor initial note, dated 4/25/25, indicated He/she is living with early onset substance use disorders (SUD) and has a severe trauma history. The Resident may benefit from tenets of trauma informed care including creating safe emotional space, actively listening, and providing empathy while validating and offering choices. The Resident has agreed to individual substance use therapy with this writer. Per medical record, assessment, and interview the Resident is living with active opiate and stimulant use disorders along with PTSD, anxiety and depression. Review of Resident #70's Medical Doctor (MD) progress note, dated 4/7/25, indicated During hospitalization he/she was evaluated by addiction team. Further review of the note failed to indicate any interventions or review of his/her SUD diagnosis outside of medication management. Review of Resident #70's Nurse Practitioner (NP) note, dated 5/1/25, indicated Patient has also significant history of polysubstance use disorder. There was no further mention of any intervention for the use disorder. Review of Resident #70's at risk progress note, dated 5/1/25, indicated Substance use being managed by methadone which is provided by [outside services]. He/she will be followed by substance use counselor. Review of Resident #70's SUD counselor progress note, dated 5/10/25, indicated This writer attempted to meet with the Resident on this day to no avail for he/she reports not feeling up to it. It was agreed this writer would re-approach later in the week. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #70's progress notes from 5/11/25 to 5/27/25 failed to indicate that the SUD counselor attempted to follow up with the Resident. Review of Resident #70's nursing progress note, dated 5/23/25, indicated resident was observed sitting in the lobby area next to the elevator, he/she appears disheveled, pupils dilated, face is flush, he/she is diaphoretic, speech is slurred and is unable to put a proper sentence together. He/she is nodding her head as he/she tries to answer questions. when asked if he/she was feeling ill, he/she replied no, when asked if he/she had taken something not prescribed, he/she again stated no. NP notified, order to send to ED (emergency department) for evaluation d/t (due to) change in mental status. Review of Resident #70's nursing progress note written by the staff development coordinator, dated 5/23/25, indicated this writer s/w (spoke with) AJH ED. resident will be admitted with dx: pneumonia. tox screen positive for cocaine. Review of Resident #70's progress notes from his/her return from the hospital on 5/24/25 to 5/27/25 failed to indicate that the SUD counselor, social worker, MD or NP reassessed or met with the Resident about his/her use of an illicit substance. Review of Resident #70's substance use disorder care plan failed to indicate the care plan was reviewed or revised with interventions addressing his/her substance use since his/her return from the hospital on 5/24/25 after using an illicit substance. Review of Resident #70's medical record failed to indicate that the resident was provided talk therapy by psychiatric services since his/her admission to the facility. Review of the Facility assessment dated [DATE], indicated the facility accepts residents with behavioral health diagnoses including SUD and provides annual training's to their staff. During an interview on 5/28/25 at 9:42 A.M., the Social Worker said when a resident is admitted with a SUD diagnosis, she will complete a SUD assessment and a comprehensive care plan. The Social Worker said the building has recently been admitting residents with the SUD diagnosis and they have hired another social worker to help out. The Social Worker said she is not aware of anyone actively using in the building. The Social Worker then said she was aware of Resident #70 actively using on 5/23/25 and did not call the SUD counselor but the Director of Nurses should have when the resident returned from the hospital on 5/24/25. The Social Worker said she should have done a new SUD assessment and updated the Residents care plan but did not because she has not had time. The Social Worker said the facility also offers behavioral health services such as medication management with a psychiatric nurse practitioner and psychiatric counseling with a therapist; however, she did not ensure Resident #70 was set up with psychiatric counseling talk therapy as he/she was only seen by the med management psychiatric Nurse Practitioner. The Social Worker said she did not contact psychiatric services since the Resident has returned to the building after being confirmed to use cocaine. The Social Worker said the Resident should have been offered Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) but was not offered those services on admission. The Social Worker said she mainly works on discharge planning and getting residents resources once they leave the facility. