STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225322	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sachem Center for Health and Rehabilitation	66 Central Street East Bridgewater, MA 02333

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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 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 record review and interview, the facility failed to ensure for one Resident (#9), out of a total sample of 19 residents with an alteration in skin integrity, specifically a Left Transmetatarsal Amputation (TMA-surgical procedure that removes the front part of the foot) received necessary treatment and services to promote healing. Specifically, the facility failed to monitor, assess, and identify wound deterioration and signs/symptoms of an infection until he/she was seen by the Wound Care Physician, and the clinical signs of infection were identified and a treatment implemented. Findings include: Review of the facility's policy titled Charting and Documentation, dated as last revised 7/2023, indicated but was not limited to the following:-The following information is to be documented in the medical record: observations, treatments performed, changes in the residents' condition, and progress toward or changes in the care plan goals and objectives.-Documentation of procedures and treatments will include care specific details including the assessment data and/or any unusual findings obtained during the procedure/treatment. Review of the facility's policy titled Change in Resident's Condition or Status, undated, indicated but was not limited to the following:-The nurse will notify the resident's attending physician when there has been a significant change in the condition, and the medical treatment plan needs to be altered.-A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention.-The nurse will record in the medical record information relative to the change in condition. Resident #9 was admitted to the facility in December 2023 with diagnoses which included protein-calorie malnutrition, Peripheral Vascular Disease (PVD-circulation disorder), Diabetes Mellitus with diabetic neuropathy (nerve damage commonly affecting the feet and legs causing numbness/pain). Review of the Minimum Data Set assessment, dated 5/4/26, indicated Resident #9 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) Assessment indicating he/she was cognitively intact, had PVD, a Multi-Drug-Resistant Organism (MDRO-bacteria resistant to multiple standard antibiotics), septicemia (serious life-threatening bloodstream infection), a wound infection, and had a surgical wound. Review of the Comprehensive Care Plan indicated but was not limited to the following:-Resident #9 has potential and actual impaired skin integrity. Interventions include Monitor for skin breakdown, Measure area weekly, Weekly Skin Assessment, Monitor for worsening skin tissue, Treatment as ordered, and Update Physician with changes in wound status. Review of the medical record including progress notes and transfer documents indicated Resident #9 was transferred to an acute care hospital in March 2026 for a fever and elevated heart rate. Review of the Hospital Discharge paperwork indicated Resident #9 was treated for fever and cellulitis (bacterial skin infection causing redness, swelling, and pain) of the left foot, to continue antibiotics and follow up with the wound clinic. The Wound Description indicated the left foot at the bottom of the foot, below amputation site was spongy, draining, and had black skin. Review of the Treatment Administration Record (TAR) for March 2026 indicated three of 12 days prior to the transfer, the treatment to the left TMA site was not signed off as administered. Review of the progress notes, skin assessments, and skilled evaluations in March 2026 leading up to the transfer failed to indicate an assessment and condition of the TMA surgical site wound or any signs/symptoms of deterioration/infection of the wound. Review of the Wound Physician Notes for March through May (continued on next page)

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

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

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	225322	A. Building B. Wing	05/20/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2026 indicated but were not limited to the following:-3/3/26 Left TMA site, duration >444 days, wound size: 1.3 x 0.8 x 0.1 centimeters (cm), 100% granulation tissue (pink/red healing tissue), moderate serous drainage (clean/pale yellow thin/watery), no signs of infection.-3/10/26 Left TMA site, wound size: 1.2 x 0.8 x 0.2 cm, 30% thick devitalized necrotic tissue (dead tissue)/70% granulation tissue, moderate serous drainage, no signs of infection.-4/7/26 Left TMA site, wound size: 0.9 x 0.6 x 0.2 cm, 80% granulation tissue/20% dermis (middle layer of skin), moderate serous drainage, no signs of infection. Improved evidenced by decreased necrotic tissue.-4/28/26 Left TMA site, wound size: 1 x 0.6 x not measurable cm, dried fibrinous exudate (scab), no signs of infection.-5/5/26 Left TMA site, wound size: 0.8 x 0.5 x 0.4 cm, 50% thick devitalized necrotic tissue/50% granulation tissue, moderate serous drainage, no signs of infection. Treatment changed to include Mupirocin 2% Ointment (prescription topical antibiotic cream to treat bacterial skin infections by stopping the growth).-5/12/26 Left TMA site, wound size: 5 x 3 x 0.4 cm, 40% granulation tissue/60% dermis, moderate serous drainage, exacerbated due to infection. One or more signs of clinical infection. Treatment changed to include Doxycycline 100 milligrams (mg) twice daily for 10 days (antibiotic). Review of the progress notes, skin assessments and skilled evaluations from March through May 2026 failed to indicate a change in condition of the TMA site, an assessment of the site, or any signs/symptom of infection until evaluated by the Wound Physician on 5/12/26 during the routine weekly visit. Furthermore, the Skilled Evaluations routinely indicated Skin Tissue had not been evaluated and the Weekly Skin Evaluations failed to indicate wound description and status of the wound. The wound was six times larger than the week prior (5/5/26 through 5/12/26), was exacerbated, and had clinical signs of infection. Review of the current Physician's Orders indicated but were not limited to the following:-Left TMA Site Normal Saline Wash (NSW), pat dry, apply Mupirocin ointment followed by bordered gauze dressing every day (5/5/26). On 5/20/26 at 1:15 PM., the surveyor observed Nurse #3 perform wound care to Resident #9 as follows:-Resident #9 was lying in bed, the left leg was exposed, and the TMA site was covered with a visibly soiled dressing, and there was a foul odor. The non-skid sock that had been over the dressing was visibly soiled with brown/yellow drainage.-The wound bed was red with grey slough (moist dead tissue), the peri wound (surrounding skin) was red, tender, and edematous (swollen).