STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225383	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westfield Gardens Nursing and Rehab	37 Feeding Hills Road Westfield, MA 01085

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37400 Based on observation, interview, and record review, the facility failed to ensure that one Resident (#48) out a total sample of 20 residents, was provided a dignified experience. Specifically, the facility failed to ensure that privacy was provided when the Resident was observed from the hallway with undergarments and legs exposed during a rehabilitation therapy session. Findings include: Review of the facility policy titled Dignity, revised August 2009, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy also included the following: -Residents will be treated with dignity and respect at all times. -Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Resident #48 was admitted to the facility in December 2024 with diagnoses including Renal Failure and Coronary Heart Disease. Review of the Minimum Data Set (MDS) Assessment, dated 12/25/24, indicated Resident #48: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. -had bilateral upper range of motion impairments. -required supervision of staff with moving from lying to sitting position. -was incontinent of bowels. -was receiving physical and occupational therapy. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 10:23 A.M., the surveyor observed the following from the hallway outside of Resident #48's room: -the door to the room was open and the privacy curtain was not drawn, -Rehabilitation Staff #2 was standing at the Resident's bedside, -the Resident was lying in bed and was being provided verbal instructions by Rehabilitation Staff #2 to move from a lying to a seated position at the edge of bed facing the doorway. -The Resident was dressed in a hospital gown and had his/her legs and incontinence brief exposed at the time. During this time, the surveyor requested Nurse #9 to observe the treatment session between Rehabilitation Staff #2 and Resident #48. During an interview at the time, Nurse #9 said Resident #48 was exposed and she could see his/her incontinence brief. Nurse #9 further said the privacy curtain or the door to the Resident's room should be closed to provide dignity and privacy. During an interview on 1/9/25 at 10:33 A.M., the Director of Rehabilitation said the privacy curtain or the room door should have been closed to provide the Resident privacy during the treatment session.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 42741 Based on resident and staff interview, the facility failed to ensure a secure space was provided for Residents' personal belongings for five of nine Residents who participated in the Resident Council Meeting. Findings include: Review of the facility Admission Agreement, undated, indicated the following: -Personal Property >We (the facility) provide residents with a locked space for personal property. The facility will provide a key to a drawer in each resident's bedside table. During the Resident Council Group Meeting held on 1/9/25 from 1:06 P.M. to 1:30 P.M., five of the nine Residents in attendance said their nightstand locked drawer did not work or they did not have a key to lock their locked drawer. One Resident said there are other residents who wander on the units and often go in and out of other resident rooms and he/she was worried about not being able to lock his/her personal belongings up. A second Resident said he/she had to purchase his/her own lockbox as the facility did not provide one for him/her. All five Residents stated they had discussed these concerns with staff but no one had fixed their nightstand locked drawer or provided them with a key. During an interview on 1/15/24 at 8:46 A.M., Nurse #9 said at the time of admission residents should be offered a key for their nightstand locked drawer but she was unsure who offered the key to the residents at the time of admission. During an interview on 1/15/25 at 8:57 A.M., the Maintenance Director said the nightstand in each room had a locked drawer but the drawers did not always work so he provided the residents with a padlock on their drawer to make it secure. The Maintenance Director said residents needed to ask a staff member to put a request in TELS (system used for maintenance to track repairs/requests) and he or his assistant would then add the padlock to the resident's nightstand. The Maintenance Director said he maintained no documentation to show which residents had requested a padlock for their nightstand. The Maintenance Director further said when he reviewed the TELS system, he had requests from two of the five residents that were dated a week prior (1/8/25 and 1/9/25) but he nor his Assistant had provided residents with a padlock for their nightstands as of 1/15/25. During an interview on 1/15/25 at 9:15 A.M., the Director of Marketing and Admissions said a key should be available to the nightstand locked drawer at the time of admission. She said part of the admission packet explained that the facility would provide the resident with a way to lock their valuables. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 1:53 P.M., the Administrator said when she started in the facility, she instituted that all residents in the facility would have a lock drawer and key regardless of cognition status because it was the resident's right to have one. She said she had the Maintenance Director complete an audit to ensure nightstands with a locked drawer and key had been provided to all residents. At the time of survey exit on 1/15/25 at 5:00 P.M., the facility did not provide any documentation to the survey team that an audit had been completed to show all residents had been offered a padlock for their nightstand or key for their nightstand drawer.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 37400 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations to ensure that one Resident (#44) out of a total sample of 20 residents, had his/her call light accessible. Specifically, the facility failed to ensure that Resident #44's call light was within reach when he/she was indisposed and was unable to call for staff assistance for personal care. Findings include: Review of the facility policy titled Resident Rights, revised October 2022 indicated the following the following resident rights: -to a dignified existence. -communication with and access to people and services both inside and outside of the facility. Resident #44 was admitted to the facility in December 2024 with diagnoses including repeated falls, abnormal gait and mobility, and Dementia. Review of the Minimum Data Set (MDS) Assessment, dated 12/11/24 indicated Resident #44: -had clear speech. -usually was understood and usually understands. -had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 11 out of 15. -had no behaviors or rejections of care. -required substantial to maximum assistance with toileting, bathing and upper body dressing. -required partial to moderate assistance with personal hygiene and was dependent on staff for transfers. Review of the Falls Care Plan, initiated 12/5/24, included the following interventions: -anticipate and meet the Resident's needs. -be sure the Resident's call light is within reach and encourage the Resident to use it for assistance as needed. On 1/8/25 at 4:25 P.M., the surveyor observed the following: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the door to Resident #44's room was closed, and the call light was not initiated. -the surveyor knocked and entered the room. -Resident #44 was seated in a wheelchair at the side of the bed and was unclothed from the waist up and holding a face cloth over his/her upper chest. A bedside table was positioned in front of him/her with a pink wash basin. -the Resident asked the surveyor if she was the one that was there to assist him/her. When the surveyor asked the Resident how long he/she had been waiting for staff, the Resident