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/28/25 at 9:55 A.M., the Director of Nursing (DON) said the SUD program is new at the facility and they have a substance abuse disorder counselor who comes in weekly and as needed, the DON said the SUD counselor was just in over the weekend. The DON said Resident #70 used an illegal substance that was confirmed by the hospital on 5/23/25, but he did not call the SUD counselor when he/she returned on 5/24/25. The DON said he told staff to do more frequent checks on the Resident when he/she returned to the facility. The DON said he expected social services to reassess the Resident and update his/her care plan to add more specific resident centered interventions to protect the Resident. During a follow up interview on 5/29/25 at 9:39 A.M., the DON said the social workers role in the SUD program is completing the SUD assessment, d/c planning, and referring to services when the resident leaves the facility out in the community. The DON said social services should be setting up virtual meetings while here at the facility but he is unaware of any residents actually accessing these meetings. The DON said the social worker should be meeting with SUD residents frequently and should be receiving psych services including talk therapy. The DON said it is prudent to have more things for the Resident to prevent relapse and we as a facility are stumbling and trying to do our best with a new program. During an interview on 5/28/25 at 10:41 A.M., the Nurse Practitioner (NP) said the expectation of the facility is when a resident is admitted with SUD diagnosis they should be supported by the facility with services. The NP said the Resident re-admitted with and had recent and chronic use of drugs. The NP said the facility should have updated the plan of care and completed a new assessment. The NP said the Resident needs extra support with his/her history. The NP said if the facility is going to have SUD residents then they need to provide the correct support. During an interview on 5/29/25 at 8:44 A.M., the SUD counselor said he has been working for the facility for about four weeks. The SUD counselor said he comes in weekly and as needed by the facility. The SUD counselor said he was unaware Resident #70 used drugs on 5/23/25 and was not told until 5/28/25 when the building contacted him to come and assess the Resident. The SUD counselor said he was in over the weekend and no one told him the Resident had used drugs. The SUD counselor said he would like to start individual and bigger groups. The SUD counselor said he is not sure who completed referrals to NA/AA and is not sure who sets it up at the facility, but he has not offered those to Resident #70. The SUD counselor said for the SUD program to work the entire disciplinary team need to be involved. During an interview on 5/28/25 at 11:12 A.M., Resident #70 was tearful and upset and said he/she has been struggling lately and would love to have someone to talk to because he/she wants to do better. The Resident said the facility said today they will be getting him/her more services. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	During a follow up interview on 5/29/25 at 9:09 A.M., the Social Worker said the facility has been taking SUD admissions for a few months and the SUD program expectations when a resident has SUD is to treat for medical and address the SUD through care planning, meetings, and other resources if the resident is open to it. The Social Worker said social services supports residents with their recovery and what they need at discharge. The Social Worker said while they are at the facility they can talk to the social worker, behavioral health team that offers both talk therapy and med management. The social worker said she did not follow-up with the Resident to ensure she was receiving all possible services from the behavioral health team. The Social Worker said she tries to do check-ins and should be writing notes after. The Social Worker said we are building on the SUD program because it is new here at the building. The Social Worker said the building may need a counselor that comes in frequently as she is not a SUD counselor and she more focuses on day to day things and discharge planning. During an interview on 5/29/25 at 9:25 A.M., the Medical Director (MD) who is also Resident #70's primary doctor at the facility said SUD programming at the facility focuses on the medical issues as the main issue and to provide services for SUD like behavioral health services. The MD said psych services are very important both medication management and talk therapy. The MD said it is very important because SUD is a mental issue. The MD said she does not recall knowing the Resident was struggling. The MD said when the Resident returned to the facility the social worker should have reassessed him/her and psych services, including the SUD counselor, should have been notified immediately. The MD said SUD is a hard diagnosis and those residents need the correct support in place including non-medical interventions. During an interview on 5/29/25 at 10:37 A.M., the Administrator said the SUD program was initiated at the facility about 4 weeks ago. He said they hired another social worker to help out the one social worker for the SUDs program. The Administrator said the residents the facility is accepting are here for medical reasons and the idea is the medical concerns get taken care of then they get discharged back to the community. The Administrator said they know residents need support for their addiction problems while the medical problems are being taken care of. The Administrator said the SUD counselor is here twice a week and as needed at night and the social worker is here for support for all the residents. The Administrator said the social worker should be checking in frequently and should step in if SUDS counselor is not here. The Administrator said the social worker should be setting up services while they are here and getting the residents what they need such as behavioral health services, addiction meetings and community resources. The Administrator said he is looking to set up NA/AA going forward. The Administrator said we are new at this and the SUD programming needs strengthening.