STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225378	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neville Center at Fresh Pond for Nursing & Rehab	640 Concord Avenue Cambridge, MA 02138

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, and record review, the facility failed to provide necessary treatment, services, interventions to promote healing and prevent new pressure ulcers from developing for two Residents (#3 and #60) out of 19 total sampled residents. Specifically, 1.) For Resident #3, who had a left heel pressure ulcer, the facility failed to implement booties (heel offloading devices which are designed to prevent and treat pressure ulcers) as ordered by the physician. 2.) For Resident #60, who had a history of a heel pressure ulcer, the facility failed to implement booties as ordered by the physician. Findings include: Review of the facility policy titled 'Skin Management Guideline', revised 8/10/17, indicated: - The purpose of this guideline is to provide information regarding the management of skin conditions and identification of pressure ulcer/injury risk factors and interventions for specific risk factors. - Risk Assessment: Reposition the resident as indicated in the care plan. - Mobility/Repositioning: Provide support devices and assistance as needed. - Monitoring: Review the interventions and strategies for effectiveness on an ongoing basis. 1.) Resident #3 was admitted to the facility in September 2018 with diagnoses including chronic kidney disease and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/16/25, indicated Resident #3 had severe cognitive deficits as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15. This MDS indicated Resident #3 did not have a pressure ulcer but was at risk of developing pressure ulcers. This MDS further indicated Resident #3 required substantial/maximal assistance with putting on/taking off footwear. Review of Resident #3's assessment titled 'Admission/readmission Evaluation', dated 5/19/25, indicated he/she was readmitted to the facility with a new left heel unstageable pressure ulcer. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's assessment titled 'Norton Scale', dated 5/19/25, indicated the Resident was at high risk for pressure ulcer development as evidenced by a score of five. Review of Resident #3's active physician's orders indicated: - Booties to bilateral heels while in bed, every shift for heels, initiated 12/29/24. - Float left heels in bed; off-load wound, every shift, 1/22/2025. - Monitor L (left) heel unstageable every shift for signs/symptoms of infection, every shift, initiated 5/19/25. On 5/27/25 at 8:03 A.M., and 5/28/25 at 6:55 A.M. and 7:52 A.M., the surveyor observed Resident #3 in bed with his/her heels directly on the mattress. Resident #3's was not wearing bilateral booties, and his/her heels were not offloaded. There were two blue booties visible in the room on his/her wheelchair, which was not within reach of the Resident during each of these observations. During an interview on 5/28/25 at 7:53 A.M., Resident #3 said he/she had a wound on his/her left heel, and it hurt when it rubbed on the mattress. Resident #3 said he/she had not worn booties on his/her heels for a while but would wear them if they were offered. Resident #3 said staff never offers to apply them. Review of Resident #3's plan of care related to skin, revised 2/18/25, indicated Resident #3 was at risk for impaired skin integrity and had a history of pressure ulcers. This care plan also indicated: - Refer to TAR (Treatment Administration Record) for current treatment regimen. Review of Resident #3's Treatment Administration Record (TAR), dated 5/27/25 and 5/28/25, indicated nursing had documented the physician's orders for booties to bilateral heels while in bed and float heels in bed, off-load wound as implemented every shift. Review of Resident #3's nursing progress notes and TAR, dated 5/27/25 and 5/28/25, failed to indicate any refusal or rationale for why his/her booties were not in place or heels offloaded. During an interview on 5/28/25 at 8:11 A.M., Certified Nurse Assistant (CNA) #1 said Resident #3 was not supposed to wear the booties or offload heels on the day shift, only on night shift. CNA #1 said Resident #3 was receptive to wearing the booties and never refuses them. CNA #1 was unaware Resident #3 had a wound on his/her left heel. During an interview on 5/28/25 at 8:18 A.M., Nurse #1 said Resident #3 had a scab on his/her left heel. Nurse #1 said if the physician's order was to have booties on or heels offloaded while in bed, then they should have been implemented while Resident #3 was bed. Nurse #1 said if Resident #3 did not wear the booties or have heels offloaded then it should not have been documented as implemented. