STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225341	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamstown Commons Nursing & Rehab	25 Adams Road Williamstown, MA 01267

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to ensure each resident received food that was palatable and served at an appetizing temperature for three units (Unit 1, Unit 2 and Unit 3), out of three units, and for three sampled Residents (#4, #93 and #136), out of a total of 26 sampled residents. Specifically, the facility failed to ensure the food provided during meals was appetizing in taste, temperature and appearance. Findings include: 1. During the initial pool process on 3/24/26 from 8:30 A.M. to approximately 2:39 P.M., residents residing in the facility said the following: -Resident #82, who resided on Unit 2, said the food was terrible, and he/she has lost seven pounds since being admitted to the facility. -Resident #93, who resided on Unit 1, said he/she receives sandwiches and will only eat the filling because the bread does not look fresh. -Resident #4, who resided on Unit 2, said portion sizes for food is never enough and he/she does not receive extra food when requested. -Resident #136, who resided on Unit 2 said the food sucks, is lousy tasting, is bland and he/she is not eating the meals because he/she did not like the taste. On 3/25/26 at 11:30 A.M., the surveyor requested test trays during lunch service for Units 1, 2 and 3 from the Food Service Supervisor. On 3/25/26 at 11:46 A.M. through 11:59 A.M., the meal cart arrived to Unit 3 and the surveyor observed the following: -11:47 A.M. resident meals were distributed by the facility staff. -11:59 A.M. the last resident meal tray was served. The surveyor obtained the test tray from the meal cart and the following temperatures were obtained with the Minimum Data Set (MDS) Nurse: >Meal was served on a divided plate. >Pureed veal with gravy: 110 degrees Fahrenheit (F), not hot, lukewarm and was loose, liquid consistency and did not hold shape/form. Not palatable. >Pureed carrots: 111 degrees F, lukewarm. (continued on next page)

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

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>Mashed potatoes with gravy: 125 degrees F, warm, bland, was not palatable. >Strawberry ice cream: 20 degrees F, melted around the edges with firmer ball of ice cream in the middle. Not palatable. At 12:13 P.M., the surveyor observed Nurse #1 provide several of the residents who were seated for the lunch meal in the Unit 3 dining room with strawberry milkshakes. During an interview at this time, Nurse #1 said she took the strawberry ice cream and made milkshakes for the residents because the ice cream was melted. On 3/25/26 at 12:07 P.M., the lunch cart arrived to Unit 2. At 12:12 P.M., the last resident lunch meal was distributed, and the test tray was obtained from the meal cart. The surveyor and the Admissions Staff completed the test tray, and the following temperatures were obtained: >Macaroni and cheese: 120 degrees F, not hot >Stewed tomatoes: 95 degrees F, warm On 3/25/26 at 12:17 P.M., the lunch cart arrived to Unit 1. At 12:37 P.M., the last resident lunch meal was distributed, and the test tray was obtained from the meal cart. The surveyor completed the test tray at this time, and the following temperatures were obtained: >Veal cutlet with gravy: 90 degrees F, warm >Mashed potatoes with gravy: 100 degrees F, warmish, bland. Not palatable >Mixed vegetables: 85 degrees F, slightly warm During an interview on 3/25/26 at 4:12 P.M., the surveyor relayed the test tray observations to the Registered Dietitian (RD). The RD said there have been several residents who have complained about the temperature of the food during meals. The RD said when food is pureed, it should hold its shape and not be loose or spread out on the plate when served. During an interview on 3/26/26 at 7:38 A.M., the Food Service Supervisor said she was aware of the residents' concerns pertaining to food temperatures. The Food Service Supervisor said the temperatures of the hot food when provided to the residents should be 150 degrees or hotter and for the cold foods to be 38-39 degrees or colder. The Food Service Supervisor said temperatures are taken frequently during meal service in the facility kitchen and are at the appropriate temperatures for service. The Food Service Supervisor further said the facility previously utilized heated metal inserts to assist with keeping the hot food hot, but these were discarded and not in use for the past several years. The surveyor relayed the test tray observations at this time, and the Food Service Supervisor said the mashed potatoes were instant and did not have flavor, and that the pureed food should maintain its shape and not be loose. The Food Service Supervisor said the cooks should be testing, tasting the resident food and adding additional seasoning to flavor it. 2. Resident # 93 was admitted to the facility in March 2024 and had diagnoses including Dysphagia and Peritonsillar Abscess. Review of Resident #93's MDS Assessment, dated 2/14/26, indicated he/she was cognitively intact (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and scored a 15 out of possible 15 on the Brief Interview of Mental status (BIMS) exam. During an interview on 3/25/26 at 9:04 A.M., Resident #93 said that he/she did not eat the scrambled eggs and potatoes on the breakfast plate because they were cold. Resident #93 said he/she had put the cold items to the side because they were unappetizing. During an interview on 3/25/26 at 11:25 A.M., Resident #93 said that staff members did not offer to warm up the scrambled eggs and potatoes and if they had, he/she would have eaten them. Resident #93 said that he/ she often received cold food and will not eat it. During an interview on 3/25/26 at 2:43 P.M., Resident #93 said that the eggs are served cold every morning and had not been appetizing to eat. Resident #93 said that he/ she had not eaten the plated breakfast food for the past several weeks because of the temperature. He/she said that staff had not offered to heat up the cold food items and did not provide an alternative option. Resident #93 said that he/she tried to be reasonable but if the food items were served warmer he/she would be able to eat more. During an interview on 3/25/26 at 4:22 P.M., the Director of Nursing (DON) said that if a resident did not eat their meal, staff should ask the resident why they did not eat the meal, and then offer the alternative food items or offer to reheat the meal if the food complaint was that the meal was too cold to eat.