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide medically related social services to one Resident (#70) who had an active diagnosis of Substance Use Disorder (SUD) (out of a total sample of 22 residents. Specifically, the facility failed to ensure the Social Worker implemented SUD interventions prior to Resident #70's hospitalization for his/her drug use and failed to re-assess after the Resident was re-admitted and confirmed to have actively use an illicit substance (cocaine). Findings include: Review of the facility policy titled, Treatment Options for Residents with Substance Use Disorder, dated 11/4/24, indicated The facility will offer appropriate and individualized treatment for all residents living with the disease of addiction or with a history of substance use disorder. Any resident admitted to the facility who is diagnosed with a substance use disorder, or is diagnosed with such while a resident, will be offered and supported with enrolling and attending appropriate, evidence based, and effective treatment from local Opioid Treatment Programs (OTP), Office Based Addiction Treatment (OBAT, or Office Based Opioid Treatment ([NAME]) programs. The facility is responsible for contacting and establishing a relationship with local treatment programs to offer OTP/OBAT/[NAME] services to any resident. Newly admitted residents with substance use disorders will be assessed by licensed substance use clinician, or designee, and offered appropriate referral to local OTP/[NAME]/OBAT if indicated, feasible, and warranted and agreed upon by resident. Substance use clinician, or designee, will provide resources to residents who request and/or accept referral to substance use treatment and will be supported/assisted with initiating treatment. Residents with substance use disorders and actively being treated as well as residents with a history of substance use disorder, will be offered behavioral health services and continued counseling. Residents with substance use disorders and actively being treated as well as residents with a history of substance use disorder, will have substance use disorder evaluations completed on admission and an individualized care plan completed by the IDT. Review of the facility policy titled, Acute Intoxication Due to Use of Opioids, dated 11/4/24, indicated Documentation and Post Intoxication Management: The Resident's care plan must be updated with information regarding substance used, and intervention to address the substance use. The resident's care team must be informed of the incident. Education about the dangers of intoxication and the dangers surrounding the use of psychoactive substances, e.g. effect of tolerance on use, must be given to the resident in a supportive manner. Resident #70 was admitted to the facility in April 2025 with diagnoses that included opioid abuse, psychoactive substance abuse, post-traumatic stress disorder (PTSD), and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/9/25, indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Further review indicated his/her PHQ 2-9 (resident mood interview) score was 18 indicating moderately severe depression. Review of Resident #70's physician order, dated 4/3/25, indicated May have Psych consult as needed. (continued on next page)

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Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #70's psych services and counseling consent indicated the Resident signed and consented to both medication management and talk therapy services on 4/3/25. Review of Resident #70's medical record failed to indicate talk therapy services were provided to the Resident. Review of Resident #70's nursing progress note, dated 5/23/25, indicated resident was observed sitting in the lobby area next to the elevator, he/she appears disheveled, pupils dilated, face is flush, he/she is diaphoretic, speech is slurred and is unable to put a proper sentence together. He/she is nodding her head as he/she tries to answer questions. When asked if he/she was feeling ill, he/she replied no, when asked if he/she had taken something not prescribed, he/she again stated no. NP (Nurse Practitioner) notified, order to send to ED (emergency department) for evaluation d/t (due to) change in mental status. Review of Resident #70's nursing progress note written by the staff development coordinator, dated 5/23/25, indicated this writer s/w (spoke with) [Hospital] ED. resident will be admitted with dx: pneumonia. tox screen positive for cocaine. During an interview on 5/28/25 at 11:12 A.M., Resident #70 was tearful and upset and said he/she has been struggling with his/her sobriety lately and would love to have someone to talk to because he/she wants to do better. The Resident said the facility said today they will be getting him/her more services but wishes he/she received more support from the