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 10:14 A.M., the Regional Director of Clinical Education and Administrator said if the physician's order was to have booties on or heels offloaded while in bed, then they should have been implemented while Resident #3 was bed. The Regional Director of Clinical Education and Administrator said if Resident #3 did not wear the booties or have heels offloaded then it should not have been documented as implemented. 2.) Resident #60 was admitted to the facility in December 2022 with diagnoses including malnutrition and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/25/25, indicated Resident #60 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #60 had one stage three pressure ulcer and was at risk of developing pressure ulcers. This MDS further indicated Resident #60 was dependent on staff for putting on/taking off footwear. Review of Resident #3's assessment titled 'Norton Scale', dated 4/27/25, indicated the Resident was at high risk for pressure ulcer development as evidenced by a score of eight. Review of Resident #60's active physician order, initiated 4/19/25, indicated: - Ensure pt (patient) is wearing Prevelon (brand name) (sic) boots while in bed, every shift for pressure injury. On 5/27/25 at 8:27 A.M. and 11:38 A.M., and on 5/28/25 at 6:53 A.M. and 8:01 A.M., the surveyor observed Resident #60 in bed with his/her heels directly on the mattress. Resident #60's was not wearing bilateral booties, and his/her heels were not offloaded. There were no booties visible in the room. During an interview on 5/28/25 at 8:22 A.M., the surveyor observed Resident #60 in bed with his/her heels directly on the mattress. Resident #60's was not wearing bilateral booties, and his/her heels were not offloaded. Resident #60 said he/she used to have a heel wound, but it had healed. Resident #60 said staff had not offered booties in a long time, so he/she thought they were longer needed. Resident #60 said if the facility thought he/she needed them, he/she would wear them. Review of Resident #60's Treatment Administration Record (TAR), dated 5/27/25 and 5/28/25, indicated nursing had documented the physician's order to ensure pt is wearing Prevelon (sic) boots while in bed as implemented every shift. Review of Resident #60's nursing progress notes and TAR, dated 5/27/25 and 5/28/25, failed to indicate any refusal or rationale for why his/her booties were not in place or heels offloaded. During an interview on 5/28/25 at 8:03 A.M., Certified Nurse Assistant (CNA) #2 said Resident #60 should wear booties when in bed because he/she used to have a wound on his/her heel. CNA #2 said she was unaware that he/she was not wearing them. CNA #2 said she had not offered them this morning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 8:06 A.M., Nurse #3 said Resident #60 does not wear booties during the day shift and is only supposed to wear them at night. Nurse #3 reviewed Resident #60's physician's order and said based on the order he/she should always wear booties when in bed but had not been. Nurse #3 said Resident #60's booties were always off before her shift begins and he/she did not have a history of refusing them. During an interview on 5/28/25 at 10:14 A.M., the Regional Director of Clinical Education and Administrator said if the physician's order was to have booties on while in bed, then they should have been implemented while Resident #60 was bed. The Regional Director of Clinical Education and Administrator said if Resident #60 had not worn the heel booties it should not have been documented as implemented. REFER TO F842.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to adequately maintain the nutrition and hydration status of two Residents (#8 and #28) out of a total sample of 19 residents.Specifically, 1. For Resident #8,the facility failed to follow up on a significant weight change. 