STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 adhere to safe food practices to prevent contamination of food and beverage items intended for resident consumption in three out of three applicable facility unit kitchenettes. Specifically, the facility failed to implement safe food practices in three out of three facility unit kitchenettes relative to labeling, dating and guidelines for food storage. Findings include: Review of the facility policy titled Dietary Department Guidelines, last updated 5/2018, indicated: >Food Preparation and Handling-Food items should be labeled and use by dated to allow for rotation of supplies.-All items stored in the refrigerator will be covered and use by date labeled.-Refrigerated foods and cold foods will be stored and held at refrigerator temperatures 40 degrees Fahrenheit or below. -Refrigeration temperatures and will be monitored and documented on approved temperature monitoring logs, twice daily.-Frozen foods will be stored between zero and negative ten degrees Fahrenheit. >Foods not prepared in the facility-Personal foods brought into the facility by family members will be kept in appropriate storage containers, refrigerated if indicated and discarded as appropriate. -Prepared foods will be labeled with the Resident's name and use by date.-Prepared foods will be discarded after three days or sooner if there is any indication of spoilage.-Food brought in by visitors must be stored in such a way as to clearly distinguish it from food used or prepared by the facility. On 9/25/25 at 8:51 A.M., the surveyor and the Food Service Director (FSD) observed the following in the Sunrise Unit kitchenette:-two open containers of peanut butter in the cabinet unlabeled and undated-one open jar of honey unlabeled and undated.>in the unit refrigerator: -one package of cotton candy grapes with no resident name, dated 9/20/25-one plastic container of soup, unlabeled and dated 9/19/25-one plastic container of macaroni, unlabeled and dated 9/21/25During an interview at the same time, the FSD said that the peanut butter containers were not the facility's and should have had the resident's names and dates opened located on them. She also said that the kitchen staff is responsible for making sure that the food is labeled, dated, has the resident's name and is thrown away after three days to prevent contamination. On 9/25/25 at 9:03 A.M., the surveyor and the FSD observed the following in the Forestview kitchenette:-the refrigerator had an out of order sign on it-a 48-ounce container of opened prune juice on the counter, undated and warm to touch-a 64-ounce container of opened cranberry juice on the counter, undated and warm to touch-a 64-ounce container of opened apple juice on the counter, undated and warm to touch>a cooler with the following items inside: -two milkshakes, melted and not firm to touch, unlabeled and undated-small ice cream container, melted and not firm to touch, unlabeled and undated-bag of frozen berries, melted and not firm to touch, unlabeled and undated-melted ice and water inside the cooler During an interview at the same time the FSD said that the refrigerator had been broken since Monday 9/22/25. She also said that all the food items in the kitchenette had not been stored at the appropriate temperatures, the items were melted or not cold enough to prevent food born illness. On 9/25/25 at 9:14 A.M. the surveyor and the FSD observed the following in the Meadowview Unit kitchenette refrigerator: -three opened packages of deli meat, unlabeled and undated -one opened package of pre-sliced cheddar cheese, unlabeled and undated -one plastic container of pasta, dated 9/19/25-one plastic container of pasta, undated -one 64-ounce container of (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	opened cranberry juice, undated -one opened container of grape jelly, undated During an interview at the same time, the FSD said that all the items in the refrigerator should have been discarded because they were older than three days, undated or unlabeled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225363	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linda Manor Extended Care Facility	349 Haydenville Road Leeds, MA 01053

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure its staff provided care and services according to Physician orders for an indwelling urinary catheter (a thin, soft flexible tube that drains urine from the bladder) for one Resident (#88) out of four applicable residents, in a total sample size of 24 residents. Specifically, the facility staff failed to insert the correct indwelling urinary catheter size in accordance with Resident #88's Physician order, placing the Resident at risk for obstruction and pain. Findings include: Review of the facility policy titled Indwelling Urinary Catheters, dated 6/24/25, included but was not limited to:-Urinary catheters should only be placed under the direction of a Physician's order, including catheter size and care. Resident #88 was admitted to the facility in January 2024 with diagnoses including Obstructive (blockage in the urinary tract preventing normal urination) and Reflux (a backward flow of urine from the bladder into the ureters and kidneys) Uropathy. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -was cognitively intact as evident by a Brief Interview of Mental Status (BIMS) score of 15ˆout a total possible score of 15. -had an indwelling catheter.ˆ Review Resident #88's Physician orders included but was not limited to: -Foley (a specific type of indwelling urinary catheter) Catheter Size: 16 French, Retention bulb (a fluid filled [NAME] that anchors the indwelling catheter into the bladder): 10 milliliters (ml), every shift, effective 5/27/24. -May flush Foley Catheter with 60ml normal saline for occlusion or leaking as needed, effective 7/7/25. -May change Foley Catheter PRN (pro re nata [as needed]) for occlusion or leakage, effective 4/10/24. Review of Resident #88's person-centered care plan for catheter care, revised 4/10/25, indicated: -Resident had an indwelling urinary catheter due to Obstructive Uropathy -Catheter size:16 French/10cc (cubic centimeter [one cubic centimeter = one ml]) retention bulb. -Change catheter.and as needed to maintain patency Review of Resident #88's Treatment Administration record from September 2025 indicated but was not limited to: -The Resident's indwelling catheter was changed on 9/23/25 at 1:24 P.M. by Nurse #2 due to occlusion (blockage). During an interview and observation on 9/25/25 at 11:03 A.M., Nurse # 1 said that he was the nurse assigned to Resident #88. At that same time the surveyor and Nurse #1 observed Resident #88's indwelling urinary catheter together. Nurse #1 said that the indwelling catheter size currently in place for Resident #88 was a size 18 French with a 30 ml retention bulb. During a follow up interview on 9/25/25 at 12:04 P.M., Nurse #1 said Resident #88 did not have the correct indwelling catheter size in place as ordered by the Residents' Physician. Nurse #1 said Resident #88 should have had a French 16 with a 10 ml retention blub in place as ordered by the Resident's Physician. Nurse #1 said that the French 18 with the 30 ml retention bulb that was in the Resident was too big and could cause Resident #88 an obstruction or pain. Nurse #1 said Nurse #2 should have obtained a physician's order if a different indwelling catheter size was inserted but had not. During an interview on 9/25/25 at 1:00 P.M., the Director of Nursing (DON) said the facility routinely stocked indwelling catheters in size French 16 with 10 ml retention bulb. The DON said that French 16 with 10 ml retention bulb catheters were available in the facility on 9/23/25. The DON said she was unsure why Nurse #2 would have inserted the incorrect catheter size on 9/23/25. During an interview on 9/29/25 at 12:43 P.M., Nurse #2 said she was the nurse that inserted Resident #88's indwelling catheter on 9/23/25. Nurse #2 said that she had attempted to irrigate the Resident's indwelling catheter due to occlusion without success and therefore the catheter needed to be changed. Nurse #2 said that Resident #88 was ordered for French 16 with 10 ml retention blub. Nurse #2 said that she thought she had inserted the correct size of French 16 with 10ml retention bulb but did not. Nurse #2 said that if Resident #88 had an indwelling catheter that was too large the large catheter could cause Resident #88 to have pain or obstruction. ˆ