-Nurse #3 measured the wound at 8 x 4.5cm. Review of the progress notes, skin assessments and skilled evaluations from May 12-20, 2026, failed to indicate the further deterioration of the TMA site. The wound was larger than the week prior (5/12/26 through 5/20/26) and had clinical signs of infection. During an interview on 5/20/26 at 1:35 P.M., Nurse #3 said weekly skin checks are done by the managers, usually the Unit Manager or the Director of Nurses (DON) and the nurses on the floor don't routinely do them. Additionally, she said the Skilled Evaluations are assigned by shift and should address the wound status, but they do not. She said if there is a change in condition of a wound it should be documented and the provider should be called. During an interview on 5/20/26 at 1:41 P.M., Unit Manager #2 said the weekly skin checks and skilled evaluations should discuss wound care, progress or deterioration and then follow up with the provider as needed. She said the weekly measurements are from the Wound Doctor notes but the description of the wound should be documented by nursing and they are not. She said the notes are a generic template and incomplete. Additionally, she said she has never seen Resident #9's wound. She said she does some of the weekly skin checks, but the DON does a lot of them. During an interview on 5/20/26 at 12:55 P.M., Resident #9 said the medicine nurse is the one that does the treatment to their foot. He/she said they do the treatment and look at my skin. He/she said the managers don't do the treatment and do not check their skin. During an interview on 5/20/26 at 2:03 P.M., the Assistant Director of Nurses (ADON)/Wound Nurse said she expects the weekly skin checks to be complete and accurate. She said the weekly measurements are done by the wound doctor, but a description of the wound and any changes should be documented by the nurse and the physician notified of any changes. She said the Skilled Notes should also include wound information related to description, drainage, size, redness, and change in condition. She said she does weekly rounds with the Wound (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Doctor so the terminology she uses from the Doctor's note may be different than what the nurses generally document, but they should be describing what is going on with a wound in the evals and notes and should have picked up on the signs of infection, notified the provider, and not waited for the Wound Doctor to identify the deterioration and infection. During an interview on 5/20/26 at 2:37 P.M., the DON said the weekly skin checks are scheduled during the week. She said active wounds have measurements done by the wound doctor weekly, new areas should be noted on the skin checks, and any changes in the current wound like drainage, redness, swelling, odor etc. should be documented. She said Skilled Evaluations are a template note and the system lets you bypass sections and complete the note. She said she reviews that the notes are done but does not review them for content. She said residents that have wounds should have the wound assessment documented. She said Resident #9's notes and evaluations do not discuss the status of his/her wound or when it started to show changes. Additionally, she said the change in wound condition and signs of infection should have been addressed by the nurses before he/she went out to the hospital with a fever in March and before they were seen by the Wound Doctor in May. She said the wound is significantly larger in size now than it was and the notes do not reflect that change in wound status. The DON said the nurses are doing the treatment, but there is no documentation except from the Wound Doctor about the wound and there should be. She said the process needs improvement as they are not capturing the change in the wound condition by skipping the skin area of the notes, not evaluating the wound, and simply writing followed by wound doctor on the skin assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure it provided an environment free of potential safety hazards for supervised residents who smoke, out of a total sample of 19 residents. Specifically, the facility failed:1. To ensure safe smoking practices were implemented for supervised residents who smoke; and2. For Resident (#58), to ensure the appropriate protective equipment was applied while smoking.Findings include:Review of the facility's policy titled Smoking Policy- Residents, revised July 2025, indicated but was not limited to:-The facility shall establish and maintain safe resident smoking practices.-The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision.-Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.-Residents are not permitted to give smoking articles to other residents.Review of the facility's policy titled Smoking Policy, undated, indicated but was not limited to:-Smoking is prohibited in any area that would create a hazardous or unsafe condition.1. On 5/18/26 at 8:46 A.M., during the 8:45 A.M. smoking time, the surveyor observed the following:- Two Activity Assistants supervising the residents during the designated smoking time- Resident #69 dropped ash from his/her cigarette onto the ground- Resident #58 used his/her first cigarette to light his/her second cigarette- Resident #69 used his/her first cigarette to light his/her second cigarette- Resident #77 handed his/her lit cigarette to Resident #34 to light their cigaretteOn 5/18/26 at 1:02 P.M., during the 1:00 P.M. smoking time, two surveyors observed the following:- Two Activity Assistants supervising the residents during the designated smoking time- Resident #58 handed a cigarette butt to Resident #12, who put it out and put it into an ashtray- Activity Aide #3 put a cigarette in his/her mouth, lit it, and passed it to #58 who smoked it- Resident #34 used his/her first cigarette to light his/her second cigarette- Resident #10 used his/her first cigarette to light his/her second cigarette- Resident #34 snuffed out his/her cigarette on their wheelchairDuring an interview on 5/19/26 at 8:09 A.M., Resident #12 said the Activity Staff supervise smoking. Resident #12 said residents cannot have lighters on them and the activity staff was responsible for lighting residents' cigarettes. Resident #12 said they are aware they are not supposed to light their second cigarette with their first cigarette, but he/she does it anyway. Resident #12 said when staff see him/her using their first cigarette to light their second cigarette they do not say anything to him/her.On 5/19/26 at 8:50 A.M., during the 8:45 A.M. smoking time, the surveyor observed the following:- Activity Aide #4 put a cigarette in his/her mouth, lit it, and passed it to Resident #28 who smoked it- Resident #34 used Resident #58's cigarette to light his/her first cigarette- Resident #34 used his/her first cigarette to light his/her second cigarette- Resident #7 and Resident #28 flicked their cigarette ash onto the patio, no ashtray was near the residents-The designated smoking area was left unattended and unsupervised for approximately four minutes, with two Residents (#28 and #29) smoking out of a total of nine present with access to a lighter.On 5/19/26 at 1:00 P.M., during the 1:00 P.M. smoking time, two surveyors observed the following:- Two Activity Aides (#1 and #4) were smoking while supervising the designated smoking time- Resident #7 flicked cigarette ash onto the patio; there was no ashtray near him/her- Activity Aide #1 put a cigarette in his/her mouth, lit it, and passed the cigarette to Resident #29 who smoked itDuring an interview on 5/19/26 at 3:08 P.M., Activity Aide #1 said the Activity Department was responsible for supervising the three designated smoking times. Activity Aide #1 said the Activity Staff was responsible for lighting the residents' cigarettes. Activity Aide #1 said residents are not supposed to use their previous cigarettes or other residents' cigarettes to light another cigarette. On 5/20/26 at 8:51 A.M., during the 8:45 A.M. smoking time, the surveyor observed the following:- One of three activity staff members were vaping- One of three activity staff members were smoking- Two Residents (#28 and #58) were sharing a vape- Resident #34 used (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his/her first cigarette to light his/her second cigarette - Resident #34 snuffed out two cigarettes on his/her wheelchairDuring an interview with observation on 5/20/26 at 9:09 A.M., the surveyor observed Activity Aide #1 assisting Resident #34 back to his/her unit. Activity Aide #1 and the surveyor observed two cigarette butts on Resident #34's wheelchair where the footrest connects to it. Activity Aide #1 said Resident #34 should have extinguished their cigarette and disposed of the