STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225338	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 2. Resident #68 was admitted to the facility in September 2022 with diagnoses including retention of urine, hydronephrosis (a condition characterized by excess fluid in a kidney due to a backup of urine), and obstructive and reflux uropathy (obstructive uropathy is a condition in which the flow of urine is blocked, causing urine to back up and injure one or both kidneys). Review of the MDS assessment, dated 04/11/25, indicated Resident #68 was cognitively impaired, as evidenced by a BIMS score of 1 out of 15. Further review of the MDS indicated he/she had an indwelling catheter. On 05/14/25 at 10:30 A.M., the surveyor observed Resident #68 lying in bed with the urinary drainage bag positioned on the left upper rail of the bed, facing the doorway. The drainage bag was fully visible and not placed in a private bag to conceal it from view. On 05/15/25 at 08:50 A.M., the surveyor observed Resident #68 sitting in bed, with the urinary drainage bag positioned on the left upper bed rail. The bag contained visible urine and was not placed in a privacy bag. During an interview on 05/15/25 at 09:00 A.M., CNA #10, along with the surveyor, observed the Resident's urinary catheter bag positioned on the left upper side rail facing the doorway, without a privacy bag. CNA #10 stated that there should be a privacy bag covering the catheter bag but was unsure why the overnight staff did not apply one. During an interview on 05/16/25 at 02:05 P.M., Unit Manager #3 stated that staff are required to keep urinary catheter bags covered to maintain privacy. During an interview on 05/20/25 at 11:45 A.M., the Director of Nursing stated that she was unaware that Resident #68's urinary drainage bag had not been covered for privacy. She said that it should always be placed in a privacy bag. During an interview on 05/20/25 at 01:45 P.M., CNA #9 stated that the catheter drainage bag must be covered to uphold the Resident's dignity. During an interview on 05/20/25 at 02:40 P.M., CNA #8 stated that the urinary catheter drainage bag must be covered to maintain the Resident's privacy. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure two Residents (#47 and #68) were treated with dignity and respect, in a total sample of 23 residents. Specifically, the facility failed: 1. To engage with Resident #47 using their preferred name (their first name shortened to a nickname), after being informed of the preferred name by the family; and 2. To provide a privacy bag to cover the urinary catheter bag of Resident #68. Findings include: 1. Review of the facility's policy titled Comprehensive Care Plans, dated November 2017, indicated the following: -recognizing each resident as an individual, we identify and meet those needs in a resident-centered environment -care plans reflect resident preferences Resident #47 was admitted to the facility in October 2024 with a diagnosis of bipolar disorder with a history of mental illness. Review of the Minimum Data Set (MDS) assessment, dated 4/11/25, indicated Resident #47 scored 15 out of 15 on the Brief Interview for Mental Status, indicating he/she was cognitively intact and the Resident had an activated Health Care Proxy. Review of the medical record indicated Resident #47 had participated in the initial Social Service and Recreation interviews and was able to provide his/her own history. Review of the medical record indicated Resident #47 had been verbal and participating in conversations and then after many months at the facility had started whispering and was difficult to understand. The medical record failed to indicate Resident #47 had been asked what he/she preferred to be called. Review of the care plans for Resident #47 failed to indicate the Resident's preferred name and referred to the Resident as Resident or {Full First Name}. During an interview on 5/14/25 at 11:40 A.M., the sister of Resident #47 said she lived five hours away and had been unable to visit the Resident in the last six months. She said there may have been a communication issue because the staff had been calling the Resident by his/her last name and then demonstrated {last name}, {last name}. She said she had to tell the staff what the Resident's name was and when the staff said the Resident's preferred name the Resident had responded right away, adding something as simple as that might be helpful. She said she was putting a sign up in the Resident's room indicating the Resident's preferred name. On 5/14/25 at 4:21 P.M., the surveyor observed Resident #47 lying in bed. There was a handwritten sign on the bulletin board in the Resident's room and one on the Resident's headboard indicating the Resident preferred to be called by their nickname. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 10:52 A.M., Certified Nursing Assistant (CNA) #6 said Resident #47 could resist care at times and needed a lot of redirection. She said the Resident whispered and did not always speak full sentences but could make his/her needs known. She said the staff usually called the Resident {Last Name}, but that she had seen a sign in the Resident's room this morning indicating to call the Resident by their nickname. During an interview on 5/15/25 at 11:35 A.M., Unit Manager #3 said Resident #47 had transferred to this unit in January 2025 and had been whispering when he/she arrived to the unit. He said he was not sure why the staff called the Resident {Last Name} and had just learned from the family that the Resident preferred to be called their nickname. On 5/15/25 at 3:45 P.M., the surveyor observed Nurse #3 redirect Resident #47 away from the elevator and said the following: {Last name}, let's get a ginger ale {Last name}, let's get a cookie The Resident was observed to start to walk away and the nurse responded, {Last Name}, {Last Name} then began to walk Resident #47 toward their room saying come {Last Name}. {Last Name}? During an interview on 5/16/25 at 9:10 A.M., Social Worker #2 said she did not know the sister of Resident #47 had placed signs in the Resident's room indicating the Resident's preferred name. She said she had always referred to the Resident by their nickname. She said she was not sure if the facility had ever asked the Resident what their preferred name was, but the staff should be following it. She said she had heard staff call the Resident by their last name, but she was not sure how that had initiated. She said all staff should be made aware of the Resident's preference to be called by their nickname.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview, the facility failed to ensure advanced directives for one Resident (#116), out of total sample of 23 residents, were executed in accordance with the Resident's wishes, specifically, their Medical Orders for Life Sustaining Treatment (MOLST medical order form that relays instructions between health professionals about a patient's care based on an individual's right to accept or refuse medical treatment). Findings include: The Facility does not have a policy for Advanced Directive formulation. Resident #116 was admitted to the facility in April 2025 with diagnoses including vascular dementia, psychotic disturbance, mood disturbance, and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 4/17/25, indicated Resident #116 scored 3 out of 15 on the Brief Interview for Mental Status exam which indicated he/she had severe cognitive impairment. On 05/14/25 at 01:54 P.M., the surveyor and Unit Manager #3 reviewed Resident #116's electronic medical record which indicated that the Resident's code status was Full Code. Review of the paper record included a valid MOLST, dated 1/16/25, indicating Resident #116's wishes were for Do Not Resuscitate, Do Not Intubate, Transfer to Hospital. The medical record failed to indicate the MOLST was enacted by the facility. During an interview on 5/16/25 at 1:48 P.M., Unit Manager (UM) #3 reviewed Resident #116's paper medical record and said a valid MOLST was signed by the Resident's Health Care Agent in January (prior to admission). The facility did not enact the Resident's MOLST, instead making the Resident a Full Code.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Resident's physician and activated Health Care Proxy (HCP) about a significant medication error so as to re-evaluate the potential need to alter the treatment plan for one Resident (#76), from a total sample of 23 residents. Specifically, the facility failed to notify the primary physician and health care proxy of a medication reconciliation error resulting in Resident #76 receiving nine additional doses of Eliquis (apixaban) (an anticoagulant medication used to treat and prevent blood clots). Findings include: Review of the facility's policy titled Medication Error Reporting, dated April 2015, indicated, but was not limited to the following: -A medication error is any preventable event that may cause or lead to inappropriate medication use, which the medication is in the control of the health care professional. -A medication error report is to be completed immediately after an error is discovered to ensure proper resident/patient follow-up. -Notify the Nurse Manager/Supervisor immediately -The person finding the error is responsible for completing the Medication Error Report and forwarding it to the Director of Nursing (DON) immediately -The DON or designee is responsible for evaluating the severity of medication errors on each error using the information on the Medication Error Report Review of the facility's policy titled Condition: Significant Change, dated April 2015, indicated but was not limited to the following: -Professional staff will communicate with the physician, resident/patient, and family regarding changes in condition to provide timely communication of resident/patient status change which is essential to quality care management. -The physician, resident/patient and/or responsible party will be notified by the nurse in the event of a change in condition. -This notification shall be documented in the clinical record. Resident #76 was admitted to the facility in August 2024 with diagnoses including osteomyelitis (infectious inflammation of the bone marrow) of the left tibia/fibula (two long bones in lower leg). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 1/24/25, indicated Resident #76 had a Brief Interview for Mental Status (BIMS) exam score of 13 out of 15, indicating he/she was cognitively intact. Resident #76's Health Care Proxy (HCP) was invoked on 11/13/24 due to encephalopathy (disturbance in brain function due to infection). Review of the medical record indicated Resident #76 was hospitalized in May 2025 for a scheduled left knee fusion due to osteomyelitis. Review of the Discharge summary, dated [DATE] at 4:03 P.M., indicated the Resident was to begin taking Eliquis 2.5 milligram (mg) tablets in the morning and Eliquis 2.5mg before bedtime per day (for a total dose of 5 mg per day) for 30 days. Review of the Physician's Orders and the electronic Medication Administration Record (eMAR) indicated the Eliquis order had been entered twice as follows: Eliquis Order #1: -Eliquis oral tablet 2.5mg: Give one tablet by mouth two times a day for {sic} prevent blood clots. Administered on the following dates and times: 5/11/25 at 8:00 A.M. and 8:00 P.M. 5/12/25 at 8:00 A.M. and 8:00 P.M. 5/13/25 at 8:00 A.M. and 8:00 P.M. 5/14/25 at 8:00 A.M. and 8:00 P.M. 5/15/25 at 8:00 A.M. Eliquis Order #2: -Eliquis oral tab 2.5mg: Give 2.5mg by mouth two times a day for anticoagulation until 6/10/25, for 30 days. Administered on the following dates and times: 5/11/25 at 8:00 A.M. and 5:00 P.M. 5/12/25 at 8:00 A.M. and 5:00 P.M. 5/13/25 at 8:00 A.M. and 5:00 P.M. 5/14/25 at 8:00 A.M. and 5:00 P.M. 5/15/25 at 8:00 A.M. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the eMAR indicated Resident #76 received Eliquis 2.5 mg two tablets (5 mg) for five days in the morning and Eliquis 2.5mg two tablets (5 mg) for four days in the evening, resulting in Resident #76 receiving nine additional doses of the medication than indicated on the discharge summary. On 5/15/25 at 2:45 P.M., the surveyor informed Unit Manager (UM) #2 of the possible duplicate order for Eliquis. During an interview on 5/15/25 at 3:40 P.M., UM #2 said it was a repeat order, and she discontinued one of the orders. Review of the physician's orders on 5/19/25 indicated one of the Eliquis orders had been discontinued on 5/15/25. Further review of the physician and nursing progress notes failed to indicate the physician, or HCP had been notified of the nine extra doses administered of Eliquis 2.5mg due to the duplicate order. During an interview on 5/19/25 at 1:15 P.M., UM #2 said she reviewed Resident #76's medication orders after the surveyor informed her of the possible duplicate order. UM #2 said she compared the Resident's current orders with the discharge summary provided by the hospital and found it was inadvertently placed into the computer twice. UM #2 said she notified the Assistant Director of Nursing (ADON) of the medication error and was instructed to discontinue one of the orders. UM #2 said she did not notify the physician or the HCP of the error, and she did not complete an incident report or investigation, she only notified her ADON. During an interview on 5/20/25 at 10:43 A.M., Family Member #1 said Resident #76's HCP has been invoked because he/she had developed confusion from an infection. She said she spoke with a nurse when Resident #76 returned from the hospital and reviewed his/her pain medication regimen. She said the facility has not discussed any other concerns with her. During an interview on 5/20/25 at 11:47 A.M., the ADON said UM #2 informed her of the duplicate order for Eliquis on 5/15/25 and she instructed UM #2 to notify the physician and discontinue the order. The ADON said when a medication error occurs the physician and HCP must be notified and a medication error report completed. The ADON said she did not notify the physician, HCP or complete a medication error report. She said she thought UM #2 did and would have to investigate it now. During an interview on 5/20/25 at 2:49 P.M., the Director of Nursing (DON) said when there is a suspected medication error, the nurse must notify the DON, the family and the physician. She said the resident must also be monitored for potential complications due to the error, and implement any new physician orders. The surveyor and DON reviewed Resident #76's medical record, and she said there is no documentation of the medication error or physician/HCP notification. She said the proper protocol was not followed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to ensure residents had a homelike environment. Specifically, the facility failed to: 1. Ensure a comfortable and homelike dining experience in one of three dining rooms; and 2. Repair a water damaged wall area around a built-in wall unit air conditioner. Findings include: 1. During dining observations throughout the survey on 5/14/25, 5/15/25, and 5/16/25, surveyors observed the following: On 5/14/25 from 8:15 A.M. through 8:30 A.M., the surveyor observed the third-floor dining room: -Five residents were seated at one round folding table (different than the other five tables), no tablecloth, all breakfast meals were served on trays -Seven out of 13 residents were served from the first meal truck and all meals were served on the meal trays -None of the six tables had tablecloths -At 8:38 A.M., the remaining six residents received their breakfast meal with the plates, bowls and cups remaining on the meal trays. On 5/14/25 at 12:30 P.M., the surveyor observed the third-floor unit dining room. All six tables had maroon tablecloths and all plates, bowls and cups were served on the table and not on a meal tray. On 5/15/25 at 8:20 A.M., the surveyor observed the third-floor unit dining room: -Five residents were seated at the round folding table, which did not have a tablecloth -All breakfast plates, bowls and cups were served on the meal tray -None of the six tables had tablecloths On 5/15/25 at 12:00 P.M., the surveyor observed the third-floor unit dining room to be set up with tablecloths. On 5/16/25 at 8:30 A.M., the surveyor observed the third-floor unit dining room to be set up without tablecloths. During an interview on 5/16/25 at 12:39 P.M., Unit Manager #3 said the tables should always have tablecloths and when he inquired with the staff about why they were not using tablecloths at breakfast they had told him, This is how we do it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/25 at 1:02 P.M., the Assistant Director of Nurses (ADON) said the third-floor unit was the only dining room used during breakfast time. She said staff should be putting tablecloths on the tables for all meals, including breakfast. She said the plates, bowls and cups should come off the serving tray for all meals and not just breakfast. During an interview on 5/16/25 at 2:29 P.M., the ADON said there was no facility policy regarding the dining experience of residents. 2. On 5/16/25 at 7:58 A.M., the surveyor observed the first-floor resident hallway with a built-in wall unit air conditioner located below a three-pane window. The area of wall between the windowsill and the built-in air conditioner had black speckles and was wet with clear liquid to the touch. The area to the right of the air conditioner had bubbling paint and was wet with spackle to the touch. The surveyor observed quick constant drips of water landing on the outside of the air conditioner. During an interview with observation on 5/16/25 at 3:23 P.M., the Director of Maintenance said the spackle had been applied to the right side of the air conditioner unit that morning and when he touched it at this time, at least 7 hours later, it continued to be wet to the touch. He said he had not noticed the black speckles between the windowsill and the air conditioner unit and had not realized it was wet to the touch. The surveyor and the Director of Maintenance went outside and observed the air conditioner above the first-floor unit built-in air conditioner to be dripping directly on to the first-floor unit. He said he thought this unit had a drip pan to prevent the upstairs air conditioner from hitting the outside siding. He touched the outside siding above the air conditioner and said it was soaked through and that was why the wall on the inside was wet.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #11 was admitted to the facility in January 2013 with a diagnosis of cirrhosis (scar tissue on the liver). Review of the medical record indicated Resident #11 developed an arterial ulcer (disruption or blockage of the arterial blood flow to an area which causes tissue to die) to the lateral (outside) of the left foot on 3/7/25. Review of the medical record indicated an order for the following treatment was initiated on 3/8/25: -cleanse with Vashe wash (wound cleanser), pat dry, apply Iodosorb gel (an antimicrobial ointment), apply a dry protective dressing followed by a kling (gauze) wrap. Review of the Wound Care Consultant's note, dated 3/28/25, indicated the arterial ulcer to the left lateral foot now had a moderate amount of purulent exudate (thick, opaque fluid with a foul odor that indicates a wound infection). The wound consultant physician recommended the following change of treatment: Vashe wash, Bactroban (a topical antibiotic), a dry protective dressing and gentle kling wrap daily. Review of the March and April 2025 TAR indicated the following treatments were in place for the arterial ulcer on the left lateral foot from 3/30/25 through 4/21/25 -cleanse with Vashe wash, pat dry, apply Iodosorb gel, apply a dry protective dressing followed by a kling wrap every evening shift -Vashe wash, Bactroban, a dry protective dressing and gentle kling wrap every day shift The March and April 2025 TARs indicate staff completed both treatments to the same wound on the left lateral foot daily. Review of the nursing progress notes indicated the wound treatments were clarified on 4/21/25, the order for Iodosorb was discontinued and the Resident would continue to receive the Bactroban treatment to the wound on the evening shift. During an interview on 5/20/25 at 2:00 P.M., Nurse #7 said she was the wound nurse at the facility until April 2025. She said the process was to go around with the wound consultant physician and conduct rounds on residents with wounds. She said on 3/28/25 Resident #11's wound was infected; the wound physician consultant had changed the treatment and the Resident was started on an antibiotic. She said toward the end of April a nurse who did not normally work on that unit had noticed that the Resident had two different treatment orders for the arterial ulcer on the left lateral foot and the Iodosorb order was discontinued at that time. She said some of the nurses who were familiar with the Resident may not have been doing both treatments, but there was no way to know as there were two different orders on two different shifts. She said the treatment with Iodosorb should have been discontinued when the treatment with Bactroban started but had not been. (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 5/20/25 at 3:00 P.M., the Regional Nurse Consultant said she had reviewed the medical record and saw there were two different orders for the same area and there should not have been. On 5/15/25 at 3:43 P.M., the surveyor observed Nurse #6 finishing the wound treatment to the left foot as she applied kling wrap and secured with tape. On 5/16/25 at 3:05 P.M. the surveyor observed the Infection Control Nurse remove the dressing to the left foot of Resident #11. The Infection Control Nurse removed the kling wrap and the surveyor observed an adhesive bandage over the lateral area of the left foot. The adhesive bandage was dated 5/15/25. The surveyor observed Resident #11 grimace as the Infection Control Nurse removed the adhesive bandage. During an interview on 5/16/25 at 3:10 P.M., the Infection Control Nurse said Nurse #6 should not have used an adhesive bandage on the arterial wound. She said the dry protective dressing (gauze), should be held on with kling wrap because the skin was so fragile. During an interview on 5/20/25 at 4:26 P.M., the DON said Resident #11 should not have had an adhesive bandage applied to the left lateral foot as this would be uncomfortable to remove. Based on observation, record review, and interview, the facility failed to ensure two Residents (#6 and #11) with wounds, out of a total sample of 23 residents, received necessary treatment and services to promote healing. Specifically, the facility failed: 1. For Resident #6, to complete weekly skin assessments and to follow the vascular physician's recommendations for care and treatment of a non-pressure wound to the Resident's left right foot; and 2. For Resident #11, to discontinue treatment to an arterial ulcer on the lateral left foot, leading to two different treatments being conducted daily and failed to follow the physician's order for the treatment by applying an adhesive bandage. Findings include: Review of the facility's policy titled Skin and Wounds, reviewed in January 2025, indicated the following: -if a resident presents with a venous, arterial or diabetic ulcer, the wound will be assessed on a weekly basis -non-pressure alterations in skin integrity also include skin tears and post op surgical incisions -ongoing monitoring and evaluation are provided to ensure optimal resident care outcomes -documentation would include: location, measurements, type of wound, thickness, drainage amount/color, appearance of wound bed, appearance of wound edges, appearance of peri wound, effectiveness of treatment (continued on next page)

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	225338	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #6 was admitted to the facility in April 2025 with diagnoses including osteomyelitis (infection in a bone), right great toe amputation, and diabetes. Review of the Minimum Data Set (MDS) assessment, dated 4/25/25, indicated he/she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Additionally, he/she had an infection of the foot and surgical wound requiring surgical wound care and application of dressings to feet. Review of Resident #6's Hospital Discharge summary, dated [DATE], indicated Resident #6 was treated for right great toe cellulitis with concern for osteomyelitis and had his/her right great toe amputated on 4/11/25. Review of Resident #6's Physician's Orders indicated, but was not limited to, the following: -Treatment Order: Cleanse with normal saline, pat dry, apply betadine gauze to incision follower [sic] by kerlix. Location (Specify) every evening shift every other day and as needed (order date 4/18/25) -Monitor Dressing: Site Right Great Toe every shift (order date 4/18/25) The Resident's Physician's Orders for his/her right great toe treatment failed to specify the treatment's location. Review of Resident #6's Short Consultation/Referral Form, dated 4/29/25, indicated the Resident was seen by his/her foot and ankle surgeon on 4/29/25. The surgeon's wound care recommendations included bandage to the right foot daily after showering, apply ABD (a highly absorbent and non-adhesive gauze pad) over incision, then ace bandage (an elastic compression bandage used to decrease swelling). Review of Resident #6's Non-Pressure Wound Evaluation, dated 4/25/25, indicated it was completed for follow-up weekly assessment of the Resident's right great toe surgical wound. The evaluation failed to include wound measurements. The evaluation indicated the wound had 100% healthy tissue types, a healthy wound edge, and no drainage or odor. Review of Resident #6's skin audits, dated 4/18/25, 4/21/25, 5/5/25, and 5/12/25, failed to include Resident #6's right foot surgical incision measurements or wound description. The Resident's medical record failed to include any additional Non-Pressure Wound Evaluations or wound measurements and descriptions. Review of the Treatment Administration Record (TAR) indicated Resident #6's right foot surgical wound dressing was changed every other day on the evening shift and skin audits were completed on 4/18/25, 4/21/25, 5/5/25, and 5/12/25. Review of the nursing, physician, and physician assistant (PA) Progress Notes for Resident #6 failed to include a description of the Resident's surgical wound or wound measurements after his/her admission to 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	During an interview on 5/15/25 at 9:03 A.M., Resident #6 said the wound on his/her right foot is healing but he/she still wears a dressing on it. During a subsequent interview on 5/19/25 at 10:19 A.M., Resident #6 said the nurses change his/her right foot dressing every other day and he/she does not know what his/her right foot surgical wound looks like because he/she cannot see it. During an interview on 5/16/25 at 2:20 P.M., the Wound Nurse said she completed wound rounds weekly on residents in the facility with wounds and tracked them on a spreadsheet. She said she was unaware she was supposed to enter the wound information into the electronic health record and had not done that for the three weeks she was conducting wound rounds. She said she last conducted wound rounds on 5/5/25 and had not been able to complete them yet for this week. Review of the Weekly Non-Pressure Injury Record failed to include Resident #6 had been seen during wound rounds. During an interview on 5/19/25 at 11:46 A.M., Unit Manager #1 said the facility's weekly skin assessments are documented in the electronic health record. Unit Manager #1 said the Wound Nurse completes the Non-Pressure Wound Evaluations weekly when she rounds and the weekly wound measurement and description should be documented there. Unit Manager #1 reviewed the Vascular Physician's 4/29/25 treatment recommendations and said the treatment order did not get transcribed and the order should match what the consulting Vascular Physician had recommended on the consult form. During an interview on 5/19/25 at 2:58 P.M., the Assistant Director of Nurses (ADON) said Resident #6's weekly wound measurements and description should be documented in the Non-Pressure Wound Evaluation in the electronic health record. During an interview on 5/20/25 at 2:03 P.M., the Director of Nurses (DON) and Regional Nurse Consultant #1 said Resident #6's wound care assessments and measurements should be documented in the electronic health record. The DON said if the wound nurse was not available, the DON, night shift nursing supervisor, or ADON would complete. The DON said she reviewed Resident #6's wound assessments with Unit Manager #1 who reported the admitting nurse documented the wound measurements in her note on 4/18/25. The DON said she and the ADON were not informed wound measurements were not taken last week. The DON said she and the Regional Nurse Consultant #2 assessed and measured the wound on 5/20/25.