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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 observations and interviews the facility failed to ensure its staff prepared, distributed and served food in accordance with professional standards for food service safety. Specifically, facility staff failed to ensure: facial hair was covered by two staff members and, one staff performed hand hygiene when they stepped away from the food tray line, touched other high touch services and, returned to the food tray line, increasing opportunities for cross contamination of exposed food. Findings include: Review of the facility policy titled Dietary: Sanitary Conditions approved on 10/27/22 indicated the following: -Hair nets and beard restraints must be worn when entering the main kitchen area. -Hand washing:.it is critical that staff involved in food preparation consistently utilize good hygiene practices and techniques for hand hygiene. On 3/25/26 from 11:30 A.M. to 12:15 P.M., the following was observed in the kitchen: -two Dietary Aides (Dietary Aide #1 and Dietary Aide #2) on the tray line with facial hair not wearing beard protectors -Dietary Aide #1 stepped off the tray line to answer the phone, picked up a pen from the counter, wrote notes on the notepad, replaced the phone and pen and returned to the tray line without performing hand hygiene. During an interview following these observations the Food Service Director (FSD) said staff should be wearing beard protectors when they have facial hair. The FSD said Dietary Aides #1 and #2 were not wearing beard protectors as required during the tray line. The FSD said when staff leave the tray line at any time, they are required to wash their hands before going back to the tray line. The FSD said when Dietary Aide #1 stepped off the tray line to answer the phone and write down the order, he should have washed his hands before going back to the line to prevent cross contamination.ˆ During an interview 3/25/26 at 12:40 P.M., Dietary Aide #1 said he stepped away from the tray line to answer the phone, wrote down an order and went to the walk-in freezer to gather items. Dietary Aide #1 said before he returned to the tray line to finish placing items on the trays, he should have washed his hands and did not.ˆ

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and records reviewed, the facility failed to maintain a safe and sanitary environment for two Residents with urinary catheters (#102 and #58), of five applicable residents reviewed with urinary catheters, out of a total sample of 26 residents. The facility also failed to ensure hand hygiene was performed during distribution of medications and that shared medical equipment was cleaned and disinfected between resident use on one unit (Unit 3), of three units observed. Specifically,For Resident #102, the facility failed to ensure that the Resident's indwelling urinary catheter drainage bag was not touching the floor on 3/24/26 and 3/25/26, increasing the Resident's risk for infection.For Resident #58, the facility failed to ensure the Resident's indwelling urinary catheter drainage bag and tubing were not touching the floor increasing the potential risk of infection.Nurse #1 failed to perform hand hygiene during medication distribution when she donned gloves, touched the computer and then touched a pill for resident consumption with the same gloved hands. Nurse #1 also failed to ensure hand hygiene was performed throughout medication distribution after doffing used gloves and before applying new gloves. During medication observation, Nurse #1 failed to disinfect shared medical equipment (vitals machine, blood pressure cuff and stethoscope) when used for multiple residents increasing the risk of cross contamination and potential spread of infection. Findings include:1.Resident #102 was admitted to the facility in February 2026, with diagnoses including retention of urine and chronic kidney disease. Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #102: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) Assessment score of 10 out of a possible score of 15. -had a diagnosis of renal insufficiency, renal failure or End-Stage Renal Disease. Review of Resident #102's Foley Catheter Care Plan, initiated 2/23/26, indicated: -Goal: The Resident would show no signs or symptoms of urinary infection. -Interventions: The Resident has a 14 French 10 milliliter (ml) indwelling Foley catheter. Review of Resident #102's Self-Care Care Plan, initiated 2/18/26, indicated: -The Resident has an alteration in ability to provide self-care/perform Activities of Daily Living (ADL's) due to functional decline and weakness. -Goal: The Resident will maintain comfort, cleanliness, and dignity. Review of Resident #102's active Care Card, undated, indicated: -The Resident is dependent on staff for toileting. -The Resident is maximum assistance for hygiene. -The Resident is maximum assistance for bed mobility. (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 Resident #102's active Order Summary Report indicated: -Urinary catheter: 14 French 10 cubic centimeters (cc) bulb every shift. Start date 3/6/26. On 3/24/26 at 11:07 A.M., the surveyor observed Resident #102 lying in bed, with his/her indwelling urinary catheter attached to the bedframe and hanging onto the floor with a portion of the bag lying on the floor. On 3/25/26 at 8:27 A.M., the surveyor observed Resident #102 lying in bed, with his/her indwelling urinary catheter attached to the bedframe and hanging onto the floor with a portion of the bag lying on the floor. During an interview on 