cigarette butts in an ashtray. Activity Aide #1 said he/she did not see the extinguished cigarette butts on Resident #34 wheelchair until the surveyor had pointed them out.During an interview on 5/20/26 at 9:10 A.M., Resident #34 said he/she uses his/her first cigarette to light his second cigarette, but the activity staff should light their cigarettes. Resident #34 said if there was not an ashtray near them then they would flick the cigarette ash onto the ground and snuff out his/her cigarette on their wheelchair. Resident #34 said if there was an ashtray near them, then he/she would use it to snuff out his/her cigarette in it.During an interview on 5/20/26 at 9:59 A.M., Activity Aide #5 said residents cannot be left unattended during the designated smoking times and at least one staff member should be present to supervise the residents. Activity Aide #5 said staff members are supposed to light all of the residents' cigarettes especially since some residents are sneaky and will try to take the lighter with them. Activity Aide #5 said some residents do use their first cigarette to light their second cigarette, but they are not supposed to.During an interview on 5/20/26 at 10:05 A.M., the Activity Director said all residents must be supervised if they are a supervised smoker and must not be left unattended and unsupervised while smoking. The Activity Director said all the residents' cigarettes must be lit by a staff member for safety. The Activity Director said while supervising smoking no staff members should be smoking, they are supervising not taking a break.During an interview on 5/20/26 at 11:52 A.M., Unit Manager #1 said there were not any independent smokers in the facility and all of the residents who smoke were supervised. Unit Manager #1 said while supervising the smoking, Activity Staff absolutely should not be smoking, they are supervising smoking not smoking themselves.During an interview on 5/20/26 at 12:07 P.M., the Administrator and the Director of Nursing (DON) said all cigarette ashes and cigarette butts must be disposed of in an ashtray. The Administrator and the DON said cigarettes must be extinguished in an ashtray and not on resident wheelchairs. The Administrator and the DON said residents must be supervised during the designated smoking times and staff needed to light all of the residents' cigarettes. The Administrator and the DON said, If you are smoking, then how are you supervising the residents who are smoking?2. Resident #58 was admitted to the facility in February 2025 with diagnoses including executive function deficit following cerebral infarction (stroke) and nicotine dependence. Review of the Minimum Data Set assessment, dated 3/11/26, indicated Resident #58 was cognitively intact as evidenced by Brief Interview for Mental Status score of 14 out of 15. Review of Resident #58's current Physician's Orders indicated but was not limited to:- Smoker. Resident may smoke with supervision, dated 4/22/25. Review of Resident #58's Smoking and Safety Assessment, dated 5/1/26, indicated but was not limited to:-Which of the following products does the Resident use: Tobacco-Does the Resident display any of the following? Drops ashes on self.-Smoking Safety Notes: -Resident #58 will continue as a supervised smoker but will have to wear the smoking apron on his/her lap. Review of Resident #58's Smoking Safety care plan indicated but was not limited to:-Focus: Resident is a smoker Date Initiated: 02/23/25 Revision on: 08/14/25-Intervention: Resident #58 will wear an apron on his/her lap when smoking, Date Initiated: 5/1/26.On 5/19/26 at 1:09 P.M., two surveyors observed Resident #58 in the designated smoking area, smoking a cigarette, with two staff members present. Resident #58 did not have his/her smoking apron donned (on).During an interview on 5/19/26 at 3:08 P.M., Activity Assistant #1 said the Activity Department was responsible for supervising residents during smoking times. Activity Assistant #1 said Resident #58 recently started wearing a smoking apron because he/she had been dropping cigarette ashes on themselves. Activity Assistant #1 said Resident #58 must wear a smoking apron every time he/she smoked. Activity Assistant #1 said Resident #58 did not have a smoking apron on during the 1:00 P.M. smoking (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time and Activity Assistant #1 and Activity Assistant #4 forgot to put Resident #58's apron on. During an interview on 5/20/26 at 11:52 A.M., Unit Manager #1 said Resident #58 was recently re-evaluated for smoking safety because he/she was observed to put cigarette ashes on his/her chest. She said Resident #58 needed to be supervised and to wear a smoking apron every time he/she smoked for safety.During an interview on 5/20/26 at 12:07 P.M., the DON said residents who smoke needed to wear the required protective clothing/equipment every time they went outside to smoke for safety. The DON said Resident #58 should have had his/her smoking apron on while smoking.

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	225322	A. Building B. Wing	05/20/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and test tray results, the facility failed to ensure staff served palatable, attractive, and flavorful food at appetizing temperatures for two out of two test trays conducted. Findings include: Review of the facility's policy titled General Food Preparation and Handling, undated, indicated but was not limited to: -Food items will be prepared to conserve maximum nutritive value, develop and enhance flavor, and keep free of harmful organisms and substances. On 5/18/26 at 1:30 P.M., the Resident Council meeting was conducted with 18 residents in attendance. During the meeting the residents collectively expressed having ongoing food concerns, with specific complaints including the following: -The facility frequently used canned food for majority of food items; -Foods provided were not appealing, with 17 out 18 residents stating, You should see the appearance and It is terrible and has no taste. During an observation with an interview on 5/18/26 at 11:40 A.M., the surveyor observed the lunch tray line and noted the Mexican rice to be white in color. Dietary Staff #1 said the Mexican rice was made without the red spices because residents said it was too spicy and did not like the rice with the red spices. On 5/18/26 at 11:42 A.M., the food truck containing Test Tray #1 left the kitchen for the Sachem unit and arrived at 11:45 A.M. At 11:59 A.M., the last tray was delivered to a resident. At 12:00 P.M., the surveyor completed a regular texture test tray with the following results in degrees Fahrenheit (F): - Fish taco: 126F, good temperature, good flavor; - Corn: 120F, warm temperature, plain flavor; - Mexican rice: 125F, white in color, lukewarm temperature, rice tasted plain - could not detect any herbs or spices. On 5/19/26 at 11:38 A.M., the food truck containing Test Tray #2 left the kitchen for the Sachem unit and arrived at 11:42 A.M. At 11:57 A.M., the last tray was delivered to a resident. On 5/19/26 at 12:04 P.M., the surveyor and Nurse #3 completed the regular texture test tray with the following results: -Pierogi casserole: 144F, warm, soft texture, flavorful; -Peas: 120F, warm temperature, texture soft and flavor bland; -Cabbage: 123F, lukewarm temperature, flavor bland - no seasoning; Nurse #3 said the peas and cabbage tasted plain with no seasoning. On 5/19/26 at 12:04 P.M., the surveyor completed the mechanical soft test tray with the following results: -Pierogi casserole: 125F, temperature warm not hot, soft texture easy to chew, flavorful; -Peas: 118F, lukewarm temperature, flavor bland with no spices; -Cabbage: 122F, lukewarm, flavor bland with no spices. During an interview on 5/20/26 at 2:33 P.M., the Administrator said food items should be prepared per policy and served at appropriate temperatures.