social worker prior to him/her using. Review of Resident #70's admission substance abuse evaluation, dated 4/7/25, indicated he/she actively used substances within the last three months. Review of Resident #70's progress notes from his/her return from the hospital on 5/24/25 to 5/27/25 failed to indicate that the social worker reassessed or met with the Resident about his/her use of an illicit substance. Review of Resident #70's social services admission note, dated 4/11/25, indicated Substance use being managed by methadone which is provided by [outside services]. He/she will be followed by substance use counselor & psych. He/she appears to be adjusting to the environment & attends smoking group. Care ongoing. The medical record failed to indicate any substance use support was provided to the Resident prior to and after the Resident's substance use on 5/23/25. Review of Resident #70's substance use disorder care plan, initiated by the social worker and dated 4/10/25, indicated the following interventions: - Assist me with my treatment program for substance use disorder which may include a Medication Assisted Treatment program. - I will be open to therapeutic discussions surrounding my substance use. - I will work towards developing coping strategies designed with me to support me in recovery. Further review of Resident #70's medical record failed to indicate the social worker at the facility had involvement with implementing the above interventions. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/25 at 9:09 A.M., the Social Worker said the facility has been taking SUD admissions for a few months and the SUD program expectations when a resident has history of substance use is to treat for any medical concerns while also addressing the addiction through care planning, meetings, and other resources if the resident is open to it. The Social Worker said she primarily works with residents with substance abuse history to ensure discharge planning and offer some support but said she is not a SUD counselor so does not really offer support regarding addiction. The Social Worker said she tries to do check-ins and should be writing notes after if a check-in occurred. The Social Worker said she would be able to assist these residents to set up on-line addiction support groups such as AA and NA, however, has not done this for any resident, including Resident #70. The Social Worker said the facility also offers behavioral health services such as medication management with a psychiatric nurse practitioner and counseling with a therapist; however, she did not ensure Resident #70 was set up with counseling talk therapy as he/she was only seen by the med management psych Nurse Practitioner. The Social Worker said we are building on the SUD program because it is new here at the building. The Social Worker said the building may need a counselor that comes in frequently as she is not a SUD counselor, and she more so focuses on day-to-day things and discharge planning. During an interview on 5/28/25 at 9:55 A.M., the Director of Nursing (DON) said the SUD program is new at the facility. The DON said Resident #70 used an illegal substance that was confirmed by the hospital on 5/23/25. The DON said he expected social services to reassess the Resident and update his/her care plan to implement more specific resident centered interventions to protect the Resident. The DON confirmed this did not happen upon the Resident's return to the facility. During a follow up interview on 5/29/25 at 9:39 A.M., the DON said the social worker's role in the SUD program is completing the SUD assessment, d/c planning, and referring to services when the resident leaves the facility out in the community. The DON said social services should be setting up virtual addiction meetings while here at the facility, but he is unaware of any residents accessing these meetings and does not believe the social worker has done this yet. The DON said the social worker should be meeting with SUD residents frequently and residents should be receiving behavioral health services including talk therapy. The DON said it is prudent to have more things for the Resident to prevent relapse and we as a facility are stumbling and trying to do our best with a new program. During an interview on 5/29/25 at 8:44 A.M., the SUD counselor said he has been working for the facility for about four weeks. The SUD counselor said he comes in weekly and as needed by the facility. The SUD counselor said he was unaware Resident #70 used drugs on 5/23/25 and was not told until 5/28/25 when the building contacted him to come and assess the Resident. The SUD counselor said he was in over the weekend, and no one told him the Resident had used drugs. The SUD counselor said he is not sure who completed referrals to NA/AA and is not sure who sets it up at the facility, but he has not offered those to Resident #70. The SUD counselor said for the SUD program to work the entire disciplinary team needs to be involved, and maybe the building needs more support as he is only one person. During an interview on 5/28/25 at 10:41 A.M., the Nurse Practitioner (NP) said the expectation of the facility is when a resident is admitted with SUD diagnosis they should be supported by the facility with services. The NP said the Resident admitted with and had recent and chronic use of drugs. The NP said the facility should have updated the plan of care and completed a new assessment. The NP said the Resident needs extra support with his/her history. The NP said if the facility is going to admit SUD residents, then they need to provide the correct support. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/25 at 9:25 A.M., the Medical Director (MD) who is also Resident #70's primary doctor at the facility said SUD programming at the facility focuses on the medical issues as the main issue and to provide services for SUD like behavioral health services. The MD said when the Resident returned to the facility the social worker should have reassessed him/her and psych services, including the SUD counselor, should have been notified immediately. The MD said SUD is a hard diagnosis and those residents need the correct support in place including non-medical interventions. During an interview on 5/29/25 at 10:37 A.M., the Administrator said they hired another social worker to help the one social worker for the SUDs program. The Administrator said the SUD counselor is here twice a week and as needed at night and the social worker is here for a support for all the residents. The Administrator said the social worker should be checking in frequently and should step in if the SUD counselor is not here. The Administrator said the social worker should be setting up services while they are here and getting the residents what they need such as behavioral services, addiction meetings and community resources. The Administrator said, we are new at this, and the SUD programming needs strengthening.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, 1. The facility failed to ensure that medications were dated once opened, according to manufacturer's guidelines. Further, the facility failed to ensure that medications with shortened expiration dates were removed from the medication cart when expired and were not available for administration in one of two medication carts observed. 2. The facility failed to ensure treatment carts were locked while a nurse was not present on both the second and third floor units. 3. The facility failed to ensure nursing staff kept the medication cart clean and organized in one of one medication cart observed on the second-floor unit. 4. The facility failed to ensure nursing staff stayed with the surveyors while doing the medication storage task on both the second and third floor units. Findings include: Review of the facility policy titled, Medication Storage in the Facility, dated 6/22, indicated the following: -It is the policy of the facility that medications, treatments, and biological are stored safely, securely, and properly following manufacturer's recommendations or facility policy. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts, and medication supplies are locked or attended by personas with authorized access. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, unlabeled, or with out secure closures are immediately removed from stock, disposed of according to procedures for medication destruction , an reordered from the pharmacy if a current order exists. 1. On [DATE] at 11:36 A.M., the surveyor observed the following with Nurse #2 in the 3rd floor low side medication cart: - two Albuterol inhalers, opened, in-use and undated. The inhaler indicates to discard after 12 months. - two Dulera inhalers, opened, in-use and undated. The inhaler indicates to discard after 12 months. - one Incruse Ellipta inhaler, opened, in-use and undated. The inhaler indicates to discard after 6 weeks. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- one Spiriva inhaler, opened, in-use and undated. The packaging indicates to discard three months after the insertion of the cartridge (which was inserted). - one Breo Ellipta inhaler, opened, in-use and undated. The inhaler indicates to discard after 6 weeks. During an interview on [DATE] at 11:37 A.M., Nurse #2 said the inhalers are all open and have been used many times by the residents, but they are not dated when they were opened. Nurse #2 said the inhalers should be dated when opened because they expire in so many days after opening. On [DATE] at 11:39 A.M., the surveyor made the following observations of the second-floor west medication cart: - one Incruse Ellipta inhaler, opened in-use and undated. The inhaler indicates to discard after 6 weeks. - one Spiriva respimat inhaler, opened, in-use and undated. The packaging indicates to discard three months after the insertion of the cartridge (which was inserted). - An opened and undated bottle of prostat liquid protein. Instructions on the bottle indicate to discard three months after opening. During an interview on [DATE] at 11:50 A.M., Nurse #3 said that inhalers and other medications like prostat with shortened expiration dates should be dated when opened. During an interview on [DATE] at 7:51 A.M., Unit Manager #1 said that inhalers and other medications with shortened expiration dates should be labeled with an open date. During an interview on [DATE] at 9:54 A.M., the Director of Nursing (DON) said all inhalers and other medications with a shortened life should be dated once opened by the nurse who opens the inhaler, if not it puts the resident at risk because the inhalers expire usually after 28 days. 2. On [DATE] from 7:17 A.M. to 7:50 A.M., the surveyor