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. Based on observation, record review, and staff interview, the facility failed to ensure that staff assisted one Resident (#84), out of a total of 23 sampled residents, in replacing bilateral hearing aids that went missing to maintain hearing ability and enhance communication. Findings include: Review of the clinical record indicated Resident #84 was admitted to the facility in February 2024. Review of the Minimum Data Set (MDS) assessment, dated 3/21/25, indicated Resident #84 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating he/she has severe cognitive impairment. The MDS indicated bilateral hearing aids present. Review of the Physician's Orders, dated May 2025, included an Audiology Consult as needed (3/10/25). On the following dates and times, the surveyor observed Resident #84 not wearing hearing aids and was unsuccessful in engaging the Resident in conversation due to their difficulty hearing: -05/14/25 at 09:35 A.M. -05/15/25 at 08:30 A.M. -05/15/25 at 02:08 P.M. -05/16/25 at 08:12 A.M. -05/20/25 at 02:09 P.M. During an interview on 05/16/25 at 02:07 P.M., the Unit Manager said Resident #84 is deaf and does not have hearing aids anymore. The Unit Manager said they have been missing for a while but could not give a specific time. He said the facility has not done anything yet to replace the Resident's hearings aids. On 5/16/25 at 3:00 P.M., the surveyor attempted to contact Resident #84's daughter, but she did not call back. Review of the facility's Appointment Book failed to indicate Resident #84 was scheduled for an appointment to have his/her hearing aids replaced. During an interview on 05/20/25 at 02:14 P.M., Certified Nursing Assistant (CNA) #9 said her assignment changes every two weeks. She said she's providing care for Resident #84 today, but it's been a while. She said she does not know what happened to the Resident's hearing aids or when they went missing. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/20/25 at 02:38 P.M., CNA #8 said the Resident has difficulty hearing and was not aware about the missing hearing aids. During an interview on 5/20/25 at 2:45 P.M., Nurse #3 said the Resident had bilateral hearing aids that they've been unable to locate. She said the social worker was aware, and was not sure why the Resident does not have a new pair of hearing aids yet. During an interview on 5/20/25 at 3:10 P.M, the Social Worker said it was recently brought to her attention that Resident #84's hearing aids were missing. She said nursing staff are responsible for scheduling the residents' appointments when needed; she would need to follow up on it.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on document review and interview, the facility failed to ensure that monthly medication regimen reviews (MRR) were communicated to the physician and addressed in a timely manner for one Resident (#76), out of a total sample of 23 residents. Specifically, the facility failed to: a. Ensure a recommendation from October 2024 by the pharmacy consultant to evaluate continued need of Oxycontin and MS Contin (both opioid medications that are used for severe pain) was reviewed and responded to by the provider; and b. Ensure February 2025 consultant pharmacist recommendations were acted upon timely to clarify the need for Protonix (reduces stomach acid) 40 milligrams (mg) twice a day, and to evaluate the need for continued use of as needed Oxycodone (medication used for breakthrough pain). Findings include: Review of the facility's policy titled Medication Regimen Review Monthly Report, dated as revised December 2019, indicated but was not limited to the following: -The Consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. -The medication regimen review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. -All findings and recommendations are reported to the director of nursing and the attending physician, the medical director and the administrator. Review of the facility's policy titled Documentation and Communication of Consultant Pharmacist Recommendations, dated as last revised December 2019, indicated but was not limited to the following: -The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate timely fashion. -The timing of these recommendations should enable a response prior to the next medication regimen review. -Recommendations are acted upon and documented by the facility staff and/or the prescriber. -If the prescriber does not respond to recommendation directed to him/her within 30 days, the Director of Nursing and/or the consultant pharmacist may contact the medical director. Resident #76 was admitted to the facility in August 2024 and had diagnoses including osteomyelitis (infectious inflammation of the bone marrow) of the left tibia/fibula (two long bones in lower leg). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of the medical record indicated a full MRR was completed by the consultant pharmacist in October 2024 and to see report for irregularities and/or recommendations. The record failed to indicate what those irregularities were or that they were addressed by a physician. Review of the MRR from October 2024 indicated that there was a recommendation left to the prescriber as follows: -Resident is receiving the following medication(s) Oxycontin and MS Contin. Please evaluate continued need. If discontinue (DC) is not indicated, please note diagnosis DX/medical necessity of current therapy in progress note. The physician/prescriber response section was blank, indicating the recommendation was never addressed or reviewed by the physician/prescriber. b. Review of the medical record indicated a full MRR was completed by the consultant pharmacist in February 2025 and to see report for irregularities and/or recommendations. Review of the MRR from February 2025 indicated that there were two recommendations left to the prescriber as follows: -This resident has been receiving the proton pump inhibitor Protonix 40mg twice a day (BID) for more than 12 weeks. Could the ongoing need for this therapy be re-assessed at this time? The physician/prescriber response section was checked I agree. Please see new order. The recommendation was signed by the physician and dated 4/9/25, two months after the recommendation was received. -Please review current as needed oxycodone use has been used 63 and 55 times between December 2024-January 2025. The physician/prescriber response section was checked I agree, please see new order. The recommendation was signed by the physician and dated 4/9/25, two months after the recommendation was received. During an interview on 5/20/25 at 12:29 P.M., the Pharmacy Consultant said he completes the monthly reports and sends them to the Director of Nursing (DON). He expects the facility to review and respond to the recommendations prior to his next monthly review. During an interview on 5/20/25 at 2:33 P.M., the DON said pharmacy recommendations are supposed to be completed within 30 days of receipt. She said the October 2024 recommendation was not addressed by the provider as it should have been it must have been an oversight. She said the February 2025 recommendations were reviewed and responded to late. She said they should have been reviewed by the provider within 30 days.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that medications were accurately reconciled by nursing for one Resident (#76), out of a total sample of 23 residents, to ensure he/she was free from a significant medication error. Specifically, the facility failed to ensure Eliquis (apixaban) (an anticoagulant medication used to treat and prevent blood clots) was administered according to physician's orders following a hospitalization for a left knee joint fusion, resulting in the Resident receiving nine additional doses of the medication. Findings include: Review of the facility's policy titled Nursing Policy & Procedure Manual, last revised 8/4/2024, indicated but was not limited to the following: -The facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any significant medication errors. -Medication reconciliation refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay. -admission processes: Compare orders to hospital records, obtain clarification as needed. -Transcribe orders in accordance with procedures for admission orders. -Have a second nurse review transcribed orders for accuracy. -Perform 24-hour chart checks to verify all new orders have been addressed. Review of the facility's policy titled Medication Error Reporting, dated April 2015, indicated but was not limited to the following: -A medication error is any preventable event that may cause or lead to inappropriate medication use, which the medication is in the control of the health care professional. -A medication error report is to be completed immediately after an error is discovered to ensure proper resident/patient follow-up. -Notify the Nurse Manager/Supervisor immediately. -Medication Error Report is completed. -Follow up notes are written related to event based on evaluation per facility policy. -The nurse manager or shift supervisor investigates the error to determine the cause. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The person finding the error is responsible for completing the Medication Error Report and forwarding it to the Director of Nursing (DON) immediately. -The DON or designee is responsible for evaluating the severity of medication errors on each error using the information on the Medication Error Report. Resident #76 was originally admitted to the facility in August 2024 and had diagnoses including osteomyelitis (infectious inflammation of the bone marrow) of the left tibia/fibula (two long bones in lower leg). Review of the Minimum Data Set (MDS) assessment, dated 1/24/25, indicated Resident #76 had a Brief Interview for Mental Status (BIMS) exam score of 13 out of 15, indicating he/she was cognitively intact. Review of the medical record indicated Resident #76 was hospitalized in May 2025 for a scheduled left knee fusion due to osteomyelitis. Review of the Hospital Discharge summary, dated [DATE] at 4:03 P.M., indicated the Resident was to begin taking Eliquis 2.5 milligram (mg) tablets in the morning and Eliquis 2.5mg before bedtime per day (for a total dose of 5 mg per day) for 30 days. Review of the Physician's Orders and the electronic Medication Administration Record (eMAR) indicated the Eliquis order had been entered twice as follows: Eliquis Order #1: -Eliquis oral tablet 2.5mg: Give one tablet by mouth two times a day for {sic} prevent blood clots. Administered on the following dates and times: 5/11/25 at 8:00 A.M. and 8:00 P.M. 5/12/25 at 8:00 A.M. and 8:00 P.M. 5/13/25 at 8:00 A.M. and 8:00 P.M. 5/14/25 at 8:00 A.M. and 8:00 P.M. 5/15/25 at 8:00 A.M. Eliquis Order #2: -Eliquis oral tab 2.5mg: Give 2.5mg by mouth two times a day for anticoagulation until 6/10/25, for 30 days. Administered on the following dates and times: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/11/25 at 8:00 A.M. and 5:00 P.M. 5/12/25 at 8:00 A.M. and 5:00 P.M. 5/13/25 at 8:00 A.M. and 5:00 P.M. 5/14/25 at 8:00 A.M. and 5:00 P.M. 5/15/25 at 8:00 A.M. Resident #76 received Eliquis 2.5 mg two tablets (5 mg) for five days in the morning and Eliquis 2.5mg two tablets (5 mg) for four days in the evening, resulting in Resident #76 receiving nine additional doses than indicated on the discharge summary. On 5/15/25 at 2:45 P.M., the surveyor informed Unit Manager (UM) #2 of the possible duplicate order for Eliquis. During an interview on 5/15/25 at 3:40 P.M., UM #2 said it was a repeat order, and she discontinued one of the orders. During an interview on 5/19/25 at 1:15 P.M., UM #2 said