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	225322	A. Building B. Wing	05/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, 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 potential transmission of communicable diseases and infections. Specifically, the facility failed:1. For Residents #22 and #6, who were on enhanced barrier precautions due to wounds, to ensure staff wore appropriate personal protective equipment (PPE) while providing care;2. For Residents #11 and #9, to ensure proper infection control practices were maintained during a dressing change;3. For Resident #37, who was on contact precaution for Vancomycin Resistant Enterococcus Faecalis (VRE, a species of enterococcus bacteria that have developed resistance to the antibiotic vancomycin) to ensure staff wore appropriate PPE while providing care; and4. To ensure proper infection control practices were followed during the smoking activity. Findings include: Review of the facility's policy titled Precautions to Prevent Infection, revised 12/2023, indicated but was not limited to the following: - Transmission-Based Precautions are for patients who are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. - Enhanced Barrier Precautions, which falls between Standard and Contact Precautions, and requires gown and glove use for certain residents during specific high-contact resident care activities that have been found to increase risk for MDRO (Multi Drug Resistant Organism) transmission. Residents defined at risk are those with indwelling medical devices or wounds who reside on units with residents known to be colonized with a novel or targeted MDRO. - High risk Resident care activities are identified as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device: central line, urinary catheter, feeding tube, tracheostomy/ventilator. - Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or patient's environment. - Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. - Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. - Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE. - Make PPE, including gowns and gloves available immediately outside of the resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure access to alcohol-based hand rub (except in the use of C.difficle and during outbreak). Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. Review of the facility's policy titled Handwashing/Hand Hygiene, revised 7/2025, indicated but was not limited to the following: - This facility considers hand hygiene the primary means to prevent the spread of infections. - All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. - Use of an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before handling clean or soiled dressing, gauze, etc.; after handling used dressings, contaminated equipment, etc.; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; before moving from a contaminated body site to a clean body site; after contact with resident's skin, and after removing gloves. - Single-use disposable gloves should be used when anticipating contact with blood or bodily fluids and when in contact with a resident who is on precautions. - Hand hygiene is the final step after removing and disposing of personal protective equipment. - The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 1A. Resident #22 was admitted to the facility in April 2026 with diagnoses including dementia and chronic obstructive pulmonary disease (COPD). Review of Resident #22's Minimum Data Set (MDS) assessment, dated 4/25/26, indicated he/she was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 1 out of 15. Furthermore, the MDS assessment indicated he/she was at risk for pressure ulcers/injuries and was being treated for skin tears. Review of Resident #22's Physician's Orders indicated but were not limited to: - 4/10/26: Enhanced Precautions – wounds; every shift. On 5/17/26 at 8:55 A.M., the surveyor observed an Enhanced Barrier Precaution (EBP) sign outside Resident #22's room, which indicated the following: - EVERYONE MUST: clean their hands, including before entering and when leaving the room. - Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225322	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy), wound care (any skin opening requiring a dressing). - Do not wear the same gown and gloves for the care of more than one person. On 5/18/26 at 9:19 A.M., the surveyor made the following observations: - Certified Nursing Assistant (CNA) #3 entered Resident #22's room with linens without donning any PPE or completing hand hygiene. - CNA #3 assisted Resident #22 with a transfer from the EOB (edge of bed) to his/her wheelchair. CNA #3 did not have a gown on during the transfer and was only wearing gloves. - At 9:35 A.M., CNA #3 assisted Resident #22 with oral hygiene while he/she was seated in their wheelchair. CNA #3 did not have a gown on while completing the tasks and was only wearing gloves. - At 9:45 A.M., CNA #3 removed and changed linens from Resident #22's bed. CNA #3 was not wearing a gown while completing the removal/changing of linens. During an interview on 5/18/26 at 11:25 A.M., CNA #3 said residents with EBP signs outside of their room require staff to wear a gown and gloves when completing high contact tasks. CNA #3 said a gown and glove needed to be worn when transferring, performing care or changing linens. During an interview on 5/19/26 at 2:27 P.M., Nurse #1 said any resident who has EBP signage requires staff to wear a gown and gloves when performing tasks such as changing linens, providing care or transferring. During an interview on 5/20/26 at 10:14 A.M., the Director of Nursing (DON) said staff should have worn a gown and gloves when providing care and transfers with Resident #22. B. Resident #6 was admitted to the facility in August 2024 with diagnoses including dementia and type II diabetes. Review of Resident #6's MDS assessment, dated 4/25/26, indicated he/she was cognitively impaired as evidenced by a BIMS score of 3 out of 15. Furthermore, the MDS assessment indicated he/she was at risk for pressure ulcers/injuries and was being treated for a diabetic foot ulcer. Review of Resident #6's Physician's Orders indicated but were not limited to: - 1/29/26: Enhanced Precautions; every shift. On 5/17/26 at 8:55 A.M., the surveyor observed an EBP sign outside Resident #6's room, which indicated the following: - EVERYONE MUST: clean their hands, including before entering and when leaving the room. - Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy), wound care (any skin opening requiring a dressing). - Do not wear the same gown and gloves for the care of more than one person. On 5/18/26 at 9:46 A.M., the surveyor made the following observations: - CNA #3 entered Resident #6's room and put dirty linens from his/her bed in a bag and brought them out to the hallway. CNA #3 did not put on a gown prior to entering Resident #6's room. CNA #3 did not perform hand hygiene prior to entering the Resident's room. - CNA #3 then brought clean linens into Resident #6's room. CNA #3 did not perform hand hygiene prior to entering the room. - At 9:50 A.M., CNA #3 entered Resident #6's room and put new linens on their bed. CNA #3 did not don (put on) a gown