2.For Resident #28,the facility failed to follow a physician's order for a fluid restriction. Findings include: Review of the facility policy titled 'Weight Management' dated 6/2024, indicated the following but not limited to: -A discrepancy of plus or minus three (3) pounds weekly for a weekly weight will require that the resident be re-weighed to validate weight discrepancy by a licensed nurse. A discrepancy of plus or minus five (5) pounds for a monthly weight will require that the resident be re-weighed to validate the weight discrepancy by a licensed nurse. -The Registered Dietician (RD) shall be notified of the validated weight gain or loss at this time. Resident #8 was admitted to the facility in April 2024 with diagnoses including chronic kidney disease and dysphagia. Review of Resident #8's Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 9 out of a total possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was moderately cognitively impaired. The MDS further indicated the Resident weighed 141 pounds (lbs.) and was on a mechanically altered diet. Review of Resident #8's Nutrition care plan initiated on 4/21/25 indicated the following interventions: -Monitor weights according to facility weight management protocol. -Provide feeding assistance as needed. -Provide supplement mighty shake. Review of the weight record for Resident #8 indicated the following weights: -4/18/25- 140.2 lbs. -4/21/25- 140.6 lbs. -5/8/25- 125.5 lbs. (10.74% significant loss from previous weight) -5/12/25- 125.4 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/19/25- 126 lbs. -5/26/25-126 lbs. Review of the weights indicated Resident #8 had a significant weight loss from 4/21/25 to 5/8/25. Review of the medical record failed to indicate that neither the Registered dietician nor the MD (physician) were notified of the significant weight loss. During an interview on 5/28/25 at 11:32 A.M., the Registered Dietician (RD) said that she usually checks all the weights on Mondays and follows up on the discrepancies. The RD said if there is significant change she will assess the resident then notify the nurse or unit manager to ensure the MD and healthcare proxy are made aware. The RD further said Resident #8 had moved floors and the weight discrepancy could be an oversight but still required a follow up. During an interview on 5/28/25 at 12:41 P.M., the Regional Director of Clinical Education and Administrator said the nursing staff should have reweighed the Resident to validate the weight and then notify the Dietician. 2.For Resident #28, the facility failed to follow a physician's order for a fluid restriction. Findings include: Review of the facility policy titled 'Fluid Restriction Guideline', dated 2/16/2018, indicated the following but not limited to: -A fluid restricted diet is one in which a resident is advised to consume a reduced amount of fluids along with foods that are high in water content (example soup, gelatin, sherbet, ice cream). A fluid restriction is ordered by a physician or practitioner for residents who have fluid intake concerns related to congestive heart failure, acute/chronic renal failure, edema (swelling that occurs when fluid builds up in the body's tissues), ascites (abdominal swelling caused by accumulation of fluid). -The following is recorder in the resident's record and the medical doctor (MD) is made aware: -Fluid restriction non-compliance -Any changes in the resident's condition. -Nursing staff will record the residents' consumption of fluids during meals and with medication pass using a facility intake and output documentation form. -A licensed nurse must check each meal tray and determine that the fluid allotment is not exceeded on the tray. Resident #28 was admitted to the facility in August 2023 with diagnoses including heart failure and chronic respiratory failure. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's Minimum Data set (MDS), dated [DATE], indicated the Resident scored a 14 out of a total possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated that the Resident had an active diagnosis of heart failure. During an observation on 5/27/25 at 8:22 A.M., the Resident was lying in his/her bed, there was a bottle of red juice half consumed on the bedside table as well as a small bottle of water. Review of the physician's orders indicated Resident #28 required a 1000 milliliter (ml) fluid restriction per every 24 hours. The breakdown of the fluid restriction indicated the following: -7-3 shift to give nursing 60 ml, breakfast 360 ml and lunch 240 ml. -3-11 shift to give nursing 60 ml, supper 240 ml. -11-7 shift to give nursing 40 ml. Review of the Medication Administration Record (MAR) for May 2025 indicated Resident #28 received the following amount of fluid in 24 hours: -1,200 ml on 5/2/25 -1,200 ml on 5/3/25 -1,200 ml on 5/4/25 -1,200 ml on 5/5/25 -1,200 ml on 5/6/25 -1,200 ml on 5/7/25 -1,100 ml on 5/9/25 -1,100 ml on 5/10/25 -1,100 ml on 5/11/25 -1,100 ml on 5/23/25 -1,100 ml on 5/24/25 -1,100 ml on 5/25/25 -1,100 ml on 5/26/25 -1,100 ml on 5/27/25 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1,100 ml on 5/28/25 Review of Resident #28's medical record failed to indicate the Resident was non-compliant with the fluid restriction or that the MD was made