3/25/26 at 8:31 A.M., Certified Nursing Assistant (CNA) #2 said that when the indwelling urinary catheter drainage bag was hanging on the floor, there was a concern for cross-contamination. CNA #2 said the indwelling urinary catheter drainage bag had the potential to touch Resident #102's skin after touching the floor. During an interview on 3/25/26 at 9:49 A.M., Nurse #3 said that indwelling urinary catheter drainage bags should not be touching the floor. She said that the floor is dirty, and the drainage bag's spout could touch the floor, which could lead to an infection in Resident #102. During an interview on 3/25/26 at 4:08 P.M., the Director of Nursing (DON) said that indwelling urinary catheter drainage bags should not be touching the floor. The DON said that when indwelling urinary catheter drainage bags were touching the floor, it would be an infection control concern. 2. Resident #58 was admitted to the facility in facility in January 2026 with diagnoses including Dementia, Bladder Cancer and Acute Urinary Retention. Review of the MDS Assessment, dated 1/9/26 indicated the following relative to Resident #58: -He/She had severe cognitive impairment as evidenced by a score of zero out of 15 possible points on the BIMS exam. -Dependent on staff with toileting, personal hygiene -Required assistance from staff with transfers. -Had an indwelling catheter. Review of the Resident's comprehensive plan of care included the following: -Activities of Daily Living (ADL) Care Plan, initiated 3/5/26, indicated the Resident was dependent on staff for wheelchair locomotion, and toileting needs. The plan of care indicated the Resident had a catheter. -Urinary Catheter Care Plan, initiated 3/4/26, included the following interventions: >secure catheter to prevent pulling and injury (3/6/26) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>position the catheter (urinary drainage) bag and tubing below the level of the bladder (3/4/26) Review of the March 2026 Physician's Orders included the following: -Urinary Catheter care every shift, initiated 1/29/26 -Enhanced Barrier Precautions (EBP), initiated 3/5/26, for foley catheter and ESBL (Extended-Spectrum Beta Lactamase: an enzyme produced by certain bacteria that makes them resistant to many common antibiotics) in the urine. -Urinary Catheter: 14 French (Fr= unit of measure) 5 milliliter (ml) balloon, may change as needed .initiated 3/4/26. On 3/25/26 at 7:46 A.M., 8:46 A.M., and 9:02 A.M., the surveyor observed Resident #58 dressed and seated in a specialized wheelchair with the urinary drainage bag and tubing resting on the floor. At 9:11 A.M., a Certified Nurse Aide (CNA) approached the Resident and provided him/her with a tactile activity blanket. During these observations, several staff were observed walking by and occasionally engaging with the Resident. On 3/25/26 at 4:31 P.M., Resident #58 was observed seated in specialized wheelchair in the common area. The urinary drainage bag and tubing remained on the floor. At 4:35 A.M., CNA #1 approached Resident #58 and assisted him/her to the Unit Dining room. While transporting Resident #58 in his/her wheelchair from the common area to the Unit dining room, the urinary drainage bag and tubing could be heard dragging on the carpet. During an interview on 3/25/26 at 4:45 P.M., CNA #1 said Resident #58 was dependent with ADL care and had a urinary catheter. CNA #1 said the Resident would often fiddle with his/her catheter tubing and that the catheter and urinary drainage bag should be positioned low for drainage. At this time, the surveyor and CNA #1 observed Resident #58. CNA #1 said the Resident's urinary drainage bag and tubing were on the floor. CNA #1 said the urinary drainage bag/tubing could get caught and/or punctured because of the positioning and would also be a concern for infection because it is on the floor. During an interview on 3/25/26 at 4:54 P.M., Nurse #2 said Resident #58 consistently pulls on his/her catheter tubing, pant leg and will sometimes put the urinary drainage bag on his/her lap. Nurse #2 said if the Resident's urinary drainage bag and tubing lying on the floor would be an infection control concern. Nurse #2 said Resident # 58 has a history of urinary tract infections, and that staff should be keeping an eye on the catheter tubing and urinary drainage bag and reposition it as needed. During an interview on 3/26/26 at 10:39 A.M., Unit Manager (UM) #1 said Resident #58's urinary catheter tubing and drainage bag should not be on the floor and that this would be an infection control concern. 3. Review of the facility policy titled Environmental Surface Cleaning, revised November 2016, indicated the following: -PDI Super Sani Plus or Clorox Hydrogen Peroxide Canister Wipes should be used by nursing staff to clean all equipment used by multiple residents. This includes thermometers, blood pressure (BP) cuffs and stethoscopes, pulse oximetry monitors (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 policy titled Hand Washing and Hand Hygiene, revised November 2016, indicated hand hygiene is the single most important method to prevent the spread of infection and is an important component of any infection prevention and control program. The policy also included the following: -When to wash or hand rub: >before and after having direct contact with residents/patients >before application of gloves and after removing gloves or other Personal Protective Equipment (PPE) >After contact with objects in the resident/patient environment including equipment or personal items in the resident/patient immediate vicinity On 3/25/26 