prior to completing the linen change. During an interview on 5/18/26 at 11:25 A.M., CNA #3 said residents with EBP signs outside of their room require staff to wear a gown and gloves when completing high contact tasks. CNA #3 said a gown and glove needed to be worn when transferring, performing care or changing linens. During an interview on 5/19/26 at 2:27 P.M., Nurse #1 said any resident who has EBP signage requires staff to wear a gown and gloves when performing tasks such as changing linens, providing care or transferring. During an interview on 5/20/26 at 10:14 A.M., the DON said staff should have worn a gown and gloves when completing linen changes in Resident #6's room. 2A. Resident #11 was admitted to the facility in December 2025 with diagnoses including cerebral infarction and stage 4 pressure ulcer of heel (stage 4 pressure ulcer is characterized by full-thickness tissue loss that exposes underlying muscle, tendon or bone). Review of Resident #11's MDS assessment indicated he/she was cognitively impaired as evidenced by a BIMS score of 3 out of 15. Furthermore, the MDS assessment indicated he/she was dependent for functional mobility, was at risk for pressure ulcers/injuries and had two stage four pressure ulcers. Review of Resident #11's Physician's Orders indicated but were not limited to the following: - 5/26/26: To right heel wound: NSW (normal saline wash) followed by hydrofera blue foam, cover with ABD pad (abdominal pad), wrap with kling; every day shift every Tuesday, Thursday, and Saturday and as needed. - 5/5/26: To left heel wound: NSW followed by hydrofera blue foam, cover with ABD pad, wrap with kling; every day shift every Tuesday, Thursday, and Saturday and as needed. On 5/19/26 at 9:09 A.M., the surveyor observed a dressing change with the Assistant Director of Nursing (ADON), who is also the wound round nurse. The following observations were made: (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- ADON completed hand hygiene prior to donning PPE (gown/gloves) before entering Resident #11's room. - After donning a gown and gloves, the ADON used her gloved hands to touch her laptop computer to confirm the Resident's dressing orders. With the same gloved hands, the ADON then opened two drawers of the treatment cart to gather the supplies for the dressing changes. - The ADON then entered Resident #11's room and placed the dressing supplies down on Resident #11's bedside dresser. - The ADON used her scissors to remove the old dressings from the right and left heels, removed her gloves, completed hand hygiene and put on new gloves. - With the new gloves donned, the ADON returned to the treatment cart and opened a drawer to gather more supplies (gauze pads) to complete the dressing changes. The ADON did not change her gloves after opening the cart and did not perform hand hygiene. - The ADON used her scissors to cut the hydrofera blue dressing to the shape of Resident #11's wound. The scissors used were not cleaned in between removing the old dressings and cutting the new treatment. - The ADON applied the dressing to the right heel and then applied the dressing to the left heel. The ADON did not change her gloves between the right heel and left heel dressings, nor did she perform hand hygiene. - The ADON grabbed linens (hand towels placed under each heel) used during the dressing changes from Resident #11's bed and then grabbed the treatment supplies with the same gloved hands used to pick up the linens. - The ADON placed the used linens down on a chair in Resident #11's room and brought the treatment supplies back to the cart outside of the Resident's room and placed them on top of the cart. The ADON then removed her PPE and completed hand hygiene. During an interview on 5/19/26 at 12:12 P.M., the ADON said she should have changed gloves between touching the treatment cart and removing Resident #11's old dressings. The ADON said she does not typically change her gloves when putting on Resident #11's new dressings because they are the same treatment. The ADON said she should have put the dirty linens in a bag and changed her gloves before bringing the treatment supplies back to the treatment cart. During an interview on 5/20/26 at 10:14 A.M., the DON said hand hygiene and glove changes are expected after removal of old dressings, when a staff member comes in contact with a surface such as a computer or treatment cart, as well as when there is contact with dirty linens. B. Resident #9 was admitted to the facility in December 2023 with diagnoses which included protein-calorie malnutrition, Peripheral Vascular Disease (PVD-circulation disorder), Diabetes Mellitus with diabetic neuropathy (nerve damage commonly affecting the feet and legs causing numbness/pain). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 5/4/26, indicated Resident #9 scored 14 out of 15 on the BIMS Assessment indicating he/she was cognitively intact, had PVD, a Multi-Drug-Resistant Organism (MDRO-bacteria resistant to multiple standard antibiotics), septicemia (serious life-threatening bloodstream infection), a wound infection, and had a surgical wound. Review of the Physician's Orders indicated but were not limited to the following: -Enhanced Barrier Precautions every shift related to wound. -Left Transmetatarsal Amputation (TMA-surgical procedure that removes the front part of the foot) Normal Saline Wash (NSW), pat dry, apply mupirocin ointment (prescription strength topical antibiotic) followed by bordered gauze dressing every day. On 5/20/26 at 1:15 PM., the surveyor observed Nurse #3 perform wound care to Resident #9 as follows: -Nurse #3 donned (put on) a gown and gloves at the doorway to Resident #9's room, entered the room with the wound care supplies and set the supplies on the table. -Resident #9 was lying in bed, the left leg was exposed, and the TMA site was covered with a visibly soiled dressing, and there was a foul odor. The non-skid sock that had been over the dressing was visibly soiled with brown/yellow drainage. -Nurse #3 poured the NSW onto the bordered gauze dressing, removed the soiled dressing, and set it aside. The dressing had brown and yellow drainage on it and the wound had a foul odor. The wound bed was red with grey slough (necrotic (dead) tissue that may be moist, loose, or stringy), the peri wound (surrounding skin) was red, tender, and edematous (swollen due to excess fluid). -Nurse #3 cleansed the wound with NS and then patted the wound dry. Nurse #3 did not change her gloves and used the same ones she used to remove the soiled dressing. -Nurse #3 measured the wound with a disposable tape measure using the same gloves used to remove the soiled dressing. -Nurse #3 picked up the tube of Mupirocin Ointment, opened the cover, and started to squeeze the ointment out of the tube directly onto the wound. She stopped before touching the wound, placed the tube back on the table and removed her soiled gloves. -Nurse #3 put clean gloves on without performing hand hygiene after removing the soiled gloves. -Nurse #3 picked the Mupirocin Ointment up from the table and squeezed the ointment onto her gloved fingers and spread the ointment on the wound bed. -Nurse #3 removed her gloves (did not perform hand