when a resident is admitted or re-admitted to the facility the admitting nurse will review the medication list provided on the discharge summary with the provider and enter the orders into the computer. She said the medications are double checked by the management team each morning during clinical report. UM #2 said she reviewed Resident #76's medication orders after the surveyor informed her of the possible duplicate order. UM #2 said she compared the Resident's current orders with the discharge summary provided by the hospital and found it was inadvertently placed into the computer twice. UM #2 said she notified the Assistant Director of Nursing (ADON) of the medication error and was instructed to discontinue one of the orders. UM #2 said she did not complete an incident report or investigation, she only notified her ADON. During an interview on 5/20/25 at 11:47 A.M., the ADON said she had provided care to Resident #76 and administered Eliquis 2.5 mg two tablets at 8:00 A.M., last week. She said she did not question it being a duplicate order because sometimes the dose is increased after surgery, and one of the orders had a stop date and the other did not. The ADON said UM #2 informed her of the duplicate order for Eliquis on 5/15/25 and she instructed UM #2 to discontinue the order. The ADON said when a medication error occurs a medication error report is completed. The ADON said she did not complete a medication error report, she thought UM #2 did. During an interview on 5/20/25 at 12:07 P.M., Nurse #9 said Resident #76 was on Eliquis 2.5 mg one tab by mouth twice a day prior to going to the hospital. She said when Resident #76 returned his/her dose had been increased to Eliquis 2.5mg two tabs by mouth twice a day, and that is what she administered. Nurse #9 said if she did not administer a medication, she would check the box that says no on the eMAR and document the reason in a nursing note. During an interview on 5/20/25 at 12:12 P.M., the surveyor reviewed Resident #76 Eliquis duplicate order EMAR administration with Nurse #8, where she signed as administered. Nurse #8 said she does not recall the Eliquis orders but if she signed it as administered then she administered the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/25 at 12:17 P.M., the surveyor reviewed Resident #76 Eliquis duplicate order eMAR administration with Nurse #4, where she signed administered. She said if the eMAR is signed as administered, then she gave the medication. Nurse #4 said if she did not give the medication, she would have documented the reason why it was not given. During an interview on 5/20/25 at 2:49 P.M., the Director of Nursing (DON) said when a resident is re-admitted to the facility they review all of the orders the next morning during the clinical meeting, and compare the orders to the discharge summary medication list. The DON said if there is a medication error, a medication error report is generated and a full investigation is conducted, including witness statements. The surveyor and DON reviewed Resident #76's medical record, and she said there was no documentation of the medication error. She said the proper protocol was not followed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 2. Resident #24 was admitted to the facility in December 2022 with diagnoses which included cerebral infarction (stroke) and senile degeneration (impaired cognition). Review of the MDS assessment, dated 4/23/25, indicated Resident #24 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Review of Resident #24's Self-Administration of Medication assessments, dated 12/30/24 and 3/22/25, indicated he/she did not desire to self-administer medication. Review of Resident #24's Physician's Orders indicated but was not limited to: -Flonase allergy relief nasal suspension 50 mcg/act (fluticasone propionate nasal spray), 1 spray in both nostrils two times a day for dry, irritated nares. May self-administer and keep at the bedside, dated 3/17/25. Further review of Resident #24's Physician's Order (3/17/25) indicated the ability/desire to self-administer Flonase predated the Self-Administration of Medication Assessment (3/22/25) and his/her record did reflect the 3/22/25 change. On the following dates of survey, the surveyor observed medication unsecured in Resident #24's room: -5/14/25 at 9:10 A.M., there was a box containing a bottle of fluticasone propionate nasal spray on his/her overbed table, -5/15/25 at 7:35 A.M., there was a box containing a bottle of fluticasone propionate nasal spray in a pink basin on his/her wheelchair at the bedside. During an interview on 5/20/25 at 9:46 A.M., Resident #24 said he/she used to keep her Flonase in the room but somebody took it away and now the nurses bring it in for him/her. During an interview on 5/20/25 at 10:02 A.M., Nurse #5 said when a resident wants to keep medication at the bedside an assessment needs to be conducted to ensure the resident understood the medication and the order and was able to safely administer the medication and then the medication should be secure in the room when not being used by the resident. Nurse # 5 said the facility had keys to the bedside table for safe keeping. Nurse #5 said Resident #24 should not have medication at the bedside. 3. Resident #23 was admitted to the facility in January 2020 with diagnoses which included COPD. Review of the MDS assessment, dated 5/2/25, indicated Resident #22 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Review of Resident #23's Self-Administration of Medication assessment, dated 4/25/25, indicated he/she did not desire to self-administer medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's Physician's Order indicated but were not limited to: -fluticasone-salmeterol inhalation aerosol powder breath activated 250-50 mcg/act (fluticasone-salmeterol) 1 application inhale orally two times a day for treat asthma rinse mouth after each use, 4/15/25 On 5/14/25 at 9:16 A.M., the surveyor observed a box containing a fluticasone salmeterol (steroid and bronchodilator combination) inhaler unsecured and on Resident #23's overbed table. During an interview on 5/20/25 at 9:49 A.M., Resident #23 said the day the inhaler was on his/her overbed table was because the night nurse left it behind. Resident #23 said he/she was not supposed to have it. During an interview on 5/20/25 at 10:02 A.M., Nurse #5 said Resident #23 should not have medication at the bedside. During an interview on 5/20/25 at 11:32 A.M., the Director of Nurses (DON) said she was not sure if the non-narcotic medication should have been locked but that medication should be in a safe place acceptable to the residents. The DON said she needed to review the policy to see if the medications needed to be locked or not. Based on observation, record review and interview, the facility failed to ensure medications were labeled and stored in accordance with acceptable professional standards for three Residents (#64, #24, #23), of a total sample of 23 residents. Specifically, the facility failed: 1. For Resident #64, to ensure the Resident's inhaler and allergy nasal spray medications were stored securely; 2. For Resident #24, to ensure the Resident's nasal spray medication was stored securely; and 3. For Resident #23, to ensure the Resident's inhaler medication was stored securely. Findings include: Review of the facility's policy titled Medication Storage in the Facility, undated, indicated but was not limited to the following: - Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. - The manner of storage prevents access by other residents. 1. Resident #64 was admitted to the facility in March 2025 with diagnoses including chronic obstructive pulmonary disease (COPD) and shortness of breath (SOB). Review of the Minimum Data Set (MDS) assessment, dated 5/5/25, indicated Resident #64 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #64's Self-Administration Medication assessment, dated 5/13/25 and 5/14/25 indicated he/she desired to self-administer medications. Furthermore, the assessments indicated he/she was safe to administer Mometasone Furoate Inhalation Aerosol Powder Breath Activated Inhaler, Albuterol Sulfate Inhalation Aerosol Power Breath Activated Inhaler, and Anoro Ellipta Inhalation Aerosol Powder Breath Activated Inhaler. Review of Resident #64's Physician's Orders included but were not limited to: - 5/14/25: May self-administer and keep at bedside. Patient wishes to self-administer Mometasone Furoate, Albuterol Sulfate, Anoro Ellipta. - 5/13/25: Mometasone Furoate Inhalation Aerosol Powder Breath Activated 220 MCG/ACT; two puff inhale orally one time a day related to COPD; unsupervised self-administration; rinse mouth with water each use to prevent incidence of candidiasis. - 4/29/25: Albuterol Sulfate Inhalation Aerosol Powder Breath Activated 108 (90 Base) MCG/ACT; two puff inhale orally every four hours as needed for SOB; unsupervised self-administration. - 4/29/25: Anoro Ellipta Inhalation Aerosol Powder Breath Activated 62.5-25 MCG/ACT; one puff inhale orally one time a day related to COPD; Unsupervised self-administration. - 4/29/25: Fluticasone Propionate Nasal Suspension 50 MCG/ACT; two sprays in each nostril one time a day for allergy. On the follow dates of the survey, the surveyor observed medication unsecured in Resident #64's room: - 5/14/25 at 9:12 A.M., there were boxes containing Fluticasone Propionate Nasal Spray, Mometasone Furoate Inhalation Aerosol Powder Breath Activated Inhaler, Albuterol Sulfate Inhalation Aerosol Power Breath Activated Inhaler, and Anoro Ellipta Inhalation Aerosol Powder Breath Activated Inhaler on top of his/her bedside nightstand. - 5/15/25 at 9:18 A.M., therer were boxes containing Fluticasone Propionate Nasal Spray, Mometasone Furoate Inhalation Aerosol Powder Breath Activated Inhaler, Albuterol Sulfate Inhalation Aerosol Power Breath Activated Inhaler, and Anoro Ellipta Inhalation Aerosol Powder Breath Activated Inhaler on top of his/her bedside nightstand. During an interview on 5/15/25 at 9:18 A.M., Resident #64 said he/she is able to self-administer the inhaler medications. The Resident said he/she prefers to keep inhaler medications at the bedside and typically leaves them in or on the nightstand. During an interview on 5/20/25 at 9:53 A.M., Nurse #10 said Resident #64 is able to self-administer inhaler medications and they are left at the bedside. Nurse #10 said she was not sure if the medications needed to be locked or secured but he/she stores them in the nightstand next to their bed. Nurse #10 said medications should not be left out on top of the nightstand and should be kept in the drawer. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 10:10 A.M., Unit Manager (UM) #1 said Resident #64 was able to self-administer his/her inhaler medications, but the Fluticasone Propionate Nasal Spray medication should not have been left at the bedside as he/she is not able to self-administer that medication. UM #1 said medications should be stored in the top drawer of his/her nightstand and it should be locked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, 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: 1. Ensure the main kitchen grout and coving were maintained in a sanitary and safe condition; 2. Ensure walk-in shelving was free of rust; and 3. Ensure food was properly stored, labeled, and dated in three of three unit kitchenettes. Findings include: 1. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 1-2 Definitions 1-201 Applicability and Terms Defined 1-201.10 Statement of Application and Listing of Terms. Easily Cleanable. (1) Easily cleanable means a characteristic of a surface that: (a) Allows effective removal of soil by normal cleaning methods; (b) Is dependent on the material, design, construction, and installation of the surface; and (c) Varies with the likelihood of the surface's role in introducing pathogenic or toxigenic agents or other contaminants into food based on the surface's approved placement, purpose, and use. 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. 6-201.12 Floors, Walls, and Ceilings, Utility Lines. Floors that are of smooth, durable construction and that are nonabsorbent are more easily cleaned. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible and that insect and rodent harborage is minimized. 6-201.13 Floor and Wall Junctures, Coved, and Enclosed or Sealed. (A) In FOOD ESTABLISHMENTS in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be coved and closed to no larger than 1 mm (one thirty-second inch). On 5/14/25 at 8:30 A.M., the surveyor observed, in the main kitchen, several areas of compromised coving and/or deeply recessed grouting in areas of the perimeter floor and wall junction. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/25 at 8:50 A.M., the Food Service Director (FSD) said the compromised coving and recessed grouting has at times harbored ants and should be repaired. During an interview on 5/13/25 at 4:30 P.M., the Administrator and surveyor observed some areas of the main kitchen floor and wall junctions. The Administrator said he expected those areas to be in good repair. 2. On 5/13/25 at 8:30 A.M., the surveyor observed, in the main kitchen walk-in refrigerator, metal shelving with extensive rust. During an interview on 5/13/25 at 8:50 A.M., the FSD and the surveyor observed the rusted shelving. The FSD said the shelving should be replaced. During an interview on 5/13/25 at 4:30 P.M., the Administrator and surveyor observed the rusted shelving in the walk-in refrigerator. The Administrator said there should be no rust on the shelving. 3. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-305 Preventing contamination from the premises 3-305.11 Food Storage. (A) Except as specified in (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. Review of the facility's policy titled Personal Food Policy, indicated but was not limited to the following: -Families and visitors of residents are permitted to bring food into the facility for the resident's use. However, nursing home residents are at risk for serious complications from foodborne illness which may occur from unsafe food handling practices. In order to ensure the safety of our residents, food may only be brought into the facility in accordance with this policy; -The staff person receiving the personal food shall label the container with the date it was brought into the facility (or the date of preparation, if known) and the name of the resident receiving it; -Dietary aides are responsible for checking nourishment refrigerators daily and discarding any unused refrigerated food after 3 days. Frozen food should be discarded after 3 months. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Dietary Department Guidelines, revised May 2012, indicated but was not limited to the following: -Foods Not Prepared in the Facility: Foods brought into the facility by family members will be kept in appropriate storage, refrigerated if indicated, and discarded as appropriate. For example, foods that require refrigeration should be discarded after 3 calendar days. On 5/14/25 at 10:30 A.M., the surveyor observed the following in the Unit 1 kitchenette refrigerator: -two prepared containers of cottage cheese, dated 5/9; -one Styrofoam cup filled with liquid with no label or date; -one opened container of Lactaid milk, undated, with the manufacturer label indicating to use within 14 days of opening; -one opened container of almond milk, undated, with the manufacturer label indicating to use within 14 days of opening; -one sealed container of lobster bisque, labeled with resident information and dated 4/23/25, with a manufacturer use by date of 5/1/25; -one takeout container of Chinese food with no label or date; -one prepackaged chicken potpie meal with no label or date; -one bag of frozen fish sticks, bag open to air, no label or date. On 5/14/25 at 10:45 A.M., the surveyor observed the following in the Unit 3 kitchenette refrigerator: -three frozen packages of empanadas, undated; -one opened bottle of water with no label or date. On 5/14/25 at 10:55 A.M., the surveyor observed the following in the Unit 2 kitchenette refrigerator: -one storage bag (unsealed) with an item wrapped in paper towel, labeled with initials, no date; -one store bought container of grapes, no date; -two opened containers of Lactaid milk, one dated 5/14 and one with no date; -a very damp white towel on the bottom of the interior refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with observation on 5/13/25 at 4:08 P.M., the FSD said dietary staff stock the unit kitchenettes and monitor items inside the refrigerators for labels and dates. The FSD said staff must label and date food and drink items stored in the kitchenettes and should also label and date any item that is open with the date opened. She said opened items can be stored in the refrigerator for three days and then must be discarded. The FSD and surveyor observed the unit kitchenettes. The FSD said the items that were not labeled and dated should have been, and any food items that are older than three days, such as the cottage cheese dated 5/9, should be discarded. The FSD also said any items past the manufacturer's expiration date, such as the lobster bisque, should also be discarded. During an interview with observation on 5/13/25 at 4:18 P.M., the surveyor observed, in the Unit 2 refrigerator, thick condensation resting on top of single serve puddings located on the top shelf. The surveyor tilted one pudding cup and observed a stream of water pour off the cup. The surveyor observed a damp white cloth underneath several single serve pudding cups on the top shelf, and a very damp white cloth on the bottom of the interior refrigerator. The FSD said she expected the refrigerator to function properly with no condensation dripping onto food items or excessive condensation build up. During an interview on 5/15/25 at 11:20 A.M., Unit Coordinator #1 said the refrigerator in the Unit 2 kitchenette had been leaking for weeks. Certified Nursing Assistant (CNA) #1 said towels were placed in the refrigerator to catch the water drippage, otherwise the water leaked out everywhere. CNA #1 said the towels in the refrigerator were switched out daily. The surveyor observed a brown-colored tinge on some edges of the towels. During an interview on 5/15/25 at 12:04 P.M., the Director of Maintenance (DOM) said a resident had stuffed the Unit 2 kitchenette refrigerator with food, which blocked airflow and caused issues with cooling and defrosting. The DOM said he was currently unaware of any continued condensation and drippage in the Unit 2 kitchenette refrigerator. During an interview on 5/15/25 at 12:13 P.M., the Administrator said a resident on Unit 2 had filled and jammed food into the kitchenette refrigerator, so much so that it blocked the seal and vent and it could not circulate. The Administrator said he had just heard about the refrigerator issue today.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility failed to ensure the garbage storage area was maintained in a sanitary condition to prevent the harborage and feeding of pests. Findings include: Review of the Pest Control Service Inspection Reports, indicated: -4/3/24: 2 out of 6 inspected exterior bait stations showed activity -10/2/24: 6 out of 6 inspected exterior bait stations showed activity -3/21/25: 5 out of 6 inspected exterior bait stations showed activity -4/2/25: 3 out of 6 inspected exterior bait stations showed activity -5/15/25: 1 out of 6 inspected exterior bait stations showed activity On 5/15/25 at 1:23 P.M., the surveyor observed the dumpster and refuse area. The surveyor observed a large pile of stacked wood pallets, piled up to the top of a wooden fence panel. During an interview on 5/15/25 at 1:25 P.M., the interim Food Service Director said the pallets had been there for a while and was not sure what the plan for them was. During an interview on 5/15/25 at 1:36 P.M., the Director of Maintenance said the pallets had been there since COVID and because the pallets were so old the garbage disposal company would not pick them up. During an interview on 5/15/25 at 1:38 P.M., the Administrator said he was aware of the wood pallets near the dumpster. The Administrator said the facility currently did not have a plan to dispose of them but needed to come up with one.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interviews, the facility failed to ensure it was administered in a manner that enabled the facility to use its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to ensure resources were utilized to ensure mechanical equipment was maintained in safe operating condition. Findings include: Review of the Town Food Inspection Report, dated 2/6/25, indicated same issue again is with walk-in freezer. Ice is now on boxes and boxes are not allowed to be contaminated with anything. Needs to be addressed again. Review of the Town Food Inspection Report follow up visit, dated 3/24/25, indicated checked walk-in freezer and girls are keeping up with it, but ice is still accumulating on left side and ceiling and on products. On 5/14/25 at 8:30 A.M., the surveyor observed the following in the main kitchen: walk-in freezer with: -condensation on the exterior of the freezer door window; -freezer door seal detached from the top right corner of the freezer door - the length of detachment was not measured but visualized to be approximately greater than 4 inches long; -freezer door seal in the bottom right corner cracked with missing part of the seal; -drops of condensation frozen on the ceiling adjacent to the condenser unit above a cardboard box of brownies; -thick ice buildup on boxes below the condenser unit; -thick ice buildup on the freezer floor under the condenser unit; and -slippery floor in the walkable area inside the freezer. Review of the facility provided e-mail correspondence, from the Physical Plant Director (Director of Maintenance), dated 2/18/25, copied to the facility administrator, and marked with high importance indicated but was not limited to: -an attempt to have a freezer repair vendor #2 come to the facility to look at the walk-in freezer door because the Health Inspector had noted nothing was being done about it as well as it having been a DPH concern on the previous survey -there had been a quote to replace the door (by freezer repair vendor #1) but the quote was no longer any good because money was owed to freezer repair vendor #1 (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-freezer repair vendor #2 had not been paid for work that was done as far back as June 2024 and would not come out until invoices were taken care of. During an interview on 5/14/25 at 8:50 A.M., the Food Service Director (FSD) said the condensation in the freezer had been a concern for a long time. The FSD said there was excessive condensation build-up inside the walk-in freezer, particularly on the ceiling, on several boxes of food stored underneath the condenser fans, and on the floor, which were all observed at that time of the interview. The FSD said the facility had tried to implement trays on the shelving beneath the condenser fans to catch condensation, but this was not effective as it caused the freezer to go into defrost mode. The FSD said kitchen staff and maintenance were working together to remove and maintain the ice buildup. The FSD said she expected the walk-in freezer to have a door seal that was not compromised and functioned properly to minimize condensation buildup inside the freezer, and for less condensation to occur inside the freezer. During a follow up interview on 5/15/25 at 10:55 A.M., the FSD said issues with the walk-in freezer have been ongoing since prior to the facility's last survey, and the town Board of Health was also aware. The FSD said she and staff would use a hammer to break up the ice and the Administrator had even used a shovel to break up the ice in the freezer. During an interview on 5/15/25 at 12:04 P.M., the Director of Maintenance (DOM) said the walk-in freezer door had not been repaired since it was identified last survey. The DOM said the needed part for the door was ordered but never received or installed due to financial reasons. On 5/19/25 at 4:29 P.M., the DOM provided the following: -a vendor quote (from freezer vendor #1), dated 4/9/24, for the freezer door replacement which indicated 100% deposit was required prior to ordering material or scheduling job; -a facility check request form, dated 4/24/24, indicated a request for check payment to the freezer vendor #1 to replace the freezer door to comply with the Department of Public Health; an approval signature was indicated and dated 4/24/24; -weekly preventative maintenance log, dated 4/12/24 to 5/12/25, indicated maintenance chipped away ice accumulation in the walk-in freezer on at least a weekly basis and was waiting for the door panel to be replaced. During an interview on 5/19/25 at 4:29 P.M., the DOM said a vendor had serviced the walk-in freezer on 5/16/25 after surveyors identified issues. He said the vendor reattached the gasket to the freezer door and had fixed a clog in the condenser drain which reportedly was causing the water drippage from the condenser onto boxes and the floor. The DOM said he was unaware that the drippage was due to a clogged condenser drain as no vendor had been monitoring, maintaining, or providing repair to the freezer unit until 5/16/25. During an interview on 5/20/25 at 2:30 P.M., the Administrator said he was newer to the facility but freezer repair vendor #2 was in on 5/26/25 and the facility was waiting for an e-mail to come in with a plan/in-voice. The Administrator said he was not sure what transpired prior to his working at the building. (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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F908