from 9:22 A.M. through 12:35 P.M., during medication distribution, the surveyor observed Nurse #1 to do the following: -9:22 A.M. returned to medication cart wearing gloves, discarded the gloves in the trash, did not perform hand hygiene, dispensed numerous medications into medication cup, put on new gloves and then touched the computer mouse with the same gloved hands. Nurse #1 took a gloved finger and removed a pill from the medication cup, crushed the remaining medications and added applesauce into the medication cup with the crushed pills and then discarded her gloves into the trash (did not perform hand hygiene). Nurse #1 poured a glass with water, touched straws, then while holding medications, and cups of water and another cup of red juice, approached Resident #58 and took the interactive activity blanket off the floor and put it on the Resident's lap (did not perform hand hygiene), then walked into a Resident's room with the cups of fluid and medications. -9:30 A.M. Nurse #1 exited the resident room, approached another resident who was seated in a wheelchair near the nursing station with putting on his/her slipper, and then returned to medication cart and began dispensing medications (did not perform hand hygiene). -9:58 A.M., Nurse #1 observed to take vitals machine and enter room [ROOM NUMBER]. Surveyor observed the Nurse obtain the Resident's vitals and exit the room but did not clean/disinfect the vitals machine. Nurse #1 placed the vitals machine outside of room [ROOM NUMBER]. -12:27 P.M., Nurse #1 took the vitals machine and approached a Resident who was seated in the activity room. Nurse #1 applied the BP cuff around the Resident's right arm and obtained measurements. Nurse #1 then removed the BP cuff and wheeled the vitals machine near the nursing station (did not disinfect the machine). Nurse #1 then opened the bottom drawer of the medication cart, retrieved a manual BP cuff and stethoscope and completed another set of vitals on the Resident. After the measurements were obtained, Nurse #1 removed the BP cuff from the Resident, folded it up and placed it back in the last drawer of the medication cart along with the used stethoscope (did not disinfect the equipment). During an interview on 3/25/26 at 12:35 P.M., Nurse #1 said when opening medication capsules, touching resident medications, gloves should be worn. Nurse #1 said hand hygiene should occur before entering and after exiting resident rooms and after removing gloves. At this time, the surveyor relayed observations from medication pass and when obtaining resident vitals. Nurse #1 said she did not perform hand hygiene when she removed her gloves and used her gloved hand to remove a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication from the medication cup after touching the computer mouse. Nurse #1 said the vitals machine and the BP cuff and stethoscope are shared medical equipment that is used for multiple residents. Nurse #1 said she did not disinfect the shared medical equipment between resident use because she was not aware that she needed to. Nurse #1 said her understanding was that the shared medical equipment would only need to be disinfected if used for a resident on precautions. During an interview on 3/26/26 at 10:39 A.M., UM #1 said hand hygiene should occur anytime gloves are discarded. UM #1 said there was a potential for cross contamination when Nurse #1 touched the computer mouse with her gloved hands and then touched the pill in the prepared medication cup. UM #1 said shared medical equipment should be disinfected with the approved cleaning product after each use with a resident and prior to using on another resident and shared medical equipment included the vitals machine and the stethoscope and manual BP cuff.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and records reviewed, the facility failed to ensure that the appropriate enteral feeding (nutrients delivered through a feeding tube directly into the stomach, duodenum or jejunum) treatment was provided for one Resident (#2) of one applicable resident, out of a total sample of 26 Residents. Specifically, for Resident #2, the facility failed to administer enteral nutrition according to the Physician's order and administered more than the prescribed volume of enteral nutrition, placing the Resident at an increased risk for complications of enteral feeding including aspiration pneumonia, diarrhea, and vomiting. Findings include:Review of the facility policy titled Enteral Tube Medication Administration, effective June 2019, indicated that the facility assures the safe and effective administration of enteral formulas.via enteral tubes. Resident #2 re-admitted to the facility in September 2025, with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (stroke), morbid obesity due to excess calories, dementia, and End-Stage Renal Disease. Review of Resident #2's March 2026 Order Summary Report indicated the following:-Nothing by mouth (NPO) diet, NPO texture, NPO consistency, related to dysphagia following cerebral infarction. Start date 2/4/26.-Enteral Feed Order five times a day related to dysphagia following cerebral infarction. Enteral nutrition via gravity or bolus (administration of a limited volume of enteral formula over brief periods of time). Formula: Jevity. Strength: 1.5 calories (cal). Volume to administer: 240 milliliters (ml) five times a day. Total formula volume: 264 ml x 5 bolus. Total free water volume: 60 ml before and after bolus administration. Start date: 2/4/26. Review of Resident #2's Tube Feeding Care Plan, initiated 3/3/26, indicated:- the Resident is dependent with tube feeding and water flushes.