hygiene) and then removed a permanent marker from her pocket and wrote the date on the bordered gauze dressing that was open on the table. -Nurse #3 applied the bordered gauze dressing to the TMA wound site with her bare ungloved hands, rubbing all 4 sides to fully secure the adhesive border, then applied tape to two of the sides to further secure the dressing. (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #3 picked up a non-skid sock from the pile, confirmed the sock Resident #9 wanted to wear, and walked to the bathroom. Nurse #3 got a pair of gloves from the bathroom and applied them without performing hand hygiene, walked back to the bedside and put the sock over the dressing, disposed of the trash, and bagged the soiled linen. -Nurse #3 removed the soiled gloves, the gown had thumb loops to hold the sleeves in place, the loops were still on her hands, hand sanitizer was applied and rubbed in with the plastic gown thumb loops still on her hands. The gown was then removed, rolled, and disposed of in the trash. The surveyor did not observed Nurse #3 perform hand hygiene after removing the gown. The table used during the dressing change was wheeled out of the room and down the hallway to be cleaned. During an interview on 5/20/26 at 1:35 P.M., Nurse #3 said Resident #9 is on EBP for their wounds and staff must wear a gown and gloves when they do care. She said when doing wound care you should sanitize your hands, remove the old dressing, clean the wound, change your gloves to put the new dressing on, and then sanitize or wash your hands when you are done. She said you should do hand hygiene between glove changes, but she did not. She said sometimes she forgets. Additionally, she said she should have put clean gloves on to apply the new dressing and not done that with her bare hands. During an interview on 5/20/26 at 1:41 P.M., Unit Manager #2 said everyone should have a gown and gloves on to perform any high contact care for Resident #9, including dressing changes. She said hands should be sanitized between glove changes, gloves should be worn to apply a dressing, and hands should be sanitized or washed after removing the gown before exiting the room. During an interview on 5/20/26 at 2:03 P.M., the ADON/Wound Nurse said hand hygiene should be done when you enter/exit a room and between glove changes. Additionally, staff should wear gloves when applying a dressing to a wound. During an interview on 5/20/26 at 2:37 P.M., the DON said gloves should be worn during dressing changes and hand hygiene should be done when entering/exiting a room and between glove changes. 3. Review of the Centers for Disease Control Management of Multidrug-Resistant Organisms in Healthcare Settings, last revised 2/15/17, indicated but not limited to: - Contact precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are transmitted by direct or indirect contact with the patient or the patient's environment. -Healthcare Personnel caring for patients on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. - Donning gown and gloves upon room entry and discarding before exiting the patient room is done to contain pathogens (example VRE). Resident #37 was admitted to the facility in April 2026 with diagnoses including benign prostatic hyperplasia (BPH - is a noncancerous enlargement of the prostate gland) and presence of urogenital implants (surgical placement of medical devices within the urinary tract). (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS Assessment, dated 4/17/26, indicated Resident #37 had a moderate cognitive deficit as evidenced by a BIMS score of 10 out of 15 and he/she had a suprapubic catheter (a flexible tube inserted through the abdomen directly into the bladder to drain urine when natural urination isn't possible). Review of Resident #37's Physician's Orders indicated but was not limited to: - Maintain VRE precautions (contact precautions) urine every shift, dated 4/29/26 - Suprapubic Catheter Site Care- maintain Enhanced Precautions every shift, dated 5/7/26 Review of Resident #37's Urine Culture results, dated 5/15/26, indicated but was not limited to: - Organism: Vancomycin Resistant Enterococcus Review of the CDC Contact Precautions sign, undated, posted outside of Resident #37's room indicated but was not limited to: - Everyone must: Clean their hands, including before entering and when leaving the room. - Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Review of the CDC EBP sign, undated, posted outside of Resident #37's room indicated but was not limited to: - EVERYONE MUST: clean their hands, including before entering and when leaving the room. - Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing On 5/17/26 at 8:38 A.M., the surveyor observed CNA #2 providing morning care to Resident #37 as follows: - CNA #2 donned gloves but failed to don a gown. - CNA #2 assisted Resident #37 in applying his/her shoes. - CNA #2 doffed her gloves, performed hand hygiene and exited Resident #37's room. - CNA #2 returned to Resident #37's room, performed hand hygiene and donned gloves. - CNA #2 failed to don a gown prior to entering Resident #37's room. - CNA #2 removed soiled linen from Resident #37's bed and placed them in the soiled linen cart. (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/17/26 at 8:43 A.M., CNA #2 said Resident #37 was on EBP because he/she had a catheter. CNA #2 said she only needed to wear a gown when doing care. On 5/18/26 at 7:06 A.M., the surveyor observed CNA #1 assisting Resident #37 with activities of daily living as follows: - CNA #1 donned gloves. - CNA #1 failed to don a gown prior to entering Resident #37's room. On 5/18/26 at 7:16 A.M., CNA #1 said he was not sure why Resident #37 was on contact precautions. CNA #1 said he had donned gloves prior to providing care but had not donned a gown. On 5/18/26 at 7:15 A.M., the surveyor made the following observations: - CNA #4 performed hand hygiene and donned gloves. - CNA #4 put shoes on Resident #37. - CNA #4 failed to don a gown prior to entering Resident #37's room. During an interview on 5/19/26 at 3:04 P.M., CNA #4 said he was not aware why Resident #37 was on contact precautions. CNA #4 and the surveyor reviewed CDC Contact Precaution sign outside Resident #37's room. CNA #4 said he did not don a gown prior to providing care to Resident #37, but he should have. On 5/19/26 at 8:10 A.M., the surveyor made the following observations: -Unit Manager #1 entered Resident #37's room and removed his/her breakfast tray. -Unit Manager #1 failed to don gloves or a gown. During an interview on 5/20/26 at 10:14 A.M., the DON, who is also the facility's Infection Preventionist (IP), said if there is an EBP sign and a Contact Precaution sign outside of a resident's room then staff must follow the higher precautions. During an interview on 5/20/26 at 11:50 A.M., Unit Manager #1 said Resident #37 had VRE in his/her urine. She said Resident #37's urine was contained in his/her catheter drainage bag. She said she would only don gloves and a gown if emptying Resident #37's catheter drainage bag, providing care, or when there is a risk of coming into contact with Resident #37's urine. During an interview on 5/20/26 at 12:07 P.M., the IP said Resident #37 had VRE in his/her urine. She said staff, prior to entering or exiting Resident #37's room, must perform hand hygiene, and don/doff gloves and a gown. 4. Review of the facility's policy titled Smoking Policy- Residents, revised July 2025, indicated but was not limited to: - The facility shall establish and maintain safe resident smoking practices. (continued on next page)