said he/she was unsure. -At the time, the surveyor attempted to initiate the Resident's call light and did not observe the call light to be visible within the Resident's reach. The surveyor walked around the Resident's room and was able to locate the Resident's call light on the opposite side of the bed from where he/she was positioned (between his/her bed and the roommate's bed). The surveyor observed the call light was laying on the floor between the two beds and not accessible to the Resident. -the surveyor exited the Resident's room to request staff assistance for Resident #44 and located Certified Nurses Aide (CNA) #2 who said she would assist him/her. During an interview on 1/8/25 at 4:56 P.M., CNA #2 said when she went in to assist Resident #44, she saw him/her seated in the wheelchair, unclothed from the waist up with a face cloth covering his/her chest. CNA #2 said she saw a wash basin positioned in front of the Resident, which was empty, and that the Resident's call light was far away from him/her and not accessible. CNA #2 said the Resident's assigned CNA had not yet provided care on that shift, so she was unsure how long the Resident was waiting for staff assistance. During an interview on 1/8/25 at 5:12 P.M., CNA #3 said she was assigned to care for Resident #44 that evening. CNA #3 said the Resident required assist of one staff with all care, was able to make his/her needs known, and was able to and did utilize the call light. CNA #3 said she had not had a chance to work with the Resident when the surveyor observed him/her, and that the Resident's call light should have been accessible. During an interview on 1/9/25 at 12:05 P.M., Nurse #3 (who was covering for the Director of Nursing) said she was notified of the surveyor's 1/8/25 observation (when the Resident's call light was not accessible to him/her to summon staff assistance) and that the Resident's call light should have been accessible to him/her.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on interview, and record review, the facility failed to ensure three Residents (#33, #60, and #22) of five applicable residents reviewed, out of a total sample of 20 residents, had the opportunity to formulate advanced directives and/or ensure that their wishes relative to advances directives were implemented. Specifically, the facility failed to: 1. For Resident #33, ensure his/her wishes relative to advanced directives were ordered by the Physician putting the Resident at risk for medical treatment that he/she did not want. 2. For Resident #22, ensure that Advanced Directives were reviewed with the Resident to allow his/her wishes to executed. 3. For Resident #60, ensure that the completed MOLST form and Physician orders matched, creating the potential for Cardiopulmonary Resuscitation (CPR) to be performed when it was not the Resident's wishes. Findings include: Review of the facility policy titled Advanced Directives, revised [DATE], indicated advanced directives will be respected in accordance with state law and facility policy. The policy also included the following: -upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she choose to do so. -information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record. -the plan of care for each resident will be consistent with his or her documented treatment preferences and/or comprehensive assessment and care plan. 1. Resident #33 was admitted to the facility in [DATE] with diagnoses including Type 2 Diabetes and Protein-Calorie Malnutrition. Review of the Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST: a medical order form signed by a licensed physician, nurse practitioner, or physician assistant, that indicates the patient's medical orders for life-sustaining treatment including resuscitation, intubation and other medical interventions) form, located in the electronic medical record and signed by Resident #33 on [DATE], indicated the following: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Section A indicated the Resident wanted to be resuscitated (chest compressions and rescue breathing if his/her heart stops) -Section B indicated the Resident did not want intubation (DNI [Do Not Intubate]: the insertion of a tube into a patient's airway to provide artificial means for breathing) and ventilation (DNV [Do Not Ventilate]: treatment to help a person breathe when they find it difficult or are unable to breathe on their own. A mechanical ventilator pushes airflow into the patient's lungs to help them breathe) -Section E where the Clinician was required to print their name, sign and date were left blank. -Sections A through C of the form indicated treatment decisions were only valid if the Sections D and E indicating the Patient or Patient Representative and Clinician (Physician or Practitioner) legally printed their names, and their signatures and the date were obtained. Review of the Resident's clinical record indicated: -an Interdisciplinary Care Plan Meeting Note dated [DATE], indicating the Resident was a full code status (all medical measures will be taken to maintain and resuscitate life including intubation and ventilation). -Advanced Directive Care Plan, initiated on [DATE] and revised [DATE], which indicated the Resident was a Do Not Resuscitate (DNR: the patient did not want chest compressions and rescue breathing if his/her heart stops). -Health Care Proxy Invocation form, dated [DATE], indicated the Resident was no longer able to make his/her own medical decisions. -A Provider Note, dated [DATE], indicating the Resident's code status was Do Not Intubate (DNI) -[DATE] Physician's orders indicating the Resident was a full code status. During an interview on [DATE] at 11:50 A.M., the surveyor and the Director of Nursing (DON) reviewed Resident #33's medical record. The DON said the MOLST form indicated the Resident did not want intubation and ventilation and was signed and dated by the Resident. The DON further said the Physician did not sign/date Section E on the MOLST form as required, therefore the wishes of the Resident (for DNI) were not valid, and he/she would be considered a full code status. The DON said the current Physician's orders indicated the Resident was a full code status and that the Advanced Directives Care Plan was not accurate. The DON further said the MOLST form should not have been filed in the Resident's clinical record until it was signed and dated by the Physician so that the Resident's wish to not have intubation and ventilation could be honored. 50563 2. Resident #22 was admitted to the facility in [DATE], with diagnoses including Rheumatoid Arthritis. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) of 9 out of a possible score of 15. Review of Resident #22's Physician orders indicated the following: -an active order for Comfort Measures Only (CMO) no weights, vitals or labs. -Obtain new MOLST to reflect DNR/ DNH/ DNI/no fluids or dialysis, initiated on [DATE]. Review of Resident #22's Medical Record indicated: -a MOLST form completed by the Resident on [DATE], indicating to Attempt Resuscitation, Intubate and Ventilate and Transfer to the Hospital. -the Resident was not invoked (was still able to make his/her own healthcare decisions) -no evidence that a new MOLST form was obtained and reviewed with the Resident as ordered on [DATE]. During an interview on [DATE] at 12:00 P.M., the Director of Nursing (DON) said that she reviewed Resident #22's medical record and advanced directives. The DON further said that Resident #22 was his/her own decision maker. The DON said there was no evidence that the MOLST form had been reviewed with the Resident or that the [DATE] order indicating to obtain a new MOLST had been addressed but it should have been. During an interview on [DATE] at 12:04 P.M., Resident #22 said no one had reviewed his/her code status or advanced directives with him/her. The Resident further said he/she would not want CPR performed if his/her heart were to stop. 3. Resident #60 was admitted to the facility in [DATE], with diagnoses including Severe Protein-Calorie Malnutrition. Review of Resident #60s MDS assessment dated [DATE], indicated the Resident was severely cognitively impaired as evidenced by a BIMS score of 3 out of a possible score of 15. Review of Resident #60's Physician orders indicated: -an active order for CPR (Cardiopulmonary Resuscitation), initiated [DATE] -an active order to admit to Hospice services, initiated [DATE] Review of Resident #60's Medical Record indicated the following: -a MOLST form, completed by the Resident's Activated Healthcare Proxy (HCP) dated [DATE], and signed by the Provider on [DATE], indicating that Resident #60 was a Do Not Resuscitate (DNR) and Do Not Intubate (DNI). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:30 P.M., the surveyor and Nurse #8 reviewed the MOLST and Physician order for CPR. Nurse #8 said the MOLST indicated Resident #60 was a DNR and DNI but the Physician's order indicates CPR. Nurse #8 further said that the Physician order should match the MOLST form. Nurse #8 said there was concern with the Physician order not matching the MOLST because if the Resident's heart were to stop, CPR could be performed when the Resident/Resident's HCP did not want CPR performed. During an interview on [DATE] at 11:49 A.M., the Director of Nursing (DON) said the process for updating a MOLST form was once the MOLST was completed, the Nurse should promptly update the Physician orders to reflect what is indicated on the MOLST form. Please Refer to F842

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42690 Based on record review, and interview, the facility failed to notify or consult with the Physician when staff did not follow the Physician's orders for one Resident (#10) out of a total sample of 20 residents. Specifically, for Resident #10, the facility staff failed to notify or consult the Physician when staff utilized a different sized Foley Catheter (a type of indwelling urinary catheter -a thin, flexible tube inserted into the bladder to drain urine outside the body) than what the Physician ordered. Findings include: Review of the facility policy titled Change in a Resident's Condition or Status, revised 12/16/21, indicated the following: -Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of change in the resident's medical/mental condition and/or status. -The Nurse will notify the resident's Attending Physician or Physician on call when there has been a (an) . need to alter the resident's medical treatment significantly. Resident #10 was admitted to the facility in May 2022 with diagnoses including urinary tract infection (UTI), retention of urine, and Chronic Kidney Disease (CKD) - Stage Three. Review of January 2025 Physician orders indicated the following: -16 Fr (French -size) Foley Catheter with 10cc (cubic centimeters) balloon to straight drainage for urinary retention. -May change as needed for leakage, dislodgement or occlusion, initiated 6/9/22. Review of a Nursing Note dated 1/1/25, indicated the following in part: -Resident had Foley Catheter changed #16 Fr with 5cc balloon. During an interview on 1/13/25 at 9:53 A.M., Nurse #5 and Nurse #7, Nurse #7 said that she was the Nurse that inserted the Foley Catheter on 1/1/25. Nurse #7 said that she filled the balloon to 5cc's because she filled it until she felt that the catheter was secure (where it would not dislodge) as she did not want it to be uncomfortable for Resident #10. Nurse #7 said that there had been no issues with the new Foley Catheter. The surveyor, Nurse #5, and Nurse #7 reviewed the different sized catheters located in a plastic bin and noted there were 16 Fr Foley Catheters, however the Foley Catheters in the bin all had 30cc balloons. Nurse #5 said that a 30cc balloon would be too big and most likely uncomfortable for the Resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 1/13/25 at 9:58 A.M., Nurse #5 said that when a different sized Foley Catheter had been utilized than what the Physician order indicated, the on-call Provider (Physician or Physician Assistant [PA]) should have been notified and a confirmation from the Provider should have been given that it was acceptable to use a different size Foley Catheter than what had been ordered. Nurse #5 said that this conversation would then have been documented and a new order would have been obtained. During an interview on 1/13/25 at 12:26 P.M., the Director of Nursing (DON) said that the Physician or PA should have been notified when a different sized balloon was used as it was not what was ordered. The DON said that she was not aware that the ordered size of 16 Fr with a 10cc balloon was not available, and this was the first she was hearing of it. The DON said when it was first identified that the facility did not have the correct size Foley Catheter and a smaller size was utilized for Resident #10, the Physician, the PA, and herself should have been notified so that they could further assess the issue. The DON said that while there is not a big difference in the 5cc balloon to the 10cc balloon, using a smaller sized balloon could put the Resident at risk for the Foley Catheter becoming dislodged. During an interview on 1/14/25 at 5:06 P.M., the PA said that was unaware that a different sized Foley Catheter had been utilized for Resident #10, other than what she had ordered. The PA said that Resident #10's Foley Catheter was changed monthly and she had never been notified that the facility did not have the correct sized Foley Cather in stock. The PA further said that she would expect the facility staff to notify her about this concern. The PA said that some concerns with using the wrong sized balloon could be urinary leakage, skin irritation/breakdown due to urinary leakage and possible discomfort. Please Refer to F690

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview, and record review, the facility failed to provide a homelike environment for two Residents (#2 and #40), out of a total sample of 20 residents. Specifically, for Resident #2 and #40, the facility failed to ensure that the bathroom sink in a shared room by both Residents was maintained in a safe and homelike manner. Findings include: Resident #2 was admitted to the facility in August 2020, with diagnoses including Type 2 Diabetes. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a possible score of 15. Resident #40 was admitted to the facility in October 2022, with diagnoses including End Stage Renal Disease (ESRD). Review of Resident #40's MDS assessment dated [DATE], indicated the following: -the Resident was cognitively intact as evidenced by a BIMS score of 15 out of a possible score of 15. During an interview on 1/9/25 at 11:12 A.M., Resident #40 said his/her bathroom sink had a broken handle and it had been that way for a long time. Resident #40 said he/she had informed maintenance multiple times but nothing was ever done about the broken sink. During an observation and interview on 1/9/25 at 11:15 A.M., the surveyor and Resident #2 observed the bathroom sink. The surveyor observed the hot water handle was broken off and difficult to turn. Resident #2 said the sink had been this way for some time and he/she had told maintenance many times but no one had fixed it. During an interview on 1/9/25 at 11:32 A.M., the surveyor and Nurse #1 observed the bathroom sink. Nurse #1 said the sink handle had been broken since she started working at the facility 6 months ago. Nurse #1 further said the process to get the sink fixed would be to put in a work order for maintenance to fix the sink. During an interview on 1/9/25 at 11:38 A.M., the surveyor and the Maintenance Director observed the bathroom sink. The Maintenance Director said he had not received work orders to repair the bathroom sink. During a follow-up interview on 1/9/25 at 1:05 P.M., Resident #2 and Resident #40 said the bathroom sink had never been repaired since it first became broken. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 5:34 P.M., Staff Member #6 said that since being broken, the sink had not been repaired.