- see Physician's orders for current feeding orders. Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #2:was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Assessment score of 13 out of a possible score of 15.had a diagnosis of malnutrition/risk for malnutrition.had a feeding tube. On 3/26/26 at 11:50 A.M., during an observation of enteral feeding administration, Nurse #6 administered two containers of Jevity 1.5 cal. Each container of Jevity 1.5 cal was observed to contain 237 ml of enteral nutrition.During an interview on 3/26/26 at 12:12 P.M., Nurse #6 said Resident #2 was ordered to receive 240 ml of Jevity 1.5 cal. Nurse #6 said the Resident received too much enteral nutrition, stating that the Resident received two containers of Jevity 1.5 cal, each containing 237 ml. During an interview on 3/26/26 at 1:29 P.M., Nurse Practitioner (NP) #1 said the expectation was that nurses followed the Provider's orders. NP #1 said Resident #2 would be monitored due to receiving more than the Physician-ordered enteral nutrition. NP #1 said that monitoring for nausea, vomiting, abdominal pain and residuals (volume of stomach contents remaining in the stomach after a feeding) was indicated. During an interview on 3/26/26 at 3:41 P.M., the Director of Nursing (DON) said Resident #2 was being monitored for abdominal distention, abdominal discomfort, vomiting, and residual volume after he/she received more than the Physician-ordered volume of enteral nutrition.

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Williamstown Commons Nursing & Rehab	25 Adams Road Williamstown, MA 01267

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to ensure that pain management was provided in accordance with the individual goals for care and preferences for one Resident (#80) out of a total sample of 26 residents.Specifically, for Resident #80, the facility failed to implement the order for Morphine (short-acting opioid medication used to treat moderate to severe pain) medication as indicated by the Physician, resulting in an increased risk for physical pain and psychological upset for the Resident.Findings include:Review of the facility policy titled Management of Controlled Substances in Skilled Nursing Facilities, effective February 2009 and revised July 2025, indicated but was not limited to the following:Ordering of controlled substances:.A new order shall be entered into the Medication Administration (MAR). In addition, an electronic prescription from an authorized prescriber shall be transmitted from a software application that meets Drug Enforcement Administration (DEA) requirements. Alternatively, a valid written prescription that is fazed by an authorized prescriber may be provided. Review of the facility policy titled Pain Management Policy, effective May 2005 and revised December 2025, indicated but was not limited to the following:-Policy: Pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.-Procedure.An individualized, interdisciplinary care plan will be developed and include pharmacological.approaches with input from: Resident.Medical Providers. Resident #80 was admitted to the facility in March 2026, with diagnoses including fracture of left patella (kneecap), dislocation of patella, anxiety disorder, and sprain of the right wrist. Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #80:was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Assessment score of 15 out of a possible score of 15.was not prescribed an opioid medication.did not receive a scheduled pain medication regimen.had presence of pain frequently, which occasionally effected his/her sleep.pain interfered with day-to-day activities frequentlypain intensity: 8 During an interview on 3/24/26 at 9:37 A.M., Resident #80 said that he/she had fallen, resulting in a fracture of his/her left patella and a torn ligament. Resident #80 said that on 3/13/26 the Physician said he would discontinue the prescribed Naltrexone (a medication used to treat alcohol use disorder, opioid use disorder, eating disorders, and obesity) medication and order Morphine as needed (PRN). Resident #80 said that this change in the treatment plan did not happen as discussed with the Physician. He/she said that the Naltrexone medication was still given to him/her following the discussion with the Physician on 3/13/26, so he/she refused to take the Naltrexone, and the Morphine medication was not available for him/her. Resident #80 said that there had been at least one time that he/she wanted to take more than the prescribed Acetaminophen (medication used to treat mild pain), but the Morphine medication was not available to him/her. He/she said that the pain at that time was maybe a five out of 10. Review of Resident #80's Pain Care Plan, initiated 3/9/26, indicated that the Resident had potential for alteration in comfort/pain related to fracture of the patella, right wrist sprain, and obesity. Interventions included to medicate per Physician's orders (see MAR). Review of Resident #80's Acute Pain Care Plan, initiated 3/16/26, indicated the Resident had a traverse fracture of the left patella, a right wrist sprain, and a urinary tract infection. Interventions included to administer pain medications per order. Review of Resident #80's Order Summary Report between 3/3/26 and 3/26/26 indicated the following:-Acetaminophen oral tablet 325 milligrams (mg). Give 2 tablets by mouth every 6 hours as needed for elevated temperature or pain not to exceed 3 grams in 24 hours. Start date 3/3/26.