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	225322	A. Building B. Wing	05/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Residents are not permitted to give smoking articles to other residents. On 5/18/26 at 1:02 P.M., during the 1:00 P.M. smoking time, two surveyors observed the following breaches in infection control: - Activity Aide #3 put a cigarette in his/her mouth, lit it, and passed it to Resident #58 who smoked it. On 5/19/26 at 8:50 A.M., during the 8:45 A.M. smoking time, the surveyor observed the following breaches in infection control: - Activity Aide #4 put a cigarette in his/her mouth, lit it, and gave it to Resident #28 who smoked it. On 5/19/26 at 1:09 P.M., during the 1:00 P.M smoking time, two surveyors observed the following breaches in infection control: -Activity Aide #1 put a cigarette in his/her mouth, lit it, and passed the cigarette to Resident #29 who smoked it. -Resident #28 smoked a vape and passed it to Resident #58 who took a puff of the vape 3 different times. During an interview on 5/19/26 at 3:08 P.M., Activity Aide #1 said the Activity staff were responsible for lighting the residents' cigarettes. Activity Aide #1 said sometimes if a resident cannot ignite their own cigarette from a lighter then staff would do it for them. Activity Aide #1 said he/she would put the cigarette in their mouth and light/ignite it, then pass it to the resident to smoke. During an interview on 5/19/26 at 9:50 A.M., Activity Aide #2 said residents should not share any smoking or vaping materials. Activity Assistant #2 said if he/she saw residents sharing smoking or vaping materials he/she would intervene. Activity Assistant #2 said he/she would not intervene when Resident #28 and Resident #58 shared smoking or vaping materials because they were friends. During an interview on 5/20/26 at 9:59 A.M., Activity Aide #5 said staff should never put resident smoking materials in their mouth because it is unsanitary. Activity Aide #5 said residents should not share smoking/vaping materials for infection control reasons. During an interview on 5/20/26 at 10:05 A.M., the Activity Director said all residents must be supervised. The Activity Director said staff should intervene if residents are sharing smoking/vaping materials. The Activity Director said staff should never put residents' smoking materials into their mouth and light it. During an interview on 5/20/26 at 11:52 A.M., Unit Manager #1 said residents should never share smoking/ vaping materials and staff should never put residents smoking materials into their mouth for infection control reasons. During an interview on 5/20/26 at 12:07 P.M., the DON, who is also the facility's IP, said for infection control concerns staff should never put smoking materials that belong to residents into their mouth and residents should not be sharing smoking materials.

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	225322	A. Building B. Wing	05/20/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record reviews, the facility failed to provide care and services consistent with professional standards for one Resident (#5), out of a total sample of 19 residents. Specifically, the facility failed to implement a physician's order for a left-hand roll. Findings include:Review of Lippincott Manual of Nursing Practice 11th edition, dated 2019, indicated the following:- The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated:- Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.- In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Resident Mobility and Range of Motion (ROM), undated, indicated but was not limited to the following:- Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM.- Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.- The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion.- Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. Resident #5 was admitted to the facility in January 2024 with diagnoses including Alzheimer's disease and muscle weakness. Review of Resident #5's Minimum Data Set (MDS) assessment, dated 5/7/26, indicated he/she was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Furthermore, the MDS assessment indicated Resident #5 required assistance from staff for functional mobility and had a range of motion impairment of one upper extremity affecting function. Review of Resident #5's Physician's Orders indicated but were not limited to the following:- 11/18/25: [NAME] (put on) hand roll to L (left) hand after A.M. care and doff (remove) with P.M. care. Check skin daily after removing; every shift. Review of Resident #5's Self-Care Performance Care Plan, last revised 7/17/25, indicated the following intervention:- Left hand roll on in A.M. and remove at HS (nighttime) - monitor skin for breakdown due to use (initiated 4/8/26). On the following dates/times, the surveyor observed Resident #5 without a left-hand roll donned:- 5/17/26 at 8:56 A.M.,- 5/18/26 at 10:05 A.M.,- 5/18/26 at 11:20 A.M.,- 5/18/26 at 2:49 P.M., and- 5/19/26 at 10:10 A.M. Review of Resident #5's May 2026 Treatment Administration Record (TAR) indicated his/her left-hand roll was administered as ordered by the physician. During an interview on 5/19/26 at 2:29 P.M., Nurse #1 said orders for adaptive equipment such as a hand roll come up on the TAR for administration. Nurse #1 said the nurse assigned to the resident when the order populates would make sure the device is put on appropriately and check the skin if applicable. Nurse #1 reviewed Resident #5's physician's orders with the surveyor and said Resident #5 had an order for a left-hand roll and it was to be placed on each morning. During an interview on 5/20/26 at 8:25 A.M., the Director of Nursing (DON) said she would expect any physician's orders for a hand roll to be administered as ordered. The DON said nursing staff should complete the treatment so they can also ensure there are no changes in skin integrity. The DON and the surveyor reviewed the observations made during the survey process and reviewed the TAR. The DON said the nurses did not indicate the Resident refused the left-hand roll and it should have been put on as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225322	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sachem Center for Health and Rehabilitation	66 Central Street East Bridgewater, MA 02333