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on record review, and interview, the facility failed to resolve a grievance timely for one Resident (#40) out of a total sample of 20 residents. Specifically, the facility failed to ensure for Resident #40 that a reported grievance of missing clothing was resolved in a reasonable time period. Findings include: Review of the undated Grievance Policy indicated the following: -The reasonable timeframe the resident can expect a completed review of the grievance is within 5 to 7 business days. -The grievance official shall be responsible to oversee the grievance process, receive and track grievances through their completion. Resident #40 was admitted to the facility in October 2022, with diagnoses including End Stage Renal Disease (ESRD). Review of Resident #40's MDS assessment dated [DATE] indicated the following: -the Resident was cognitively intact as evidenced by a BIMS score of 15 out of a possible score of 15. Review of the Grievance Binder indicated: -a grievance form dated 6/25/24, reporting a missing /Led Zeppelin shirt with resolution date, completed by and Resident/Responsible Party satisfaction sections left blank. -a grievance form dated 12/6/24, indicating missing three clothing items including a Led Zeppelin shirt with resolution date indicating 12/31/24. During an interview on 1/8/25 at 3:12 P.M., Resident #40 said he/she was missing clothing including a Led Zeppelin t-shift for a few months. Resident #40 said that he/she had reported it to staff but has not heard back from staff about the missing items. On 1/9/25 at 4:10 P.M., the surveyor requested a copy of the 6/25/24 grievance form and the Social Worker (SW) provided the surveyor with a grievance, which was the same grievance form previously reviewed that now had a resolution date, completion date, and Resident/Responsible Party Satisfied sections filled in. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 4:14 P.M., the Administrator said the process is to review and complete grievances the next day after they were received, and she filled out the completion date of the 6/25/24 grievance based on that process. The Administrator further said there is no log or evidence she has to indicate that was the date it was completed or that the Resident was informed and satisfied as the grievance form newly indicated. During a follow-up on 1/9/25 at 4:27 P.M., Resident #40 said that no one had followed up with him about his/her missing clothing until today. Resident #40 further said that he was told once that laundry had found the missing items but he/she had never received the missing items back. Resident #40 said he/she never told anyone he/she was satisfied with the resolution of his/her grievance. During an interview on 1/9/25 at 4:38 P.M., the surveyor and the SW reviewed the 12/6/24 grievance. The SW said that the facility policy is that a reasonable amount of time for a Resident to expect a grievance to be completed is 5 to 7 days. The SW further said that the 12/6/24 grievance was not resolved in that timeframe.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, record review, and interview, the facility failed to protect one Resident's (#42) right to be free from neglect, out of a total sample of 20 residents. Specifically, the facility failed to provide goods and services to Resident #42 relative to his/her request for a snack, resulting in Resident #42 attempting to exit the facility, wandering into other resident rooms, and displaying restlessness and agitation. Findings include: Review of the facility policy titled Abuse Policy, revised September 2022 indicated the following: -Neglect is defined as the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of the facility policy titled Resident Rights, revised October 2022 indicated the following: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' rights to: a. A dignified experience b. Be treated with respect, kindness and dignity c. Be free from abuse, neglect . d. Self determination Resident #42 was admitted to the facility in May 2022, with diagnoses including Major Depressive Disorder, Dementia, and Generalized Anxiety Disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #42 sometimes makes him/herself understood and understands others, responding adequately to simple, direct communications only and has clear, distinct, intelligible words when speaking. Review of Resident #42's Nutritional Risk Care Plan indicated: -Monitory snacks, additional meals provided by family and counsel [sic] PRN, initiated 4/4/23 -Offer extra fluids to the Resident daily, initiated 10/30/24 Review of Resident #42's Activity Care Plan indicated: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident enjoys soda and sweets, initiated 5/18/22 and revised 4/24/24 On 1/13/25 from 10:39 A.M. to 11:32 A.M., the surveyor observed the following: -10:39 A.M.: Resident #42 exited the day room (located in a room behind the nurses station) asking for snacks. -Nurse #5 said she would get Resident #42 a snack. -Nurse #5 resumed working and did not provide Resident #42 with a snack. -10:49 A.M.: Resident #42 attempted to exit the day room through the alarmed door leading to the outside porch. >The alarm sounded however Resident #42 continued to try and push the door open. >Staff redirected the Resident, asking him/her to sit down to listen to the music. -10:51 A.M.: Resident #42 came out of the day room, into the hallway, asked for a snack, became frustrated stating he/she was hungry and there was no food. -Nurse #11 said she would bring the Resident a snack. -Nurse #11 resumed working and did not provide Resident #42 with a snack. -10:52 A.M.: Resident #42 said to the surveyor it's terrible. When the surveyor asked what was terrible, Resident #42 said I'm hungry and there's nothing! -Resident #42 proceeded to stand at the counter mumbling, became agitated and restless. -10:54 A.M.: the surveyor, Resident #42, Nurse #11 and Nurse #5 stood at the nurses station. >Nurse #11 said to Nurse #5 that she still had not gotten Resident #42 a snack, Nurse #5 said that she had forgotten as well. Neither Nurse #5 or Nurse #11 provided Resident #42 with a snack. -10:55 A.M.: Resident #42 wandered back into the day room and sat down. Resident #42 was alone in the day room, with no television or music on. -Resident #42 began to talk to him/herself becoming irritated and frustrated making statements like, let's go, and this is enough. -11:03 A.M.: Resident #42 was seated in the day room and still had not been provided a snack. -Certified Nurses Aide (CNA) #11 entered the day room eating a bag of Doritos. -11:11 A.M.: Resident #42 made statements like I'm getting out of here, that's it, let's go, I'm gone, and I'm getting out of here. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #42 began to wander up and down the hallway. Another resident who was seated in the hallway yelled hey that's not the bathroom as Resident #42 attempted to enter a closet. -Resident #42 proceeded to walk to the end of the hallway, into another resident's room. Another resident told the staff again, who then intervened and redirected Resident #42. -11:16 A.M.: Resident #42 was agitated, walking fast down the hallway. The Resident was easily redirected by staff and brought back into the day room. Resident #42 asked the two staff who brought him/her into the day room if there was food. Staff turned on music and said yes lunch will be here soon. -11:21 A.M.: Resident #42 stood up to leave the day room, and one staff redirected the Resident to sit down. -11:31 A.M.: Staff came to the day room to bring Resident #42 to lunch. -11:32 A.M.: As Resident #42 walked with staff to the dining room he/she said, I can't wait to eat I am so hungry. During an interview on 1/14/25 at 7:48 A.M., with CNA #4 and CNA #5, CNA #4 said if Resident #42 is asking for snacks in the morning after breakfast and before lunch they would get him/her something to eat as he/she does not have any food limitations. CNA #4 said that Resident #42 was able to make his/her basic needs known, was alert to him/herself, and will respond appropriately to basic questions. CNA #5 said that the Resident likes hot tea, root beer or crackers. CNA #5 said that the Resident's family usually brings him/her in snacks that are kept in his/her room. During an interview on 1/14/25 at 9:30 A.M., the Administrator said that the staff could have provided Resident #42 a snack, and the staff are never supposed to eat in resident care areas. The Administrator said that this situation was not only a resident right's concern but could be an infection control concern as well.