observed both treatment carts on the third-floor unit unlocked and unsupervised. The surveyor was able to access the treatment cart which contained medicated ointments and creams in it. Multiple staff members and residents were observed to go by the carts. On [DATE] at 7:55 A.M. the surveyor and Nurse #4 observed the high side treatment cart on the third-floor unit unlocked. Nurse #4 said the treatment cart should be locked at all times unless a nurse is present at it. On [DATE] at 8:25 A.M., the surveyor observed the low side treatment cart on the third-floor unit unlocked and unsupervised. The surveyor was able to access the treatment cart which contained medicated ointments and creams in it. On [DATE] at 6:42 A.M. the surveyor observed an unlocked treatment cart on the third- floor unit. The surveyor was able to access the treatment cart which contained medicated ointments and creams in it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 6:46 A.M. the surveyor observed two unlocked treatment carts on the second-floor unit. The surveyor was able to access the treatment cart which contained medicated ointments and creams in it. On [DATE] at 7:42 A.M., the surveyor observed one unlocked treatment cart on the second- floor unit. Multiple residents were also observed ambulating in the hallway past the unlocked treatment cart. During an interview and observation on [DATE] at 7:51 A.M., Unit Manager #1 observed the unlocked treatment cart and said that all treatment and medication carts should be locked and secured when unattended. During an interview on [DATE] at 9:54 A.M., the Director of Nursing (DON) said treatment carts are expected to be locked at all times unless a nurse is working in that cart. The DON said it can put residents at risk if they are able to access the treatment supplies. 3. On [DATE] at 11:39 A.M., the surveyor made the following observations of the second-floor west medication cart: - A bottle of liquid Trizomal Glutathione (a supplement that supports overall health) with no cover on it. - Nine loose pills in one of the medication cart draws. - A sticky red substance that was spilled in the medication cart. During an interview on [DATE] at 11:50 A.M., Nurse #3 said that medication carts should be kept clean and free of spills and other loose pills. He further said that storing liquid medication without a cover should not happen. During an interview on [DATE] at 7:51 A.M., Unit Manager #1 said that her expectation is that medication carts are kept clean and tidy. During an interview on [DATE] at 9:54 A.M., the Director of Nursing (DON) said he expects nursing to keep their medication carts clean of loose pills and spills. 4. During the observation of the medication cart on [DATE], the nurse unlocked the medication cart for the surveyor at 11:39 A.M., and did not return to the medication cart until 11:50 A.M., 11 minutes after unlocking the medication cart for the surveyor. During an observation of the medication room on [DATE] at 11:38 A.M., on the third-floor unit, medication room Nurse #4 left the surveyor alone in the medication room and did not return. During an interview on [DATE] at 11:50 A.M., Nurse #3 said that he should not have walked away and left the medication cart unattended with the surveyor. During an interview on [DATE] at 7:51 A.M., Unit Manager #1 also said that the nurse should not have left the surveyor unsupervised at the medication cart or in the medication room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:54 A.M., the Director of Nursing (DON) said nursing staff are expected to stay with the surveyors while the surveyor is in the medication cart and the medication room.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide follow-up dental services and obtain dentures for one Resident (#21), out of a total sample of 22 residents. Findings include: Review of the facility policy titled, Eye, Podiatry and Dental Care, dated 6/2022, indicated the following: -It is the policy of the facility to implement an eye, podiatry, and dental health program, which assures that each resident receives the necessary care on an as needed basis. -Following the initial assessment each resident is routinely assessed by nursing specific to these areas for changes in baseline or additional needs. Resident #21 was admitted to the facility in July 2017 with diagnoses including Alzheimer's Disease, diabetes, heart failure and muscle weakness. Review of Resident #21's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated the Resident is cognitively intact. During an interview on 5/27/25 at 11:46 A.M., Resident #21 was observed sitting in his/her wheelchair with his/her bedside table in from of him/her and was waiting for lunch. The Resident was observed to not have any natural teeth. Resident #21 said he/she had teeth pulled months ago and he/she has been waiting to be measured for dentures. The Resident said staff had not discussed this process with him/her and he/she had been waiting a while. Review of Resident #21's medical record indicated the following: -A signed consent to be treated by the dentist in the facility. -A physician's order for dental consult as needed, initiated on 3/11/2018. -A nursing note dated 9/11/24 which indicated Resident #21 had several teeth extracted by the dentist. -A dental visit note dated 10/21/24 which indicated the following: Reviewed Med HX (medical history): confirmed with nursing patient is COVID-19 negative and afebrile (without fever).; PT (patient) presents for follow up for ext (extraction) #23, 24, 25, 26, 27 (teeth) on 9/11/24. Patient states that (he/she) feels good. Clinical exam reveals the area is healing well, slight indentations where incisors were, bone very low in area of #27. Recommend another 4 weeks of healing prior to starting impression for dentures. NV (next visit): Denture step 1 if approved. -An oral health care plan last revised 5/27/25, with the following intervention: Coordinate arrangements for dental care, transportation as needed/as ordered. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #21's medical record failed to indicate the dentist completed the denture impressions or that the facility contacted the dental service to ensure this would occur. During an interview on 5/29/25 at 8:03 A.M., Unit Manager #1 said Resident #21 had all of his/her teeth pulled and the dentist has not seen the Resident since. Unit Manager #1 said the Medical Record Director typically sets up all dental visits and believes the Resident was missed. The surveyor and Unit Manager #1 then reviewed the recommendation made by the dentist on 10/21/24 for impressions to be made to start the process for dentures and Unit Manager #1 said this never happened. During an interview on 5/29/25 at 9:52 A.M., the Director of Nursing said the Medical Record Director schedules all dental appointments and is responsible, along with nursing, to review recommendations and ensure all recommendations are completed. The Director of Nursing said he was unaware Resident #21 had a recommendation for dentures, and this should have been followed up by the nursing staff to ensure the Resident obtained dentures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for Resident #14, the facility failed to implement Enhanced Barrier Precautions (EBP) for a resident with an open wound, colostomy, and IR drain (a drainage procedure performed by Interventional Radiology). Findings Include: Review of the Centers for Disease Control (CDC) website indicated the following, dated June 28, 2024: -Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Resident #14 was admitted to the facility in December 2024 with diagnoses of necrotizing fasciitis, septicemia and diabetes mellitus. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/7/25, indicated that Resident #14 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating the Resident was cognitively intact. On 05/27/25 at 08:22 A.M. the surveyor observed Resident #14 in his/her room in bed, the Resident's IR drain was visible and there was no EBP sign on or near the Resident's door. On 5/28/25 at 8:43 A.M., the surveyor observed Unit Manager #1 assessing Resident #14's abdominal wound by physically prodding the resident's abdomen with her hands; the unit manager was wearing gloves but had not donned a gown. During the observation the Resident's colostomy was visible. There was no EBP sign on or near the Resident's door. During an interview and observation on 5/28/25 at 9:12 A.M. the surveyor observed Unit Manger #1 assessing Resident #14, the Unit Manger donned gloves but did not don a gown. The Unit Manager made physical contact with the tubing of the Resident's drain and the Resident's colostomy was visible. There was no EBP sign on or near the Resident's door and the unit manager said the Resident should have been on enhanced barrier precautions. Review of Resident #14's care plans indicated Resident #14 had potential/actual impairment of skin integrity related to a surgical wound and sacral wound; further review of the care plan failed to indicate an intervention for enhanced barrier precautions (EBP). Review of Resident #14's physician's orders indicated the following active orders: (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Right buttock wound wet to dry dressing twice a day, and also if soaked. Place saline-soaked gauze over the wound followed by dry abdominal pad or dry gauze over the wet dressing. Then secure with large adhesive boarder gauze to keep intact, initiated on 12/17/24. - Wound care, apply dry gauze to right open area abdominal fold. Change twice daily, initiated on 5/28/25. - Colostomy care every shift, initiated 12/4/24. - Empty IR drain and record output every shift, initiated on 2/10/25. Further review of Resident #14's physician's orders failed to indicate an order for EBP. During an interview on 5/29/25 at 9:44 A.M. the Infection Preventionist (IP) said anyone with a wound or drain should be on EBP and that Residents on EBP should have a physician's order and care plan for the use of EBP. The IP said staff assessing a wound or manipulating a tube should be wearing a gown. The IP said there should be a sign on the doorway denoting the Resident was on EBP. The IP said she was aware that Resident #14 did not have a sign and was not on EBP but that he/she should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	05/29/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to administer Pneumococcal vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations for three Residents (#65, #29 and #5), out of a total sample of five residents reviewed for immunizations. Findings include: Review of facility policy titled, Immunizations and