aware of fluid intake over the 1,000 ml fluid restriction. During an interview on 5/28/25 at 11:43 A.M., Nurse #3 said the Resident was on a 1,000 ml fluid restriction and nurses are supposed to follow the physician orders with the fluid restriction, if the total fluid intake was over the restriction the MD would be made aware. She further said if the Resident was non-compliant with the fluid restriction this would be documented in the medical record as excess consumption and could lead to fluid overload (too much water in the body). During an interview on 5/28/25 at 11:51 A.M., Resident #28 said he/she was aware of the 1,000 ml fluid restriction and pointed out to a dietary slip taped on his/her closet indicating that's what he/she is supposed to follow. During an interview on 5/28/25 at 12:39 P.M., the Regional Director of Clinical Education and Administration said Resident's on fluid restriction should be monitored adequately and if intake is documented above the fluid restriction orders it should be reported to MD as this could cause a resident to go into fluid overload.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observations, interviews, and record review, the facility failed to provide care and maintenance of a peripherally inserted central catheter (PICC), consistent with professional standards of practice for one Resident (#60), out of a total sample of 19 residents. Specifically, for Resident #60, the facility failed to implement a physician's order for weekly routine PICC dressing changes, as required. Findings include: Review of the facility policy titled 'Central Vascular Access Device (CVAD) Dressing Change', revised 1/25/04, indicated: - Verify prescriber order. - Perform sterile dressing changes using Standard - Aseptic Non Touch Technique: at least weekly. Resident #60 was admitted to the facility in December 2022 with diagnoses including sepsis and urinary tract infection. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/25/25, indicated Resident #60 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #60 received intravenous medications. Review of Resident #60's physician's order, initiated 5/9/25, indicated: - Change PICC Line Catheter Site Dressing, every day shift every 7 day(s). - Change PICC Line Catheter Site Dressing, as needed. On 5/27/25 at 8:27 A.M., the surveyor observed Resident #60 in bed with a PICC dressing on his/her right arm which was dated 5/9/25, which was 19 days prior to observation. The bottom quarter of the PICC dressing was lifting, exposing the catheter to air. Resident #60 said the PICC dressing had not been changed recently and had only been changed twice since he/she was readmitted to the facility 4/19/25. During an interview on 5/27/25 at 11:38 A.M., Nurse #2 and the surveyor observed Resident #60's PICC dressing. Nurse #2 said the PICC dressing was dated 5/9/25. Nurse #2 said the PICC dressing should have been changed every seven days, and it was overdue to be changed. Nurse #2 further said that this PICC dressing should have been changed because it was lifting and not intact. Review of Resident #60's nursing progress note, dated 5/9/25 to 5/27/25, failed to indicate any rationale for PICC dressing not being changed according to the physician's order. Review of Resident #60's Treatment Administration Record (TAR), dated 5/10/25 to 5/27/25, indicated: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/16/25: Nurse #1 documented the physician order to Change PICC Line Catheter Site Dressing as completed, when it was not. - 5/23/25: Nurse #4 documented the physician order to Change PICC Line Catheter Site Dressing as completed, when it was not. - The physician order to Change PICC Line Catheter Site Dressing, as needed was not implemented during this time frame. During an interview on 5/27/25 at 11:40 A.M., Nurse #2 and the surveyor reviewed the TAR, dated 5/10/25 to 5/27/25. Nurse #2 said since the PICC dressing had not been changed since 5/9/25, it should not have been documented as completed. On 5/28/25 at 12:05 P.M., the surveyor attempted to contact Nurse #4 by telephone. Nurse #4 did not return the telephone call. During an interview 5/28/25 at 12:11 P.M., Nurse #1 said she absolutely did not change Resident #60's PICC dressing on 5/16/25 and was unsure why it is documented that she did. During an interview on 5/27/25 at 2:18 P.M., Unit Manager #1 said Resident #60's PICC dressing should have been changed every seven days but was not. During an interview on 5/28/25 at 10:14 A.M., the Regional Director of Clinical Education and Administrator said PICC dressings should be changed as ordered by the physician. REFER TO F842.