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50563 Based on observation, and interview, the facility failed to ensure medications were administered according to professional standards of practice on one unit (Willow) out of a total of two units. Specifically, the facility failed to ensure that medications were administered to one resident at a time to mitigate the risk for medication errors. Findings include: Review of Lippincott Nursing Procedures 9th edition (2023), indicated the following: -Avoid distractions and interruptions when preparing and administering medication to prevent medication errors. During an observation on 1/7/25 at 8:46 A.M., the surveyor observed Nurse #1 with medications on a small black tray. The tray contained 3 medication cups and 3 drinks. The medication cups had no visible labels on the cups to indicate the resident the medication would be administered to. The surveyor observed Nurse #1 enter a room with the tray, administer one cup of medication and drink to a resident and then leave the room with 2 medication cups and 2 drinks remaining on the tray. During an observation and interview on 1/7/25 at 5:09 P.M., the surveyor observed Nurse #1 with medications on a small black tray. The tray contained 3 medication cups and 3 drinks. Two medication cups had a first name written on the cups and one medication cup had no visible label to indicate who the medication was intended for. Nurse #1 said the process for medication administration is to pour medications and then administer them to one resident at a time. During an interview on 1/7/25 at 5:16 P.M., Nurse #3, who was covering for the Director of Nursing (DON) said that the expectation during medication administration is that the Nurse should pour and administer medications to one resident at a time to ensure accuracy of administration.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37400 Based on observation, interview and record review, the facility failed to provide grooming assistance for one Resident (#51), out of a total sample of 20 residents. Specifically, the facility failed to ensure that Resident #51 was assisted with facial hair removal when he/she required assistance from staff with personal hygiene. Findings include: Review of the facility policy titled Quality of Life- Dignity, revised August 2009, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect ad individuality. The policy also included the following: -Residents shall be groomed as they wish to be groomed . Resident #51 was admitted to the facility in January 2023 with diagnoses including Dementia with anxiety. Review of the Activities of Daily Living (ADL) Care Plan, initiated 1/11/23, indicated the Resident had a deficit related to activity intolerance, confusion, Dementia and impaired balance, and included the following intervention: -required one staff participation with personal hygiene, revised 1/17/23 Review of the Minimum Data Set (MDS) Assessment, dated 12/13/24, indicated: -Resident #51 had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of a possible 15. -had no rejections of care during the assessment period. -required supervision with personal hygiene (included grooming and facial hair removal). The surveyor observed Resident #51 was out of bed and dressed for the day, and had facial hair approximately measuring one to one and half inches in length on his/her upper lip and lower chin on the following dates/times: -1/7/25 at 10:41 A.M. -1/7/25 at 2:02 P.M. -1/8/25 at 3:58 P.M. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/14/25 at 12:13 P.M. During an interview on 1/7/25 at 11:54 A.M., the Resident's Representative said Resident #51 could have issues with care at times, but the facility staff re-approach him/her for personal care. During an interview on 1/14/25 at 2:25 P.M., Certified Nurses Aide (CNA) #10, who had worked with Resident #51 frequently, said he/she required supervision with personal care. CNA #10 said due to the Resident's memory decline, staff would need to assist him/her with brushing his/her hair and any facial hair removal. CNA #10 said Resident ##51 was receptive to staff assistance with his/her care. When CNA #10 observed Resident #51, she said he/she had long facial hair on his/her chin that curled and should be removed. CNA #10 further said that it looked like the Resident's facial hair had not been removed for a while, and staff would have to provide him/her assistance with this task because a razor would need to be used. CNA #10 further said if staff observed Resident #51 with facial hair, it should be removed. During an interview on 1/14/25 at 2:33 P.M., Nurse #2 said if Resident #51 had facial hair, the staff should assist with removal. During an interview on 1/14/25 at 3:10 P.M., the Director of Nursing (DON) said the facility had been working on ensuring unwanted facial hair was removed for residents. The DON further said that Resident #51 was receptive to removing his/her facial hair, and staff should assist with this.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview, and record review, the facility failed to obtain orders for wound treatments in accordance with professional standards of practice for two Residents (#49 and #56) out of a total sample of 20 residents. Specifically, the facility failed to: 1. For Resident #49, ensure that hospital discharge recommendations for treatment of the Resident's skin condition were appropriately implemented placing the Resident at risk for worsening of the skin conditions. 2. For Resident #56, obtain a Physician order for wound treatments recommended by the Wound Doctor resulting in the Resident's sacral wound not being treated timely. Findings include: Review of the facility policy Skin and Wound Management System, revised September 2022, indicated the following: -Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection. 1. Resident #49 was admitted to the facility in October 2022, with diagnoses including Dementia. Review of Resident #49's Minimum Data Set (MDS) assessment dated [DATE], indicated: -The Resident was rarely/never able to understand or be understood by others. Review of the Hospital Discharge Summary dated 12/29/24, indicated: -The Resident was treated for Sepsis and Cellulitis of the Left Hand. -Discharge Medications including: >Bacitracin Topical (an antibiotic ointment used to treat/prevent infections in wounds or on the skin) 1 application topically two times a day for seven days to [sic] left hand. Review of Resident #49's December 2024 through January 2025 Physician orders indicated no evidence of a treatment order or order for Bacitracin Topical to the Resident's left hand. Review of Resident #49's Nursing Progress Notes indicated the following: -a Nursing Note dated 12/29/24, indicating the hospital recommended Bacitracin dressing to the left hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a late entry progress note, entered on 1/9/25, dated for 12/30/24 at 10:47 A.M., indicating: >Cellulitis to upper extremity. Not applicable for Wound MD to follow. Further review of the medical record indicated no evidence that the discharge instructions recommending a treatment of Bacitracin Topical ointment was addressed with a Physician. The surveyor observed Resident #49 with an undated, disheveled appearing white wrapped bandage on his/her left hand on the following dates and