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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 to: 1. Maintain an infection prevention and control program which included a complete and accurate system of surveillance to identify any trends or potential infections; 2. Review and document laboratory results for a total of 71 patients on two out of two units swabbed for Group A Streptococcus, as a measure of surveillance after three identified residents who resided in the facility tested positive; 3. Ensure proper hand hygiene was completed prior to meals for residents eating in the first floor dining area; 4. Ensure appropriate personal protective equipment (PPE) was utilized for Resident #27, who was on Enhanced Barrier Precautions (EBP), while providing direct care; 5. Follow proper hand hygiene standards while administering an injection to Resident #40; 6. Follow infection control standards for Resident #60 while completing a dressing change; 7. Follow proper hand hygiene standards while administering a nasal spray to Resident #20; 8. Ensure proper cleaning and disinfecting of shared resident equipment after use; and 9. Ensure staff implemented appropriate use of PPE for Resident #76 on Contact Precautions and follow infection control standards while completing a dressing change. Findings include: 1. Review of the facility assessment, dated 4/29/25 and reviewed with the QAA/QAPI committee on 4/29/25, indicated but was not limited to: -Services provided based on resident need: a. Infection prevention and control: Identification and containment of infections, prevention of infections. Resident and family education related to infection and the prevention of infection. Review of the facility's policy titled The Infection Prevention Program, revised 3/2024, included but was not limited to the following: -This facility follows the professional standards set forth as recommended by the CDC/OSHA. The goal of the Infection Prevention Program is to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility has a system in place for the prevention, identification, reporting, investigation and control of infections and communicable disease of residents, staff, and visitors. -Responsibility for ongoing collection and analysis of data and required follow up is assigned to the Infection Preventionist (IP). -Elements of the Infection Prevention Program includes monitoring and documenting infections, tracking and analyzing outbreaks of infections, managing resident health initiatives and provision of early, uniform identification and reporting of infections. -The IP will perform surveillance and investigation of infections to prevent, to the extent possible, the onset and spread of infection. -Analyze trends and clusters of infection, and any increase in the rate of infection or resistant organisms, in a timely manner. -Maintain the monthly infection reports by unit to record each resident infection. Review of the facility's policy titled Surveillance for Healthcare, dated as revised 3/2024, included but was not limited to the following: -Surveillance is defined as the ongoing, systematic collection, analysis, interpretation and dissemination of data. -The facility will closely monitor all residents who exhibit signs/symptoms of infection. The IP will record the information on the Infection Control Log. -The IP will gather additional data for infection tracking and reporting and provide consultation and education as needed. -The IP or designee will monitor the residents with infections and/or potential infections by completing the Monthly Infection Report by Unit. Review of the Monthly Resident Infection and Antibiotic Stewardship Report Tool, identified as the facility's line listings, indicated the information needed for completion included but was not limited to: the date, resident name, site of infection, type of infection, culture results, signs and symptoms of infection, and treatment/intervention. Further review of the line listings from January 2025 through April 2025 indicated but was not limited to the following: -The January 2025 report tool had missing documentation for 22 out of 26 residents. Specifically, 22 of the 25 residents had no documented signs and symptoms of an illness. -The February 2025 report tool had missing documentation for 14 out of 15 residents. Specifically, 14 of the 15 residents had no documented signs and symptoms of an illness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The March 2025 report tool had missing documentation for 18 out of 21 residents. Specifically, 18 of the 21 residents had no documented signs and symptoms of an illness. -The April 2025 report tool had missing documentation for 9 out of 12 residents. Specifically, 9 of the 12 residents had no documented signs and symptoms of an illness. During an interview on 5/19/25 at 3:39 P.M., the Director of Nurses (DON) said the facility utilizes McGeer criteria to determine if an infection is present. She said each unit has an infection binder where nurses would document infections present. She said the nurses should document the signs and symptoms in the medical record and on the line listings to determine if McGeer criteria is met prior to treating. The surveyor and DON reviewed the line listings from January through April 2025 together. The DON further said she remembers line listings being a concern last year and that symptoms were not identified. After reviewing the line listings, the DON said the documentation is inconsistent and should be written on the line listing and in the medical record. 2. Review of the Group A Streptococcus surveillance testing on two units within the facility indicated a total of 71 residents were swabbed to rule out the organism. On 5/19/25 at 1:10 P.M., the DON was able to provide the surveyor laboratory results for the first-floor unit, but said she was awaiting the second floor results, despite being in the medical record at this time. On 5/19/25 at 2:15 P.M., the surveyors reviewed the records of all 71 residents. Each medical record indicated the test results for the surveillance testing were resulted and uploaded to the electronic medical record on 5/16/25. Each of the labs indicated the lab result had not been reviewed and the medical record failed to indicate documentation that the laboratory result was reviewed and results were documented. During an interview on 05/19/25 at 4:26 P.M., the DON said it is the expectation that nurses review the labs as they come into the facility. She said the laboratory results returned on 5/16/25 and the nurses on the units should have checked the results to see if any of the residents were positive. She said it is her expectation that all nurses document in the medical record when lab results are reviewed and the results. She further said once the physician reviewed the lab result, it would then show as reviewed in the medical record. The DON reviewed the results for one of the 71 residents and was unable to locate documentation related to the laboratory results being reviewed for the infection surveillance of Group A Streptococcus. 3. Review of the facility's policy titled Section I - The Infection Prevention Program, revised 3/2024, indicated but was not limited to the following: - Hand Hygiene: + When to Wash Hands (at a minimum): before eating and drinking. (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 facility's policy titled Hand Hygiene, dated April 2015, indicated but was not limited to the following: - Policy: to protect residents/patient from health-care associated infections. - When to use Alcohol Hand Sanitizer: encouraging residents use prior to eating or group activities. On 5/14/25 at 12:08 P.M., the surveyor made the following observations in the first-floor main dining room: - Drinks were provided to 10 residents in the dining room by facility staff. No hand hygiene was performed by staff prior to providing or after serving drinks to residents. No residents were observed to perform or be provided hand hygiene. - At 12:35 P.M., trays arrived for residents in the dining room area. No hand hygiene was provided to residents prior to meals being delivered to tables. On 5/15/25 at 12:24 P.M., the surveyor made the following observations in the first-floor main dining room: - 10 residents were seated at tables throughout the dining area. - No hand hygiene was performed for residents prior to meals being delivered. - No hand hygiene was performed by staff prior to delivering trays and/or after delivering meals to residents in the dining area. During an interview on 5/20/25 at 1:12 P.M., Nurse #5 said hand hygiene should be performed prior to meals times. Nurse #5 said residents should have hand hygiene completed prior to being served meals. During an interview on 5/30/25 at 2:02 P.M., the DON said her expectation was for hand hygiene to be completed prior to mealtime and after mealtimes for both staff and residents. 4. Review of the facility's policy titled Enhanced Barrier Precautions Policy, undated, indicated but was not limited to: - It is the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms (MDROs). Novel or targeted MDROs are organisms that are resistant to all or most antibiotics tested, are uncommon in a geographic area, or have special genes that allow them to spread their resistance to other germs. - Enhanced barrier precautions require the use of gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk for transmission of multi-drug resistant organisms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- High-contact resident care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care. - Signage will be posted on the door or wall outside of the resident room indicating the need for enhanced barrier precautions, the required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. Resident #27 was admitted to the facility in November 2024 with diagnoses including right above knee amputation, sepsis, and infection of the skin and subcutaneous tissue. Review of Resident #27's Physician's Orders indicated but were not limited to the following: - 5/14/25: Enhanced Barrier Precautions (EBP): RLE (right lower extremity) wound. On 5/19/25 at 8:10 A.M., the surveyor observed the Centers for Disease Control and Prevention (CDC) EBP sign posted on the wall outside of Resident #27's room. The sign indicated prior to entering the room: everyone must clean their hands and that providers and staff must wear gloves and a gown for high-contact resident care activities such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and wound care. Gowns and gloves were in a bin outside of the room's door. On 5/19/25 at 10:59 A.M., the surveyor observed the following: - Certified Nursing Assistant (CNA) #1 entered Resident #27's room without performing hand hygiene, wearing a gown, or wearing gloves. Resident #27 who was in his/her wheelchair followed CNA #1 into the room. - CNA #1 was observed making Resident #27's bed, including touching linens in the room. - CNA #1 drew the curtain while standing next to Resident #27. - CNA #1 exited the room with a bag of linens and Resident #27 was in bed. During an interview on 5/19/25 at 11:06 A.M., CNA #1 said she assisted transferring Resident #27 from his/her wheelchair to his/her bed. CNA #1 said she also removed linens from Resident #27's room. CNA #1 said she did not have to wear any PPE when working with Resident #27. During an interview on 5/19/25 at 11:26 A.M., Nurse #1 said staff need to wear PPE when performing high contact activities with Resident #27. Nurse #1 and the surveyor reviewed the observations made in Resident #27's room. Nurse #1 said CNA #1 should have been wearing a gown and gloves if assisting Resident #27 with transferring and changing linens. During an interview on 5/19/25 at 3:02 P.M., the DON said when staff are working or assisting residents on EBPs they must wear gowns and gloves. The DON said CNA #1 should have been wearing a gown and gloves to provide direct care to Resident #27. 5. Review of the facility's policy titled Medication Administration by Route or Dosage, dated as revised March 2017, indicated but was not limited to the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Subcutaneous Injections: Wash hands, wear gloves Review of the facility's policy titled Hand Hygiene, dated April 2015, indicated but was not limited to the following: -To protect residents from health care associated infections -When to use alcohol hand sanitizer -Only when visible soil is absent -After contact with resident intact skin -After removing gloves -Before entering the resident room -Before exiting the resident rooms -Before and after dressing changes On 5/14/25 at 9:17 A.M., the surveyor observed Nurse #4 standing next to her medication cart that was located at the nursing station. Resident #40 requested she administer their Trulicity (GLP-1 injection used to treat type II diabetes), before he/she leaves the unit. Nurse #4 reached into her medication cart and took out the medication and an alcohol swab pad. Nurse #4 did not perform hand hygiene or don (put on) gloves. She lifted Resident #40's left shirt sleeve, cleansed the area with the alcohol pad, and administered the injection with her bare hands. Nurse #4 then disposed of the used injection into the sharps container that was located on her medication cart. Nurse #4 did not perform hand hygiene. She then went to her keypad and mouse on the computer that was located on top of the medication cart and began typing. On 5/14/25 at 9:19 A.M., Nurse #4 then walked to the coffee cart and poured a cup of coffee, walked down the hall and entered an office out of the surveyor's view. At no time did the surveyor observe Nurse #4 perform hand hygiene. During an interview on 05/14/25 at 9:21 A.M., Nurse #4 said she is supposed to wear gloves while administering an injection but did not. She said she gave the injection at the nursing station because the Resident requested it. Nurse #4 said she should have used hand sanitizer before and after she gave the injection but forgot. 6. Review of the facility's policy titled Clean Dressing Technique, undated, indicated but was not limited to the following: -Licensed staff members will use clean dressing technique for all dressing changes unless otherwise specified by the MD. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sanitize hands -Establish clean field (can be unsterile plastic field, clean linen, etc.) -Gather supplies and place on clean field, including several clean gloves -Sanitize hands and apply clean gloves -Remove old dressing and discard in plastic bag -Remove gloves, sanitize hands and apply clean gloves -Cleanse wound with solution ordered. -Remove gloves, sanitize hands and apply clean gloves -Dress wound -Remove gloves and sanitize hands Resident #60 was admitted to the facility in November 2024 with diagnosis including type II diabetes. Review of the Physician's Order indicated the following: -Left foot second toe normal saline wash, followed by bacitracin, oil emulsion and clean dry dressing, change daily. Order discontinued on 5/12/25 During an interview with observation on 5/14/25 at 10:28 A.M., Nurse #4 said Resident #60 requested a covering be applied to his/her left second toe and she was going to apply a dressing. The surveyor observed the following: -On the Resident's overbed table was an open ripped box of donuts and a remote control, visible crumbs, circular stains which appeared to be left from drinks and a large puddle of a clear liquid substance pooling on the edge of the table. -Nurse #4 placed a pile of open 4x4 gauze pads directly onto the overbed table, along with a 2x2 bordered gauze dressing with the date and her initials written on it, and a single-use container of normal saline. -Nurse #4 then opened the container of normal saline and squirted it onto the whole pile of open 4x4 gauze. -Nurse #4 took the top 4x4 gauze and rubbed the gauze on Resident #60's second left toe and then placed the used gauze back onto the overbed table (next to the pile of normal saline soaked 4x4 gauze). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #4 then took the 2x2 bordered gauze and covered Resident #60 left second toe with the dressing. -Nurse #4 then removed all the dressing supplies, disposed of them in the trash, removed her gloves, and performed hand hygiene. During an interview on 5/14/25 at 12:01 P.M., Nurse #4 said she was not aware she had to place a clean barrier between the clean dressing supplies and the table. She said she should have cleaned the table before putting the clean dressing supplies on it, but did not have any cleaning wipes with her. Nurse #4 said she was going to put the clean dressing supplies on the Resident's bed but figured that it was worse than the bed table. 7. Review of the facility's policy titled Decontamination of Resident Items, undated, indicated but was not limited to the following: -It is the policy of this facility to reduce and/or prevent the spread of infection through indirect contact by cleaning, sanitizing or disinfecting resident equipment, medical devices and the environment -Items require disinfection after each use using a disinfectant wipe. During an observation on 5/14/25 at 12:10 P.M., the surveyor observed Nurse #4 with the blood pressure machine on wheels take Resident #76 blood pressure in the hallway as follows: Nurse #4 applied the blood pressure cuff to Resident #76's left arm. Nurse #4 did not clean the cuff prior to applying it to the Resident's arm. Once she completed the blood pressure, she returned the machine to the center of the hallway and plugged it in. Nurse #4 did not clean the blood pressure cuff after use. During an interview on 5/14/25 at 12:12 P.M., Nurse #4 said she should have cleaned the blood pressure cuff after she used it, but the machine did not have any cleaning wipes in the basket. 8. On 5/15/25 at 8:35 A.M., the surveyor observed Nurse #12 prepare Resident #20's medications which included the following: -Flonase 50 micrograms (mcg) (treats allergies) nasal spray -Nurse #12 entered Resident #20's room with the Flonase in her hand and administered one squirt into each nostril of Resident #20. -Nurse #12 handed the Resident a tissue and exited the room. -Nurse #12 did not perform hand hygiene after administering the medication. -Nurse #12 then returned to the medication cart and began documenting in the medical record. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/25 at 8:39 A.M., Nurse #12 said she should have performed hand hygiene after administering the medications and before touching her medication cart, but she did not have any hand sanitizer on her cart available for use. 9. Resident #76 was admitted to the facility in August 2024 and had diagnoses including osteomyelitis (infectious inflammation of the bone marrow) of the left tibia/fibula (two long bones in lower leg). Review of the Physician's Orders indicated the following: -Maintain contact precautions -Remove wound vac dressing on or about seven days post-op and apply light dressing On 5/15/25 at 10:58 A.M., the surveyor observed a sign posted outside of Resident #76's room that said Contact Precautions everyone must: Clean their hands, including before entering and when leaving room. Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Nurse #4 was observed inside the room adjusting Resident #76's bed linens. Nurse #4 was not wearing a gown or gloves. Nurse #4 then exited the room, did not perform hand hygiene, and walked down the hall, then entered the clean utility room. On 5/15/25 at 11:00 A.M., the surveyor observed Nurse #4 enter Resident #76's room again and did not perform hand hygiene prior to entering. Nurse #4 did not put on a gown or gloves prior to entering. Nurse #4 placed a hand towel on Resident #76's overbed table, and placed a pile of 4x4 open gauze dressings, one 4x4 bordered gauze with the date 5/15/25 and her initials on it, and a single use tube of normal saline. During an interview on 5/15/25 at 11:01 A.M., Unit Manager (UM) #2 observed Nurse #4 in the room with the surveyor. UM #2 reviewed the contact precaution sign posted outside of Resident #76's room and said everyone must perform hand hygiene and wear a gown and gloves prior to entering the room. UM #2 said Nurse #4 should have on a gown and gloves while she is in the room, and she does not. On 5/15/25 at 11:02 A.M., the surveyor and UM #2 observed Nurse #4 exit Resident #76's room and perform hand hygiene. Nurse #4, UM#2 and the surveyor reviewed the contact precaution sign together and Nurse #4 said she only needs to wear a gown and gloves if she is going to touch the Resident. The surveyor reviewed the earlier observation with Nurse #4 in the room adjusting the Resident's linen and not performing hand hygiene after exiting the room. Nurse #4 said the Resident requested her to fix his/her bedding and it was not her intention to touch the Resident without a gown or gloves on. Nurse #4 said she always uses hand sanitizer when she leaves a resident's room but was focused on getting the supplies ready to complete a dressing change. On 5/15/25 at 11:09 A.M., the surveyor observed Nurse #4 and UM #2 administer a dressing to Resident #76. The surveyor observed the following: -Nurse #4 and UM #2 performed hand hygiene and donned a protective gown and gloves and entered the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/25 at 12:20 P.M., the Infection Control Nurse (ICN) said Resident #76 is on contact precautions for MRSA (Methicillin-resistant Staphylococcus aureus) (antibiotic resistant infection) in his/her left knee. The ICN said use of a protective gown and gloves are required anytime you enter the room. During an interview on 5/20/25 at 2:02 P.M., the DON said her expectation is when a nurse completes a clean dressing change, they must clean the table with an antibacterial cleanser, place a clean barrier in between the dressing supplies and the table. She said dressing supplies should never be placed directly onto the surface. The DON said nurses must cleanse their hands and change their gloves in between removing the old dressing and touching the clean dressings. The DON said all shared resident equipment must be cleansed after use. She said the best practice is to clean the equipment before and after use. The DON said all staff must adhere to the precaution signs. She said no one should enter a contact precaution room without donning a protective gown and gloves first. The DON said hand hygiene must be performed before and after administering medications. She said gloves must be worn to administer nasal sprays and to give injections.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program. Findings include: Review of the facility's policy titled Infection Control Prevention Program - Antibiotic Stewardship, revised 3/2024, indicated but was not limited to the following: - It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's infection prevention and control program. The goal of this program is to reduce inappropriate antimicrobial use, improve patient care outcomes and reduce possible consequences of antimicrobial use. - The facility will establish an antimicrobial stewardship team (AMS) dedicated to improving antimicrobial use. - The core members of the AMS team will include, but not be limited to the Medical Director, Pharmacy Consultant, Director of Nurses (DON), and Infection Preventionist (IP). - The facility uses the Updated McGeer's criteria to define infections. - When symptoms of an infection are identified, the following measures will be implemented: nursing staff shall notify MD (physician)/APRN (nurse practitioner) and responsible party; symptoms will be reviewed with the MD/APRN and further testing will be obtained per MD/APRN order; test results will be reviewed with the MD/APRN when available; all orders will include dose, duration, and indication of antibiotic; the duration of the ABT (antibiotic) therapy will be defined and/or regularly reviewed by the prescriber; antibiotics will be reassessed 48-72 hours after initiation to ensure the antibiotic is still indicated or adjustments should be made. - All infections will be tracked [NAME] (sic) the IP or designee and reviewed for trends. Review of the facility's policy titled Infection Control Prevention Program - Antibiotic Prescribing Practices, revised 3/2024, indicated but was not limited to the following: - Goal: to improve antibiotic ordering practices within the facility. - It is the policy of this facility that antibiotic prescribing practices are implemented as part of the facility's Antibiotic Stewardship Program for the purpose of optimizing the treatment of infections and to reduce adverse events associated with the antibiotic use. - The decision to prescribe an antibiotic will be guided by medical knowledge, best practices, and professional guidelines. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Antibiotics will be administered only as prescribed by the physician or other authorized practitioner. - Reassessment of the antibiotic will be conducted after 2-3 days for appropriateness factoring in results of diagnostic tests, laboratory results, and/or changes in the clinical status of the resident. Review of the facility's policy titled Infection Control Prevention Program - Surveillance for Healthcare-Associated Infections (HAIs), revised 3/2024, indicated but was not limited to the following: - This facility will closely monitor all residents who exhibit signs/symptoms of infection. - The nurse or nursing assistant will notify the IP of suspected infections, who will record the information of the Infection Control Log. - Document in the narrative nurses notes every shift of presence or absence of symptoms. Review of the facility's Surveillance Sheets for May 2025 indicated but were not limited to the following: Resident #29 had an upper respiratory infection (URI) concern with an onset date of 5/12/25. The surveillance indicated that the concern did not rise to the level of infection as determined by the facility criteria, however an antibiotic was prescribed for five days. Review of Resident #29's nursing progress notes indicated an antibiotic was initiated on 5/12/25 with no symptoms documented. A late entry note for 5/12/25 was written after the concern for antibiotic usage was brought to the facility's attention and indicated the Resident had congestion. Further review of the physician and nurse practitioner progress notes indicated on 5/14/25 Resident #29 had a congested cough. No further specific signs or symptoms of infection were indicated in the medical record. Review of Resident #29's medical record, including nursing, physician and nurse practitioner progress notes, failed to indicate reasoning for continued antibiotic usage even though the symptoms did not meet McGeer criteria. Resident #99 had a skin concern with an onset date of 5/1/25. The surveillance indicated that the concern did not rise to the level of infection as determined by the facility criteria, however an antibiotic was prescribed for seven days. Review of Resident #99's nursing progress notes indicated on 4/28/25 he/she had some swelling to their right lower extremity. The nursing progress notes on 5/1/25 indicated an antibiotic was started for seven days. Further review of the physician and nurse practitioner progress notes failed to include information related to the right lower extremity infection. No further specific signs or symptoms of infection were indicated in the medical record. Review of Resident #99's medical record, including nursing, physician and nurse practitioner progress notes, failed to indicate reasoning for continued antibiotic usage even though the symptoms did not meet McGeer criteria. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 7:52 A.M., the Director of Nursing (DON) said the medical record should contain documentation of all the residents' signs and symptoms of infection. The DON said the IP documents in progress notes when a resident does not meet antibiotic usage criteria, and any conversations had with the prescriber. The DON said progress notes should identify a prescriber's rationale for continued use of an antibiotic that does not meet McGeer criteria. The DON said there needs to be clearer documentation in the medical record indicating the residents' signs and symptoms of infection and/or rationale for continued antibiotic usage.