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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. Based on policy review, observation and staff interview, the facility failed to ensure pharmaceutical services met the needs of each resident. Specifically, the facility failed to ensure insulin and intravenous emergency kits were replaced by the pharmacy after being opened on two out of three units. Findings include: Review of the facility policy titled 'Emergency Medication Supplies (Emergency kits), dated 11/15/24, indicated the following: -The facility may request an on-demand exchange of the emergency kit as needed by calling the pharmacy and arranging the exchange. -To indicate the emergency kit was opened by the facility staff and replacement of the box or replenishment of removed doses is needed, the tamper -evident lock or seals provided by the pharmacy may be a different color than the original one placed by the pharmacy. On 5/28/25 at 10:03 A.M., during the inspection of the medication room on the second floor. The surveyor observed an insulin kit in the refrigerator; the kit was opened and some of the contents had been removed from the kit. There was no documentation indicating what had been removed, when it was removed and who had removed the items. There was no way of knowing if the kit had been reordered from the pharmacy for a replacement kit. During an interview on 5/28/25 at 10:09 A.M., Nurse #1 said when the emergency kits are opened, they need to be reordered immediately. She further said she was not sure when the kit had been accessed and if it had been reordered. On 5/28/25 at 10:38 A.M., during an inspection of the medication room on the third floor. The surveyor observed an intravenous (IV) kit was opened and some of the contents had been removed from the kit. There was no documentation indicating what had been removed, when it was removed and who had removed the items. There was no way of knowing if the kit had been reordered from the pharmacy for a replacement kit. During an interview on 5/28/25 at 10:41 A.M., Nurse #5 said no residents were receiving any type of intravenous medication on the unit. She said she does not know when the kit was opened. Nurse #5 said the kit should be reordered from the pharmacy once it's opened. During an interview on 5/28/25 at 12:36 A.M., the Regional Director of Clinical Education and Administrator said the emergency kits should be reordered upon accessing them.

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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 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. Based on observations and interviews the facility failed to ensure drugs and biologicals were stored in accordance with acceptable professional standards of practice. Specifically, nursing failed to ensure medications were dated once opened, and stored according to manufacturer's guidelines, in one of three medication carts observed. Findings include: Review of the facility policy titled 'Storage and Expiration Dating of Medications and Biologicals', dated 8/1/24, indicated the following: -Once any medication or biological is opened, facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (example, vial, bottled, inhaler) when the medication has a shortened expiration date once opened. On 5/28/25 at 9:56 A.M., the surveyor and Nurse #1 observed the second floor medication cart: -Two bottles of Lumigan eye drops, opened and undated. -One bottle of pilocarpine eye drops, opened and undated. -One bottle of latanoprost eye drops, opened and undated. -One bottle of timolol eye drops, opened and undated. During an interview on 5/28/25 at 10:02 A.M., Nurse #1 said nurses are responsible for dating the eye drops when they are opened. During an interview on 5/28/25 at 12:38 P.M., the Regional Director of Clinical Education and Administration said eye drops should be dated upon opening.

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	225378	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neville Center at Fresh Pond for Nursing & Rehab	640 Concord Avenue Cambridge, MA 02138

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews, and record reviews, the facility failed to accurately document in the medical record for two Residents (#60 and #3) out of 19 total sampled residents. Specifically, 1.) For Resident #60, the nurses inaccurately documented: a.) a peripherally inserted central catheter (PICC) dressing change as being completed when it was not; b.) heel booties (heel offloading devices which are designed to prevent and treat pressure ulcers) as being implemented when they were not; and c.) side rails were padded when they were not. 2.) For Resident #3, the nurses inaccurately documented heel booties being implemented and heels being offloaded when they were not. Findings include: Review of the facility policy titled 'Charting and Documentation', revised 2/4/17, indicated: - Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1.) Resident #60 was admitted to the facility in December 2022 with diagnoses including sepsis, urinary tract infection, and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/25/25, indicated Resident #60 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #60 received intravenous medications and was dependent on staff for putting on/taking off footwear. 