times: -1/7/25 at 8:35 A.M. -1/7/25 at 2:57 P.M. -1/8/25 at 3:18 P.M. During an interview on 1/8/25 at 3:20 P.M., Nurse #1 said that she was the Nurse who reviewed the re-admission paperwork with the on-call Provider when Resident #49 returned from the hospital. Nurse #1 said she did not enter the recommended treatment order but did discuss it with the on-call Provider who told her to have the Resident seen by the Wound Doctor the following day. Nurse #1 further said she observed the bandage to be in place on 1/7/25 when she worked, looked under the dressing and observed the blisters appeared to have opened but left the dressing in place. Nurse #1 said she was unsure how long that bandage had been in place. During an interview on 1/9/25 at 11:51 A.M., Nurse #3, who was covering for the Director of Nursing (DON), said the expectation was that the recommendation should have been entered at the time of admission in case the Wound Doctor does not come in or cannot see the Resident. The surveyor and Nurse #3 reviewed the late entry Wound Nurse and Nurse #3 said the note indicated that the Wound Nurse determined the Wound Doctor would not see the Resident. During a follow-up interview on 1/9/25 at 1:15 P.M., Nurse #1 said that she had entered a verbal order that Nurse #3 obtained from the Physician Assistant (PA) for Bacitracin on 1/8/25 but the PA saw the Resident today (1/9/25) and discontinued the order. Nurse #1 said she should not have entered a verbal order she did not take from the Provider. During a follow-up interview on 1/9/25 at 1:16 P.M., Nurse #3 said she did not take an order from the PA, but she had told Nurse #1 to call the Provider and obtain an order for treatment. During an observation on 1/9/25 at 1:23 P.M., the surveyor observed Resident #49's left hand with Nurse #1 and Nurse #3. The areas to Resident #49's knuckles and between his/her fingers were not fluid filled and appeared to be scabbed over. During a follow-up interview on 1/9/25 at 1:27 P.M., Nurse #3 said that Nurse #1 should not have entered a Physician order without obtaining it from the Provider as this was outside her scope of practice. Nurse #3 further said that there would be concern relative to entering an order without obtaining it from a Provider as well as concern relative to not addressing a hospital discharge recommendation for treatment as this could cause the skin condition to worsen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #56 was admitted to the facility in December 2024, with diagnoses including Type 2 Diabetes and Chronic Kidney Disease Stage 3A. Review of the MDS assessment dated [DATE], indicated Resident #56: -had mild cognitive impairment as evidenced by a BIMS score of 12 out of possible score of 15. -had Moisture Associated Skin Damage (MASD-a condition where the skin becomes inflamed or eroded from continuous exposure to moisture such as urine or perspiration). Review of the Nursing Evaluation with [NAME] form dated 12/26/24, indicated Resident #56 was documented with a skin alteration to the sacrum. Review of the Wound Doctor Progress notes indicated the following: -On 12/30/24 the Wound Doctor did an initial evaluation of Resident #56 and classified the area to the buttocks as MASD. The Wound Doctor made a recommendation for zinc paste (a medicated ointment used to treat skin conditions such as MASD) to the wound base daily and as needed. -On 1/6/25 the Wound Doctor did a follow-up evaluation of Resident #56 and continued to recommend zinc paste to the wound base daily and as needed. -On 1/13/25 the Wound Doctor did a follow-up evaluation of Resident #56 and continued to recommend zinc paste to the wound base daily and as needed. Review of Resident #56's Physician orders indicated no evidence of an order for zinc paste. Review of Resident #56's Progress Notes indicated no evidence the Wound Doctor's recommendation was addressed with the Provider. During an observation and interview on 1/14/25 at 3:30 P.M., the surveyor observed Resident #56 lying in bed. Resident #56 said he/she had cream applied to his/her bottom by the Certified Nurses Aides (CNAs) during care but never by the Nurse. During a wound observation and interview on 1/14/15 at 3:35 P.M., the surveyor and Nurse #16 observed Resident #56's buttocks. Nurse #16 said there was an open area to the right buttock. Nurse #16 further said there was no order for treatment to the Resident's buttocks. During an interview on 1/15/25 at 8:08 A.M., the surveyor and Nurse #9 reviewed the wound consults and Physician orders. Nurse #9 said that there should have been an order in place for zinc paste based on the Wound Doctor recommendations but there was not. During an interview on 1/15/25 at 8:16 A.M., the Assistant Director of Nursing (ADON) said that there had not been an order for zinc paste in place until he reviewed the 1/13/25 Wound Doctor note on 1/14/25 and obtained the order. The ADON further said that the CNAs had been applying barrier cream but that this was not the same as zinc paste.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37400 Based on observation, interview, and record review, the facility failed to ensure one Resident (#117) out of a total sample of 20 residents, was free from potential accidents/hazards. The facility also failed to minimize risk of accident/hazards during medication pass on one of two units observed. Specifically, 1. For Resident #117, the facility failed to ensure one to one (1:1) direct supervision was provided during oral intake as ordered by the Physician, increasing the potential risk of choking and aspiration (food/fluids that enters the lungs). 2. On the [NAME] Unit, the facility failed to ensure that poured medications were maintained in a safe manner to prevent access to and accidental ingestion by residents for whom the poured medication was not intended to be administered. Findings include: 1. Resident #117 was admitted to the facility in January 2025 with diagnoses including Transient Cerebral Ischemic Attack (TIA), dysphagia and pneumonitis due to inhalation of food and vomit. Review of the Hospital Discharge Note, dated 1/3/25, indicated the following: -Resident #117 presented to the hospital with symptoms of a stroke including left sided weakness, facial droop, slurred speech and word finding difficulty. -hospital course was complicated by continued aspiration and aspiration pneumonia. Review of the Certified Physician Assistant (PA-C) Progress Note, dated 1/6/25, indicated: -Resident had mild oropharyngeal (middle part of the throat at the back of the mouth) dysphagia. -Resident started on level 2 diet (mechanical soft/ground meats) with thin liquids and direct supervision with all oral intake. Review of the January 2025 Physician's orders indicated: -1:1 feed, must be upright for all meals, no straws, every day and evening shift for aspiration risk, initiated 1/6/25 -aspiration precautions (practices put into place to help prevent food and fluids from entering the lungs), head of the bed up at all times when in bed, every shift for aspiration precautions, initiated 1/6/25 -Mechanical Soft, ground meats, thin liquids diet texture, initiated 1/7/25 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Speech Language Pathology (SLP) Swallow Evaluation, initiated 1/7/25 Review of the Speech Therapy Evaluation and Plan of Treatment Note, dated 1/7/25, indicated: -Resident was referred to speech therapy related to his/her TIA which impacted swallowing skills and put him/her at increased risk of aspiration. -Resident presents with mild oropharyngeal dysphagia. -Resident needs to be upright for all intake, have supervision with meals, consume foods using a slow rate and take small bites. -Recommended soft and bite sized solids, mechanical soft/ground textures, thin (regular) liquids. Review of the Activities of Daily Living (ADL) Care Plan, initiated 1/6/25, included the following Eating: -Resident required supervision to eat, initiated 1/7/25 and revised 1/8/25 Review of the Respiratory Care