-Naltrexone HCl oral tablet 50 mg. Give 1 tablet by mouth two times a day for blocking opioid receptors. Hold medication while taking Morphine. Start date 3/9/26.-Morphine Sulfate oral tablet 15 mg. Give 1 tablet by mouth every 8 hours as needed for pain until 3/31/26. Start date 3/26/26, End date 3/31/26. Review of Resident #80's MAR dated March 2026 indicated the following:-Naltrexone HCl oral tablet 50 mg. Give 1 tablet by mouth two times a day (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for blocking opioid receptors. Hold medication while taking Morphine (Scheduled for 8:00 A.M. and 8:00 P.M.) was not administered at 8:00 P.M. on 3/14/26, at 8:00 A.M. and 8:00 P.M. on 3/15/26, at 8:00 P.M. on 3/16/26, and at 8:00 A.M. on 3/17/26 due to the Resident's refusal. The medication was placed on hold beginning at the 8:00 P.M. dose on 3/17/26. Review of fax records from Nurse #7 to the Physician, dated 3/16/26, indicated:-Nurse #7 wrote: You spoke with this resident on Friday. He/she said you told him/her you would order Morphine for him/her and put his/her on Naloxone (sic) on hold. Currently no orders in place. He/she refused his/her Naloxone (sic) today but there are no Morphine orders if he/she asks.-The Physician responded: I'll order the Morphine PRN. It's OK to stop Naltrexone for now. I spoke with his/her psychiatrist. During an interview on 3/26/26 at 12:43 P.M, the Physician said that on 3/13/26 he had a discussion with Resident #80 regarding his/her pain management treatment plan, and it was agreed upon that the Physician would discontinue the Naltrexone medication order and would order the Resident for Morphine medication as needed. The Physician said that the Resident had wanted a Morphine medication order as needed in case his/her pain had become intolerable again. The Physician said he had sent a script for the Morphine medication to the wrong pharmacy on 3/13/26. He said that the facility contacted him on 3/24/26 regarding the Morphine medication, and it was at that time that he sent the script to the facility's contracted pharmacy. The Physician said that the process for the ordering of controlled substances was that the Provider generated a script in the Provider's software, which would then be sent to the facility's contracted pharmacy. He said that he thought the nurse entered the order into the Resident's Electronic Health Record (EHR), which he would then sign. He said that if he was not able to enter the order into a resident's EHR, he would send the script to the facility's contracted pharmacy. The Physician said that he had provided verbal communication to a nurse on 3/13/26 regarding the change to Resident #80's pain management treatment plan. He said that he did not write a progress note for the visit with Resident #80 with date of service of 3/13/26. The Physician said that Resident #80 should have had an order for Morphine medication to be administered as needed in the Resident's EHR at the time of the interview. During an interview on 3/26/26 at 1:35 P.M., Nurse #7 said that she provided care for Resident #80 on 3/16/26. Nurse #7 said that Resident #80 had refused the prescribed Naltrexone medication, stating that the Resident informed Nurse #7 of a discussion with the Physician on 3/13/26. Nurse #7 said that the Resident told her that the Naltrexone medication was supposed to be placed on hold and he/she was supposed to have a Morphine medication order to be utilized as needed. Nurse #7 said that she then faxed the Physician to inform the Physician that there were not any Morphine medication orders in place for Resident #80 at that time. Nurse #7 said that the Physician responded, and said that he would order Morphine medication as needed and put the Naltrexone medication on hold. Nurse #7 said that her expectation was the Physician would enter an order remotely for the Morphine medication. Nurse #7 said that she placed the Naltrexone medication order on hold at that time. Nurse #7 said that she checked Resident #80's Physician's orders on 3/25/26 and noted that the Resident did not have a Morphine medication order in place at that time. Nurse #7 said that she again faxed the Physician at that time to notify him that Resident #80 did not have a Morphine medication order in place. During an interview on 3/26/26 at 2:46 P.M., the Pharmacist said that the facility's contracted pharmacy received a script for Morphine on 3/24/26 at 5:03 P.M. He said that the Morphine was sent out to be delivered to the facility on 3/24/26 around 10:30 P.M. The Pharmacist said that the pharmacy had not received any scripts for Morphine prior to this date. During an interview on 3/26/26 at 3:17 P.M., the Director of Nursing (DON) said that the expectation was that the nurse entered the Physician's orders into Resident #80's EHR. The DON said that her concern with having a treatment plan that included Morphine medication without an order for the Morphine medication was that the facility should be able to manage pain that Resident #80 was having. The DON said that the Morphine medication order should have been implemented on 3/13/26.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to provide pharmaceutical services to meet the needs for one Resident (#80) out of a total sample of 26 residents, and maintain accurate records of controlled substances (drugs or chemicals that the government regulates for its manufacture, possession, and use, that are classified into schedules based on their potential for abuse) for one Unit (Unit Two) out of three units reviewed. Specifically,1. For Unit Two, the facility staff failed to maintain accurate documentation in the Controlled Substance Register (Narcotic Book), relative to the recording of prescription numbers and receipt dates being recorded on the individual pages when a new controlled medication was entered into the Register or the information for a medication was transferred from one page to another. 