Vaccines- Residents, dated as revised 02/2022, indicated the following: -It is the policy of the facility that all residents receive immunizations and vaccinations that assist in preventing infectious diseases, unless medically contraindicated, or otherwise ordered by the resident's attending physician, or refused by the resident or resident's activated HCP (health care proxy). -Procedure: 1. Vaccine information statements and consent for pneumococcal, influenza and covid-19 will be a part of the residents' admission packed. Consent for these vaccinations will be obtained from the resident or resident representative at the time of admission. -2. Orders for administration of pneumococcal vaccine, covid-19 and annual influenza vaccine will be obtained/ or written by the resident's MD/NP (Medical Doctor/ Nurse Practitioner) on admission. Review of the CDC guidance Pneumococcal Vaccine Timing for Adults, dated 10/2024, indicated but was not limited to the following: For Adults [AGE] years old or older, vaccine recommendations are as follows: -Unvaccinated adults should receive: a) PCV20 (Prevnar 20, a pneumococcal conjugate vaccine) or PCV21 vaccine (Capvaxive, a pneumococcal conjugate vaccine) or b) PCV15 followed by PPSV23 at least one year later -Adults who have received PPSV23 vaccine only (at any age): a) PCV20 or PCV21 vaccine administered at least one year after PPSV23 was received -Adults who have received PCV13 vaccine at any age: a) PCV20 or PCV21 vaccine administered at least one year after PCV13 was received -Adults who have received PCV13 at any age and PPSV23 when younger than age [AGE]: a) PCV20 or PCV21 at least 5 years after PCV13 or PPSV20 vaccine was received. 1a. Resident #65 was admitted to the facility in June 2024 with diagnoses that included post-traumatic stress disorder and depression. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #65's most recent Minimum Data Set (MDS) Assessment, dated 3/21/25, indicated a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 indicating that the Resident has severe cognitive impairment. The MDS further indicated that Resident #65's pneumococcal vaccination was not up to date, and the vaccine was not offered to the resident. Review of Resident #65's medical record indicated a consent to receive the pneumococcal vaccine signed and dated 10/7/24. Further review of the medical record failed to indicate that the Resident received the pneumococcal vaccine. During an interview on 5/29/25 at 9:36 A.M., the Infection Preventionist said that she is aware that Resident #65 has a signed consent to receive the pneumococcal vaccine, but that he/she has not received it yet. The Infection Preventionist said that the facility has been unable to obtain the vaccines from the pharmacy. During an interview on 5/29/25 at 10:01 A.M., the Director of Nurses said that he was not aware that the facility was unable to obtain the pneumococcal vaccine from the pharmacy. He said that if the Resident has consented to the vaccine, then it should be administered. 1b. Resident #29 was admitted to the facility in November 2023 with diagnoses that included parkinsonism and dementia. Review of Resident #29's most recent MDS Assessment, dated 4/30/25, indicated a BIMS score of 6 out of a possible 15, indicating that the Resident had severe cognitive impairment. Further review of the MDS indicated that the Resident's pneumococcal vaccine is up to date. Review of Resident #29's medical record indicated a consent to receive the pneumococcal vaccine signed and dated 9/21/24. Further review of the medical record failed to indicate that the Resident received the pneumococcal vaccine. During an interview on 5/29/25 at 9:36 A.M., the Infection Preventionist said that she is aware that Resident #29 has a signed consent to receive the pneumococcal vaccine, but that he/she has not received it yet. The Infection Preventionist said that the facility has been unable to obtain the vaccines from the pharmacy. During an interview on 5/29/25 at 10:01 A.M., the Director of Nurses said that he was not aware that the facility was unable to obtain the pneumococcal vaccine from the pharmacy. He said that if the Resident has consented to the vaccine, then it should be administered. 1c. Resident #5 was admitted to the facility in April 2023 with diagnoses that included anemia and dementia. Review of Resident #5's most recent MDS, dated [DATE], indicated a BIMS score of 5 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated that the Resident's pneumonia vaccine is up to date. Review of Resident #5's medical record indicated a consent to receive the pneumococcal vaccine signed and dated 9/20/24. Further review of the medical record failed to indicate that the Resident received the pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 9:36 A.M., the Infection Preventionist said that she is aware that Resident #5 has a signed consent to receive the pneumococcal vaccine, but that he/she has not received it yet. The Infection Preventionist said that the facility has been unable to obtain the vaccines from the pharmacy. During an interview on 5/29/25 at 10:01 A.M., the Director of Nurses said that he was not aware that the facility was unable to obtain the pneumococcal vaccine from the pharmacy. He said that if the Resident has consented to the vaccine, then it should be administered.