Plan, initiated 1/8/25, indicated Resident #117: -had an altered respiratory status, difficulty breathing related to recent aspiration pneumonia and included the following interventions also initiated 1/8/25: >elevate the head of the bed >monitor for signs and symptoms of respiratory distress and report to the Medical Doctor (MD) Review of the Certified Nurses Aide (CNA) documentation for January 2025 indicated Resident #117 was marked as independent for 18 meals provided out of 22 meals. Further review of the CNA documentation indicated supervision was provided for four of the 18 meals. Review of the CNA Care Card, as of 1/15/25, indicated: -Resident requires supervision to eat -mechanical soft/ground meat diet as ordered, no straws -1: 1 assist at meals On 1/14/25 at 12:32 P.M., the surveyor observed the following during the lunch meal: -the privacy curtain was pulled and Resident #117 was unable to be observed from the doorway/hallway (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #117 was sitting upright in bed. A meal tray was on the bedside table positioned in front of the Resident and contained a plate of ground kielbasa and sauerkraut. -Resident #117 was observed to eat applesauce, and a half of a banana was also on the bedside table. -No staff were observed in the Resident's room during this time. During an interview on 1/14/25 at 2:48 P.M., Nurse #2 said Resident #117 required supervision for all oral intake due to aspiration risk. Nurse #2 said there are strategies in place to remind the Resident to take small bites and chew food thoroughly and that he/she should not be eating food without supervision from staff. During an interview on 1/14/25 at 2:58 P.M., CNA #10, who frequently worked on the unit and knew all of the residents well, said Resident #117 did not require supervision with meals. CNA #10 further said there were only two residents that required supervision and Resident #117 was not one of them. On 1/14/25 at 4:22 P.M., Resident #117 was observed sitting upright in bed with the privacy curtain pulled so he/she was not visible from the hallway. The surveyor observed an empty cookie wrapper and an unopened package of peanut butter crackers were on the bedside table positioned near the Resident. During an interview at the time, the Resident said he/she ate the cookie and was saving the peanut butter crackers for later. On 1/15/25 at 8:07 A.M. through 8:44 A.M., the surveyor observed the following during the breakfast meal: -The privacy curtain was pulled and Resident #117 was unable to be visualized from the hallway. -Resident #117 was lying in bed with his/her eyes closed. The head of the bed was slightly elevated, and two drinks and a package of peanut butter crackers were observed on the bedside table within reach. -CNA #9 delivered the Resident's breakfast tray and exited the room shortly after. -at 8:14 A.M., Resident #117 was heard coughing from within the room. The surveyor knocked and entered the room at this time and saw the Resident lying upright in bed. Half of the glass of orange juice had been consumed and the Resident's meal tray contained French toast with no crust, scrambled eggs and a bowl of [NAME] Krispies. During an interview at the time, the Resident said he/she needed assistance to sit more upright in bed. The call light was initiated initiated by the Resident with verbal cues by the surveyor at this time. -at 8:19 A.M., CNA #9 entered the room, responded to the call light, and exited shortly after. The privacy curtain remained pulled around the Resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-at 8:22 A.M., the Resident was seated upright in bed with his/her breakfast meal positioned in front of him/her. The Resident was observed to be eating breakfast at this time. No staff were observed in the Resident's room. -at 8:44 A.M., CNA #9 entered the Resident's room and removed his/her breakfast tray. During an interview on 1/15/25 at 8:48 A.M., CNA #9 said Resident #117 consumed most of the cold cereal, some of the French toast and consumed all of the juice and milk. CNA #9 said the Resident was able to eat independently and needed assistance earlier with positioning the bedside table in front of him/her. During an interview on 1/15/25 at 12:11 P.M., the surveyor relayed previous observations of Resident #117 with the Director of Nursing (DON). The DON said Resident #117 had a Physician's order for 1:1 supervision with eating and was at risk for choking if not provided. 50563 2. On 1/8/25 at 4:09 P.M., the surveyor observed during a medication pass administration performed by Nurse #10: -Nurse #10 gathered and prepared medication and supplies to administer medications via Gastric Tube (G-tube: a tube inserted into the stomach to provide a means to provide nutrition and medications to a person who has difficulty swallowing or meeting nutritional needs the traditional way). -Nurse #10 performed hand hygiene, donned gloves and entered the resident's room with supplies, setting three medication cups on the window sill. -The surveyor observed that Nurse #10 did not bring the necessary water into the Resident's room for flushing the G-tube before and after, as well as for administering medications. -Nurse #10 exited the room to obtain water for flushes and medication administration and left the three medication cups unattended on the window sill. -Nurse #10 returned to the Resident's room and completed the medication pass process. During an interview on 1/8/25 at 4:40 P.M., Nurse #10 said she should not have left medications unattended because there was a risk that another resident could have taken them placing residents at risk for accident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42690 Based on observation, record review, and interview, the facility failed to provide appropriate treatment and services relative to an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body, for one Resident (#10) out of a total sample of 20 residents. Specifically for Resident #10, the facility staff failed to follow the Physician order's relative the Foley Catheter size (a type of indwelling urinary catheter), and ensure the proper size Foley Catheter was available in the facility, increasing the Resident's risk for indwelling urinary catheter complications. Findings include: Review of facility policy titled, Catheter Care, Urinary, revised September 2014, indicate the following: -Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. 2. Assemble the equipment and supplies as needed. Resident #10 was admitted to the facility in May 2022 with diagnoses including urinary tract infection, retention of urine, and Chronic Kidney Disease - Stage Three. Review of January 2025 Physician orders indicated the following: -16 Fr (French -diameter size) Foley Catheter with 10cc (cubic centimeters) balloon to straight drainage for urinary retention. May change as needed for leakage, dislodgement or occlusion, initiated 6/9/22. Review of a Nursing Note dated 10/25/24 at 5:22 A.M., indicated the following in part: -Noted that rt (resident) had no urinary output in foley bag. Upon catheter inspection it was found to be 3/4 of the way out of his/her bladder. Balloon emptied for 5 ml (milliliters) yellowish liquid. Upon removal of foley, a large blood clot came out at the tip of the Foley catheter. Blood clot removed and #14 Fr catheter inserted without difficulty, 5 ml balloon filled. 