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure two Residents (#23 and #87), out of a total sample of five residents reviewed for immunizations, were screened for eligibility to receive the recommended pneumococcal vaccination, residents/residents' representatives were educated on the benefits and potential side effects of the vaccine, and were offered and administered (if applicable) the vaccine in a timely manner. Specifically, the facility failed: 1. For Resident #23, to ensure the Resident's medical record included documentation that indicated the Resident/Resident's Representative was provided education regarding the benefits and potential side effects of pneumococcal vaccination and declined vaccination; and 2. For Resident #87, to ensure the Resident's medical record included documentation that indicated the Resident/Resident's Representative was provided education regarding the benefits and potential side effects of pneumococcal vaccination and either consented to receive or refused vaccination. Findings include: Review of the facility's policy titled Immunization of Residents, revised October 2024, indicated, but was not limited to, the following: -All eligible residents will be offered the influenza and pneumococcal vaccines unless medically contraindicated. The resident or the resident's legal representative will be provided education regarding the pros and cons of the vaccine prior to administration. The resident or resident's legal representative has the right to refuse the vaccine. -Procedure for Pneumococcal Vaccination of Residents *Each resident or their responsible party will be asked on admission if they have previously had any pneumococcal vaccinations and their age at the time of vaccination. *The pneumococcal conjugate vaccine will be offered to all eligible residents and the risks and benefits will be provided to the resident or resident's legal representative prior to administration of the vaccine. The resident or resident's legal representative has the right to refuse the vaccine. *Adults aged 65 years or older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive a pneumococcal conjugate vaccine. Review of the Centers for Disease Control and Prevention (CDC) guidance titled Pneumococcal Vaccine Timing for Adults, dated October 2024, indicated but was not limited to the following: Adults 50 years or older: -No prior pneumococcal vaccine history (or received PCV7 at any age and no other pneumococcal vaccines): (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Option A: Administer PCV20 or PCV21 for all adults 50 years or older who have never received any pneumococcal vaccine *Option B: Administer PCV15 followed by pneumococcal polysaccharide vaccine (PPSV23) at least a year later -Received PPSV23 only (at any age): *Option A: Administer PCV20 or PCV21 at least a year later *Option B: Administer PCV15 at least a year later -Received PCV13 only (at any age): *Administer PCV20 or PCV21 at least a year later -Received PCV13 at any age and PPSV23 at younger than 65 years: *Administer PCV20 or PCV21 at least five years later 1. Resident #23 was admitted to the facility in February 2024 and was [AGE] years old. Review of Resident #23's electronic health record indicated the Resident refused pneumococcal conjugate vaccination. Review of the Resident's full medical record failed to indicate the Resident's pneumococcal vaccination history had been obtained or that the Resident's eligibility for the pneumococcal vaccine had been determined. Further review failed to indicate any education was provided to the Resident or their legally responsible party or that a consent or declination form for pneumococcal conjugate vaccination was obtained. 2. Resident #87 was admitted to the facility in March 2025 and was [AGE] years old. Review of Resident #87's electronic health record failed to indicate the Resident had received or refused a pneumococcal conjugate vaccine. Review of the Resident's full medical record failed to indicate any pneumococcal vaccination history had been obtained or that the Resident's eligibility for the pneumococcal vaccine had been determined. Further review failed to indicate any education was provided to the Resident or their legally responsible party or that a consent or declination form was obtained. During an interview on 5/20/25 at 11:29 A.M., the Director of Nurses said she could not find the pneumococcal consent/declination forms for Resident #23 or Resident #87 that should be in the Residents' medical records.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure mechanical equipment in the main kitchen was maintained in safe operating condition, specifically (a) the plate warmer cart and (b) the walk-in freezer in the main kitchen. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 4-5 Maintenance and Operation 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. Review of the facility's policy titled Dietary Department Guidelines, revised May 2012, indicated but was not limited to the following: -Equipment: Any piece of equipment, dish, or utensil will be discarded when it is cracked, broken, discolored, or abraded. Review of the Town Food Inspection Report, dated 2/6/25 indicated same issue again is with walk-in freezer. Ice is now on boxes and boxes are not allowed to be contaminated with anything. Needs to be addressed again. Review of the Town Food Inspection Report follow up visit, dated 3/24/25 indicated checked walk-in freezer and girls are keeping up with it, but ice is still accumulating on left side and ceiling and on products. On 5/14/25 at 8:30 A.M., the surveyor observed the following in the main kitchen: 1. Plate warmer with no plate covers; 2. Walk-in freezer with: -condensation on the exterior of the freezer door window; -freezer door seal detached from the top right corner of the freezer door - the length of detachment was not measured but visualized to be approximately greater than 4 inches long; (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-freezer door seal in the bottom right corner cracked with missing part of the seal; -drops of condensation frozen on the ceiling adjacent to the condenser unit above a cardboard box of brownies; -thick ice buildup on boxes below the condenser unit; -thick ice buildup on the freezer floor under the condenser unit; and -slippery floor in the walkable area inside the freezer. During an interview on 5/14/25 at 8:50 A.M., the Food Service Director (FSD) said the plate warmer in the main kitchen did not have plate covers to aid in its practical use. The surveyor touched the side of one plate located in the plate warmer and the plate was lukewarm. The FSD said the plate warmer worked sporadically, which was of concern due to it being an electrical piece of equipment. The FSD said the facility provided the kitchen with an additional plate warming unit received from another facility, however, the acquired plate warming unit did not work and could not be used. The FSD said she expected the current plate warmer in the main kitchen to be in good working condition with all its parts. During an interview on 5/14/25 at 8:50 A.M., the FSD and the surveyor observed the walk-in freezer together. The FSD said the condensation in the freezer had been a concern for a long time. The FSD said there was excessive condensation build up inside the walk-in freezer, particularly on the ceiling, on several boxes of food stored underneath the condenser fans, and on the floor, which were all observed at that time. The FSD said the facility had tried to implement trays on the shelving beneath the condenser fans to catch condensation, but this was not effective as it caused the freezer to go into defrost mode. The FSD said kitchen staff and maintenance were working together to remove and maintain the ice buildup. The FSD said she expected the walk-in freezer to have a door seal that was not compromised and functioned properly to minimize condensation buildup inside the freezer, and for less condensation to occur inside the freezer. During an interview on 5/14/25 at 4:30 P.M., the Administrator and the surveyor observed the plate warmer and the walk-in freezer in the main kitchen. The Administrator said he was new to the facility in recent months and had been working toward accommodating the kitchen and providing repairs. The Administrator said he expected the plate warmer and the walk-in freezer door to function properly and not be compromised. During an interview on 5/15/25 at 10:55 A.M., the FSD said concerns about the walk-in freezer and plate warmer have always been communicated verbally. The FSD said issues with the walk-in freezer have been ongoing since prior to the facility's last survey, and the town Board of Health was also aware. The FSD said she and staff used a hammer to break up the ice and the Administrator had even used a shovel to break up the ice in the freezer. During an interview on 5/15/25 at 10:55 A.M., the FSD said a food vendor representative had taken pictures of the facility's plate warmer today and would reach out to a third-party vendor for repair as he felt it could be fixed. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/15/25 at 12:04 P.M., the Director of Maintenance (DOM) said the walk-in freezer door had not been repaired since it was identified last survey. The DOM said the needed part for the door was ordered but never received or installed due to financial reasons and the workaround was breaking down ice accumulation weekly if not daily. During an interview on 5/15/25 at 12:04 P.M., the DOM said the plate warmer in use had started having issues about three months ago. The DOM said the plate warmer had one working side and there were no covers or domes to place over the stored plates. During an interview on 5/15/25 at 12:04 P.M., the DOM said the facility had previously used TELS (a software platform designed to manage day-to-day challenges of building operations) to manage maintenance requests but had moved to paper reporting; each floor and the kitchen entered maintenance issues in logbooks located on each unit and near the kitchen. The DOM said maintenance constantly monitored the logbooks. The DOM said staff would also call, text, or verbalize maintenance concerns to him. During an interview on 5/16/25 at 11:30 A.M., the freezer repair vendor #2 said a drain was clogged in the walk-in freezer, causing it to go into defrost mode. He said he unclogged the drain which will keep the unit from going into defrost mode and stop the ice from accumulating inside the walk-in freezer and on the boxes. The vendor said one motor was not secured, so he replaced the fan blade and secured the motor on correctly. He said he secured the gasket onto the door with screws but recommended a new door for the walk-in freezer. The vendor said there should have been and should continue to be regular maintenance on the motors and drains he serviced. On 5/16/25 at 11:30 A.M., the surveyor observed, in the walk-in freezer, accumulated water that had dropped down from the condenser motor and froze on the floor and on boxes of stuffed shells, bacon, cheese tortellini, cheese manicotti, lasagna, and turkey breast roast. The freezer repair vendor Service Invoice indicated the technician found the following: -fan blade broken due to fan motor not properly installed to [NAME] -clogged drain -door falling apart and door closure broken causing door not to close -heater wire cut as well so the door cannot defrost -technician replaced broken fan blade and properly installed mount and tested to ensure system functionality; unclogged drain and cleared out dirt/dust/debris; installed new door closer which will help until door can be replaced fully On 5/14/25, 5/15/25, and 5/19/25, the surveyor had requested in-house and vendor maintenance logs and documentation for the walk-in freezer. During an interview on 5/19/25 at 4:29 P.M., the DOM provided the following: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-a vendor quote, from freezer repair vendor #1, dated 4/9/24, for the freezer door replacement which indicated 100% deposit was required prior to ordering material or scheduling job; -a facility check request form, dated 4/24/24, indicated a request for check payment to freezer vendor repair #1 to replace the freezer door to comply with the Department of Public Health; an approval signature was indicated and dated 4/24/24; -weekly preventative maintenance log, dated 4/12/24 to 5/12/25, indicated maintenance chipped away ice accumulation in the walk-in freezer on at least a weekly basis and was waiting for the door panel to be replaced. During an interview on 5/19/25 at 4:29 P.M., the DOM said the last coordination effort to repair the walk-in freezer door was the work order quote and the check request from April 2024. During an interview on 5/19/25 at 4:29 P.M., the DOM said a vendor (freezer vendor repair #2) had serviced the walk-in freezer on 5/16/25 after surveyors identified issues. He said the vendor reattached the gasket to the freezer door and had fixed a clog in the condenser drain which reportedly was causing the water drippage from the condenser onto boxes and the floor. The DOM said he was unaware that the drippage was due to a clogged condenser drain as no vendor had been monitoring, maintaining, or providing repair to the freezer unit until 5/16/25. During a telephonic interview on 5/19/25 at 4:35 P.M., the Director of Resident Support Services (DRSS) said the vendor who assessed the walk-in freezer said there was a shattered condenser fan and the freezer door had gasket issues. The DRSS said the walk-in freezer and plate warmer should be in good and safe working condition.