1a.) Review of Resident #60's physician's order, initiated 5/9/25, indicated: - Change PICC Line Catheter Site Dressing, every day shift every 7 day(s). On 5/27/25 at 8:27 A.M., the surveyor observed Resident #60 in bed with a PICC dressing on his/her right arm which was dated 5/9/25, which was 19 days prior to observation. Resident #60 said the PICC dressing had not been changed recently and had only been changed twice since he/she was readmitted to the facility 4/19/25. During an interview on 5/27/25 at 11:38 A.M., Nurse #2 and the surveyor observed Resident #60's PICC dressing. Nurse #2 said the PICC dressing was dated 5/9/25. Nurse #2 said the PICC dressing should have been changed every seven days, and it was overdue to be changed. Review of Resident #60's Treatment Administration Record (TAR), dated 5/10/25 to 5/27/25, indicated: - 5/16/25: Nurse #1 documented the physician order to Change PICC Line Catheter Site Dressing as completed, when it was not. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/23/25: Nurse #4 documented the physician order to Change PICC Line Catheter Site Dressing as completed, when it was not. During an interview on 5/27/25 at 11:40 A.M., Nurse #2 and the surveyor reviewed the TAR, dated 5/10/25 to 5/27/25. Nurse #2 said since the PICC dressing had not been changed since 5/9/25, it should not have been documented as completed. On 5/28/25 at 12:05 P.M., the surveyor attempted to contact Nurse #4 by telephone. Nurse #4 did not return the telephone call. During an interview 5/28/25 at 12:11 P.M., Nurse #1 said she absolutely did not change the PICC dressing on 5/16/25 and was unsure why it is documented that she did. During an interview on 5/27/25 at 2:18 P.M., Unit Manager #1 said Resident #60's PICC dressing should have been changed every seven days but was not. Unit Manager #1 said the PICC dressing should not have been documented as completed if it was not. During an interview on 5/28/25 at 10:14 A.M., the Regional Director of Clinical Education and Administrator said PICC dressings should be changed as ordered by the physician. The Regional Director of Clinical Education and Administrator further said the PICC dressing should not have been documented as completed if it was not. 1b.) Review of Resident #60's active physician order, initiated 4/19/25, indicated: - Ensure pt (patient) is wearing Prevelon (brand name) (sic) boots while in bed, every shift for pressure injury. On 5/27/25 at 8:27 A.M. and 11:38 A.M., and on 5/28/25 at 6:53 A.M. and 8:01 A.M., the surveyor observed Resident #60 in bed with his/her heels directly on the mattress. Resident #60's was not wearing bilateral booties, and his/her heels were not offloaded. There were no booties visible in room. During an interview on 5/28/25 at 8:22 A.M., the surveyor observed Resident #60 in bed with his/her heels directly on the mattress. Resident #60's was not wearing bilateral booties, and his/her heels were not offloaded. Resident #60 said he/she used to have a heel wound, but it had healed. Resident #60 said staff had not offered booties in a long time, so he/she thought they were longer needed. Resident #60 said if the facility thought he/she needed them, he/she would wear them. Review of Resident #60's Treatment Administration Record (TAR), dated 5/27/25 and 5/28/25, indicated nursing had documented the physician's order to Ensure pt is wearing Prevelon (sic) boots while in bed as implemented every shift. Review of Resident #60's nursing progress notes and TAR, dated 5/27/25 and 5/28/25, failed to indicate any refusal or rationale for why his/her booties were not in place or heels offloaded. During an interview on 5/28/25 at 8:03 A.M., Certified Nurse Assistant (CNA) #2 said Resident #60 should wear booties when in bed because he/she used to have a wound on his/her heel. CNA #2 said she was unaware that he/she was not wearing them. CNA #2 said she had not offered them this morning. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 8:06 A.M., Nurse #3 said Resident #60 does not wear booties during the day shift and is only supposed to wear them at night. Nurse #3 reviewed Resident #60's physician's order and said based on the order he/she should always wear booties when in bed but had not been. Nurse #3 said Resident #60's booties were always off before her shift begins and he/she did not have a history of refusing them. Nurse #3 said the physician's order to Ensure pt is wearing Prevelon (sic) boots while in bed should not have been documented as implemented when it was not. During an interview on 5/28/25 at 10:14 A.M., the Regional Director of Clinical Education and Administrator said if the physician's order was to have booties on while in bed, then they should have been implemented while Resident #60 was bed. The Regional Director of Clinical Education and Administrator said if Resident #60 had not worn the heel booties it should not have been documented as implemented. 