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to:-Ensure food items were properly dated and stored in the main kitchen; and-Ensure the main kitchen and food storage areas were maintained in a sanitary and safe condition. Findings include:Review of the 2022 Food Code by the United States Food and Drug Administration (FDA) indicated, but was not limited to: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. 3-305.12 Food Storage, Prohibited Areas. FOOD may not be stored:(G)Under leaking water lines, including leaking automatic fire sprinkler heads, or under lines on which water has condensed;(I) Under other sources of contamination. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Except when PACKAGING FOOD using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 Celsius (41 Fahrenheit) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3- 501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). 6-101.11 Surface Characteristics. (A) Except as specified in (B) of this section, materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: (1) SMOOTH, durable, and EASILY CLEANABLE for areas where FOOD ESTABLISHMENT operations are conducted. Smooth means: (3) A floor, wall, or ceiling having an even or level surface with no roughness or projections that render it difficult to clean. Review of the facility's policy titled (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	General Food Preparation and Handling, undated, indicated but was not limited to:-Food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and keep free of harmful organisms and substances;-Leftovers must be dated, labeled, covered, cooled and stored (within 1/2 hour after cooking or service) in a refrigerator;-Use leftovers within 7 days per 2013 Food Code or discard. Check state regulations for more details. Review of the facility's policy titled Food Storage, undated, indicated but was not limited to:-Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination;-Storage areas will be free from rodent and insect infestation;-All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods;-Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2017 Federal Food Code;-Refrigerated food storage: all foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. Review of the facility's policy titled Dry Storage Areas, undated, indicated but was not limited to:-Dry storage areas will be maintained to keep food safe and free of infestation or contamination;-floors, walls, shelves and other storage areas will be kept clean;-canned and dry foods should be labeled with date of receipt so that they will be used within six months of delivery (or according to the manufacturer's guidelines). -the storeroom will be cleaned on a regular basis. Floors will be swept and mopped at least weekly and more often as needed. On 5/17/26 at 7:25 A.M., the surveyor observed the following in the refrigeration units:-one container of prepared turkey with a use by date of 5/16/26;-one container of prepared rice with a use by date of 5/16/26;-Shredded lettuce wilted and slightly brown with no label or date;-one container of prepared tuna salad with use by date of 5/15/26;-one plastic container of beets wrapped in plastic with use by date of 5/14/26;-one open carton of nectar thickened apple juice, dated 5/5, with manufacturer's instructions to discard 7 days after opening;-one open carton of nectar thickened cranberry juice, dated 5/7, with manufacturer's instructions to discard 7 days after opening;-one open carton of nectar thickened orange juice, dated 5/7, with manufacturer's instructions to discard 7 days after opening;-one clear pitcher containing yellow thickened fluid labeled puree covered with plastic wrap with no date;-honeydew melon covered in plastic wrap with no date;-one small cup of diced cucumber with no label or date;-one small cup of diced ham with no label or date;-one small cup labeled turkey salad with no date;-one container of frozen egg product covered in plastic wrap with use by date of 5/6/26 with manufacturer instructions indicated: Thawed product at 40 F (degrees Fahrenheit) or below, use within 3 days after opening. Thawing instructions: place frozen container in refrigerator at 40 F or below up to 3 days; and,-one tray holding many small single serve sized cups of condiments with no label or date on the tray or cups. On 5/17/26 at 7:25 A.M., the surveyor observed mouse droppings underneath food storage shelving in the dry storage room. On 5/18/26 at 7:45 A.M., the surveyor observed in the main kitchen:-one container of opened teriyaki sauce on dry storage shelf in prep area, half full and warm to touch, with manufacturer best by date of 1/14/22 and manufacturer instructions to refrigerate after opening;-one container of refrigerated liquid egg product dated 5/3/26-5/6/26; -boxes of vegetables open to air in the walk-in refrigerator housed on shelves that were extensively rusted; and-ceiling grid (metal rails that hold the drop ceiling in place) throughout the main kitchen were peeling- located over food prep and food service areas and in areas where clean kitchenware and cookware were held and stored. On 5/18/26 at 1:40 P.M., the surveyor observed the following in the dry storage room: -three bags of crispy onion topping, one with best by date of 9/30/23 and two with best by date of 9/18/24;-three cans of diced chili peppers dated as received on 5/31/19 with no discernable use by or best by date;-large, dried splotch of red liquid substance on the floor underneath the shelving that held containers of barbecue sauce; -mouse droppings in one area near a white sticky pad underneath the food shelves. During an interview on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/20/26 at 2:15 P.M., Dietary Aide #1 said all prepared and opened food should be labeled and dated and dated food items should be discarded once they are beyond their use by date. During an interview with Dietary Aide #1 and the Registered Dietitian (RD) on 5/20/26 at 2:15 P.M., Dietary Aide #1 said the Food Service Director, who was not in the facility during survey, typically oversees the dry storage area though staff operate on a first in, first out method of food rotation. She said she was unsure of the storage protocol for foods several years past their best by dates, such as the bags of crispy onion topping, however she discarded them just to be safe. The RD said any food that is several years beyond its best by date should be discarded. Dietary Aide #1 also said she was unsure of the protocol for canned foods that were dated as received approximately six years ago with no manufacturer date on item, however she discarded them to be safe. During the same interview and observation on 5/20/26 at 2:15 P.M., the RD, Dietary Staff #1, and the Surveyor observed the spilled red residue and mouse dropping on the floor in the dry storage room. Dietary Aide #1 said the dry storage room floor should be swept and mopped daily but it does not appear that staff are doing that. The RD and Dietary Aide #1 said they would expect the floor to be clean of debris and pest droppings. During an interview on 5/20/26 at 2:15 P.M., the RD, Dietary Aide #1, and the Surveyor observed the rusted walk-in refrigerator shelves and the peeling ceiling rails throughout the main kitchen. Dietary Aide #1 said despite the shelves being rusty, they were cleaned regularly. The RD said she expected the ceiling rails to be smooth and not peeling. During an interview on 5/20/26 at 2:33 P.M., the Administrator said shelving in the main kitchen should not be rusted, the ceiling rails should be smooth, not peeling, and the floors in the kitchen and food storage areas should be clean with no spills or debris or mouse droppings.