2. For Resident #80, the facility failed to acquire Auvelity (medication used to treat Major Depressive Disorder [MDD]) medication and administer Auvelity medication as ordered by the Physician, resulting in an increased risk for depression symptoms. Findings include: Review of the facility policy titled Management of Controlled Substances in Skilled Nursing Facilities, revised on June 24, 2025, included: -It is the responsibility of staff who administer or otherwise manage medications to safeguard controlled substances in a manner consistent with Federal and State Law, and organizational policy. -Purpose: - to minimize the opportunity for abuse or diversion of controlled substances. - to provide for proper ordering, storage, disposal, and security of controlled substances. - to promote occupational and patient safety. -Storage: -Medication information is logged into the Controlled Substances Register as follows: >Each new Patient Page shall include: >Prescription number and date. >complete transfer information at the bottom of inventory page, two Licensed nursing staff signatures – the recording nurse and the witnessing nurse are required. On 3/25/26 at 8:19 A.M., during a record review and interview, Nurse #3 and the surveyor reviewed the Controlled Substance Record (Narcotic Book) in Book #2025-6. Review of the Record showed that. - the headings on many of the pages were not completed. - four of the index pages were worn out and torn with pieces missing. - one page of Lorazepam (antianxiety) medication 34 tablets did not indicate whether the medication was discontinued, transferred to another page, or destroyed. - two pages of Controlled Substance medications Tramadol (pain) and Lyrica (nerve pain medication) were transferred by one nurse to different pages. Nurse #3 said that the headings should have been completed when the controlled medications were entered into the Record, or when the medications were transferred in the Record from one page to another, but they had not been. Nurse #3 further said two nurses are expected to sign as the transferred and witnessed nurses at the bottom of the page, but they did not. On 3/25/26 at 8:39 A.M., during a record review and interview, Nurse #4 and the surveyor reviewed the Controlled Substance Record (Narcotic Book) in Book #2025-8. Review of the Record showed that: - the headings on many of the pages were not completed. - three of the index pages were worn out and torn with pieces missing. - page 12 of the controlled substance book indicated that a Lorazepam liquid medication 27.25 milliliters (ml) had been removed from count to be destroyed on 12/8/2025, but there was no indication that the medication had been destroyed. - two pages of Controlled Substance medications Dilaudid (pain) and Lyrica were transferred by one nurse to different pages. Nurse #4 said that the headings should have been completed when the controlled medications were entered into the Record, or when the medications were transferred in the Record from one page to another, but they had not been. Nurse #4 further said two nurses are expected to sign as the transferred and witnessed nurses at the bottom of the page, but they did not. On 3/25/26 at 8:51 A.M., during a record review and interview, Nurse #5 and the surveyor reviewed the Controlled Substance Record (Narcotic Book) in Book #2025-7. Review of the Record showed that: - the headings on many (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the pages were not completed. - three of the index pages were worn out and torn with pieces missing. - eight pages had no prescription numbers and no dates documented for the receipt of the medications. - six pages were transferred by one nurse to different pages without a second nurse. Nurse #5 said that the headings should have been completed when the controlled medications were entered into the Record, or when the medications were transferred in the Record from one page to another, but they had not been. Nurse #5 further said two nurses are expected to sign as the transferred and witnessed nurses at the bottom of the page, but they did not. During an interview on 3/25/26 at 10:09 A.M., the Director of Nursing (DON) said that when the page number was changed in the Controlled Medication Log, the prescription number and date filled must be transferred to the new page. The DON said that the headings of each page in the Controlled Medication Log should be complete to include the prescription number and date the prescription was filled. The DON said that when Controlled Substance Medication is removed from count, there must be documentation of the destruction in the Book. The DON further said two nurses are expected to transfer pages and sign. 2. Review of the facility policy titled Provider Pharmacy Requirements, effective October 2013, indicated but was not limited to the following: -Policy: Regular and reliable pharmaceutical service is available to provide residents with prescription.medications. -All.new medication orders are received and available for administration on the day they are ordered by the physician or before the time the first dose would ordinarily be administered. -Medications will be delivered by the primary pharmacy or back-up pharmacy. Review of the facility policy titled Arrangements with Non-Contract Pharmacy, effective December 2013, indicated that a resident may request that medications be obtained from a pharmacy other than the facility's provider pharmacy. Resident #80 was admitted to the facility in March 2026, with diagnoses including MDD, anxiety disorder, obsessive-compulsive disorder, panic disorder, and Trichotillomania (hair-pulling disorder). Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #80: was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Assessment score of 15 out of a possible score of 15. was prescribed an antidepressant medication. had little interest or pleasure in doing things nearly every day. was feeling down, depressed, or hopeless nearly every day. was feeling tired or had little energy nearly every day. had poor appetite or overeating nearly every day. felt bad about him/herself nearly every day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/24/26 at 9:37 A.M., Resident #80 said that upon admitting to the facility, it took nearly three to four days for the facility to have all of his/her prescribed medications available to administer. Resident #80 said he/she was prescribed several psychiatric medications, and it was concerning that they were not available when he/she admitted to the facility. Resident #80 said he/she believed the facility did not have the prescribed Auvelity medication. Resident #80 said that his/her partner had brought in all of his/her medications from home when the Resident admitted to the facility, however the facility explained to the Resident that he/she was not allowed to use his/her home medications. Resident #80 said that the facility additionally ran out of the Auvelity medication about two days ago, and it was not available for his/her use for one evening dose. Review of Resident #80's Mood Care Plan, initiated 3/4/26, indicated that the Resident was at risk for fluctuation in mood related to depression, anxiety, obsessive-compulsive disorder, binge eating, trauma and Trichotillomania. Review of Resident #80's Psychotropic Medications Care Plan, initiated 3/9/26, indicated that the Resident used psychotropic medications related to an extensive psychiatric history including Obsessive-Compulsive Disorder, MDD, anxiety disorder, panic disorder, Trichotillomania, and binge eating disorder. The Care Plan included: -Goal: The Resident will be free of psychotropic drug related complications, including.cognitive/behavioral impairment. -Interventions: Administer psychotropic medications as ordered by the Physician. Review of Resident #80's Order Summary Report between 3/3/26 and 3/26/26 indicated the following: -Auvelity oral tablet Extended Release 45-105 milligrams (mg) (Dextromethorphan Hydrobromide-Bupropion Hydrochloride). Give 1 tablet by mouth two times a day related to MDD. Start date 3/4/26. Review of Resident #80's Medication Administration Record (MAR) dated March 2026 indicated the following: -Auvelity oral tablet Extended Release 45-105 mg (Dextromethorphan Hydrobromide-Bupropion Hydrochloride). Give 1 tablet by mouth two times a day related to MDD (Scheduled for 8:00 A.M. and 8:00 P.M.) was not administered at 8:00 A.M. and 8:00 P.M. on 3/4/26, at 8:00 A.M. on 3/5/26, at 8:00 A.M. on 3/6/26, and at 8:00 P.M. on 3/21/26. Review of Resident #80's Progress Notes indicated the following: -On 3/4/26 at 11:12 A.M. medications (not specified) not available, not in Pyxis (electronic medication dispensing system). Pharmacy notified. Doctor aware. -On 3/4/26 at 8:12 P.M. Auvelity oral tablet Extended Release 45-105 mg medication not available and on order from the pharmacy. -On 3/5/26 at 11:41 A.M. Auvelity oral tablet Extended Release 45-105 mg medication not available. Pharmacy contacted. Medication will be in later on today. Doctor aware. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 3/6/26 at 10:02 A.M. Auvelity oral tablet Extended Release 45-105 mg Awaiting order from pharmacy. Doctor aware. -On 3/21/26 at 7:29 P.M. Auvelity oral tablet Extended Release 45-105 mg on order. During an interview on 3/26/26 at 2:46 P.M. and a follow-up interview on 3/26/26 at 3:17 P.M., the Pharmacist said that the facility's contracted pharmacy received an order for Auvelity medication on 3/3/26 at 7:16 P.M. The Pharmacist said the medication needed to be special ordered. The Pharmacist said that a 30-day supply of Auvelity medication was sent out to be delivered to the facility on 3/5/26 around 3:00 P.M. The Pharmacist said that the pharmacy would typically recommend that the facility ask residents to bring in their medication from home when the pharmacy could not provide the medication to be administered as ordered by the Physician. The Pharmacist said the Auvelity medication should have been available to administer to Resident #80 on 3/21/26, as the medication should not have run out since the initial delivery of the medication on 3/5/26 to the facility. During an interview on 3/26/26 at 3:17 P.M., the Director of Nursing (DON) said that when a medication was not available to be administered as ordered by the Physician, the Provider should be notified so that there could be a discussion as to whether the medication was available in the Omnicell (electronic medication dispensing system). The DON said that the contracted pharmacy was the only pharmacy the facility utilized. During an interview on 3/26/26 at 4:10 P.M., the Nurse Consultant said that the expectation was that medications were delivered from the pharmacy by the following shift. The Regional Nurse said the facility could have asked Resident #80 to bring in the Auvelity medication from home when it was not available to be administered to the Resident.