1c.) Review of Resident #60's active physician order, initiated 4/19/25, indicated: - Padded side rails when in bed, every shift, for seizure. On 5/27/25 at 8:27 A.M. and 11:38 A.M., and on 5/28/25 at 6:53 A.M. and 8:01 A.M., the surveyor observed Resident #60 in bed with both side rails in place and not padded. There were blue side rail pads placed on the floor against the wall in the Resident's room. During an interview on 5/28/25 at 8:22 A.M., the surveyor observed Resident #60 in bed with both side rails in place and not padded. Resident #60 said he/she does not like the side rail pads because they pop off and hit him/her in the face. Resident #60 said the side rail pads have not been in place for a long time. Review of Resident #60's Treatment Administration Record (TAR), dated 5/27/25 and 5/28/25, indicated nursing had documented the physician's order for padded side rails when in bed as implemented every shift. During an interview on 5/28/25 at 8:03 A.M., Certified Nurse Assistant (CNA) #2 said Resident #60 refuses to have the side rail pads applied because he/she doesn't like them. CNA #2 said the CNAs should alert the nurse every time the Resident refuses them so the nurse can document it as refused. CNA #2 further said that the side rail pads had been against the wall and had not been applied to the side rails in a long time, but are kept handy in case they are needed. During an interview on 5/28/25 at 8:06 A.M., Nurse #3 was unaware Resident #60 required the side rails to be padded. Nurse #3 said the order for padded side rails when in bed should not be documented as implemented if they were not in place. During an interview on 5/28/25 at 10:14 A.M., the Regional Director of Clinical Education and Administrator said if the physician's order was to have padded side rails when in bed, then they should have been implemented while Resident #60 was bed. The Regional Director of Clinical Education and Administrator said if Resident #60 refused the side rail pads it should not have been documented as implemented. 2.) Resident #3 was admitted to the facility in September 2018 with diagnoses including chronic kidney disease and diabetes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 4/16/25, indicated Resident #3 had severe cognitive deficits as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15. This MDS indicated Resident #3 required substantial/maximal assistance with putting on/taking off footwear. Review of Resident #3's active physician's orders indicated: - Booties to bilateral heels while in bed, every shift for heels, initiated 12/29/24. - Float left heels in bed; off-load wound, every shift, 1/22/2025 On 5/27/25 at 8:03 A.M. and 5/28/25 at 6:55 A.M. and 7:52 A.M., the surveyor observed Resident #3 in bed with his/her heels directly on the mattress. Resident #3's was not wearing bilateral booties, and his/her heels were not offloaded. There were two blue booties visible in room on his/her wheelchair, which was not within reach of the Resident during each of these observations. During an interview on 5/28/25 at 7:53 A.M., Resident #3 said he/she had a wound on his/her left heel, and it hurt when it rubbed on the mattress. Resident #3 said he/she had not worn booties on his/her heels for a while but would wear them if they were offered. Resident #3 said staff never offers to apply them. Review of Resident #3's Treatment Administration Record (TAR), dated 5/27/25 and 5/28/25, indicated nursing documented physician's orders for booties to bilateral heels while in bed and float heels in bed, off-load wound as implemented every shift. Review of Resident #3's nursing progress notes and TAR, dated 5/27/25 and 5/28/25, failed to indicate any refusal or rationale for why his/her booties were not in place or heels offloaded. During an interview on 5/28/25 at 8:11 A.M., Certified Nurse Assistant (CNA) #1 said Resident #3 is not supposed to wear the booties or offload heels on the day shift, only on night shift. CNA #1 said Resident #3 was receptive to wearing the booties and never refuses them. During an interview on 5/28/25 at 8:18 A.M., Nurse #1 said if the physician's order was to have booties on or heels offloaded while in bed, then they should have been implemented while Resident #3 was bed. Nurse #1 said if Resident #3 did not wear the booties or have heels offloaded then it should not have been documented as implemented. During an interview on 5/28/25 at 10:14 A.M., the Regional Director of Clinical Education and Administrator said if the physician's order was to have booties on or heels offloaded while in bed, then they should have been implemented while Resident #3 was bed. The Regional Director of Clinical Education and Administrator said if Resident #3 did not wear the booties or have heels offloaded then it should not have been documented as implemented.