100 ml pink tinged hematuria returned immediately. F/C (Foley Catheter) now draining clear yellow urine in tubing/bag. Further review of the medical record indicated no documented evidence that the Physician or Physician Assistant (PA) had been notified or consulted with to allow for a different sized Foley Catheter other than the 16 Fr with a 10cc balloon as ordered by the Physician, to be utilized. Review of a Nursing Note dated 10/25/24 at 8:00 A.M., indicated the following in part: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Writer in to assess Resident this am shift, noted patient's color to be pale, presenting with labored breathing. Resident was responsive and mental status noted to be at baseline. -Writer called PA, Provider recommended to have Resident sent out for further evaluation. Review of a Nursing Note dated 10/31/24 at 8:19 A.M., indicated the following in part: -Continue on IV ABT/UIT [sic] (Intravenous antibiotic for Urinary Tract Infection) Review of the Physician Assistant (PA) Progress note (Amended) dated 11/19/24, indicated the following in part: -Readmit note from 11/15/24 hospital transfer -Transferred out due to decreased mental status. -He/she was evaluated at the hospital and diagnosed with recurrent UTI (Urinary Tract Infection). -He/she was started on a 7-day course of IV (intravenous) Meropenem (antibiotic) -Will change Foley on the FIRST OF EVERY MONTH. Review of a Nursing Note dated 1/1/25, indicated the following in part: -Resident had Foley Catheter changed, #16 Fr with 5cc balloon. Further review of the medical record indicated no documented evidence that the Physician or PA had been notified or consulted with to allow for a different sized Foley Catheter other than the 16 Fr with a 10cc balloon, as ordered by the Physician, to be utilized. During an interview on 1/13/25 at 9:53 A.M., with Nurse #5 and Nurse #7, Nurse #7 said she was the Nurse who inserted Resident #10's Foley Catheter on 1/1/25. Nurse #7 said that she filled the balloon to 5cc's because she used her judgment and filled it until she felt that the catheter had been secured (where it would not dislodge) as she did not want the catheter to be uncomfortable for Resident #10. Nurse #7 said that there had been no issues with the new Foley Catheter. The surveyor, Nurse #5, and Nurse #7 reviewed the different sized catheters in the plastic bin in which they were stored for the facility and noted there were 16 Fr Foley Catheters, however they all had 30cc balloons. Nurse #5 said that a 30cc balloon would be too big and most likely uncomfortable for the Resident. During a follow-up interview on 1/13/25 at 9:58 A.M., Nurse #5 said when a different sized Foley Catheter had been utilized than what the Physician order indicated, the on-call Provider (Physician or PA) should have been notified and a confirmation from the Provider should have been given that it was acceptable to use a different size Foley Catheter, than what had been ordered. Nurse #5 said that the Provider conversation would then have been documented and a new order would have been obtained. Nurse #5 further said that she thought the facility used to have Foley Catheters with 10cc balloons available and is not sure why they no longer do. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/13/25 at 12:26 P.M., the Director of Nursing (DON) said that the Physician or the PA should have been notified when a different sized balloon was used as it was not what was ordered. The DON said that she was not aware that the ordered size of 16 Fr with a 10cc balloon was not available, and this was the first she was hearing of it. The DON reviewed Resident #10's catheter orders and said that the order for a 16 Fr Foley Catheter with a 10cc balloon had been ordered and was in place since 6/9/22. The DON additionally said that a catheter audit had previously been completed and she was surprised that this had not been identified as a result of the audit. The facility staff did not provide evidence of the catheter audit. The DON further said that while there is not a big difference in the 5cc balloon to the 10cc balloon, using a smaller sized balloon could put the Resident at risk for the catheter becoming dislodged. During an interview on 1/14/25 at 2:01 P.M., the Medical Supplies Coordinator said that the supplier she is required to use does not have 16 Fr Foley Catheter with a 10cc balloon available only 16 Fr with a 5cc balloon. The Medical Supplies Coordinator said she put a medical supply order in weekly and is not able to place orders outside of the weekly window. The Medical Supplies Coordinator said that if there is something that the facility requires emergently, she can use the corporate card and go to the local store to purchase the required item. The Medical Supplies Coordinator further said that since she had been working in this role (about one year), she could not recall keeping the 16 Fr Foley Catheter with a 10cc balloon in stock. During an interview on 1/14/25 at 5:06 P.M., the PA said that she was unaware that a different sized Foley Catheter other than what she had ordered had been utilized for Resident #10. The PA said that Resident #10's Foley Catheter was changed monthly and that she had never been notified that the facility did not have the correct sized Foley Catheter in stock. The PA further said that she would expect the facility staff to notify her about this concern. The PA said that some concerns with using the wrong sized balloon could be urinary leakage, skin irritation/breakdown due to urinary leakage and possible discomfort.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51571 Based on observation, interview, and record review, the facility failed to provide nutritional care and services, according to professional standards of practice for two Residents (#40 and #12) out of a total sample of 20 Residents. Specifically, the facility failed to: 1. For Resident #40, accurately monitor and assess the Resident's fluids intake amounts as ordered by the Physician. 2. For Resident #12, obtain a re-weight when the Resident experienced weight loss. Findings include: 1. Resident #40 was admitted to the facility in October 2022, with diagnoses including end stage renal disease (ESRD), dependence on renal dialysis and chronic systolic heart failure. Review of the Facility Policy titled End-Stage Renal Disease, Care of a Resident with, established 2001, last revised January 2019, indicated the following: -Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents as applicable. -Examples of education and training of staff may include: a. The nature and clinical management of ESRD (including nutritional needs). b. The type of assessment data that is to be gathered about the resident's condition on a daily basis or per shift basis as required. Review of the Facility Policy titled Intake, Measuring and Recording, established 2001, and last revised October 2010, indicated the following: -The purpose of this procedure was to accurately determine the amount of liquid a resident consumes in a 24-hour period. -Verify that there was a physician's order for this procedure and/or that the procedure is being performed per facility policy. -At the end of your shift, total the amount of all liquids the resident consumed. -Record all fluid intake on the intake and output record. -Report other information in accordance with facility policy and professional standards of practice. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) Assessment, dated 1/3/25, indicated that Resident #40: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. -was on Dialysis. -was on a Therapeutic diet. Review of Resident #40's Care Plan, initiated 10/15/24 and revised 1/14/25, indicated: -1200 milliliter (ml) Fluid Restricted - 480 ml Nursing, 720 ml dietary (240 ml per meal), initiated 1/14/25 -monitor intake and output, initiated on 3/7/23. Review of Resident #40's January 2025 Physician orders indicated: -Fluid intake for the 11:00 P.M. to 7:00 A.M. = 120 ml every night shift. Order active 3/20/23. -Fluid intake for the 3:00 P.M. to-11:00 P.M. = 480 ml every evening shift. Order active 3/20/23. -Fluid intake for the 7:00 A.M. to -3:00 P.M. = 600 ml every day shift. Order active 3/20/23. -Total and record last 24-hours of fluid intake. -Notify medical team if over 1200 ml every shift related to end stage renal disease. Order active 7/23/23. Review of Resident #40's Medication Administration Record (MAR) from November 2024 through January 2025 indicated no documented evidence that 24-hour fluid amount totals were obtained and assessed for the Resident. Review of Resident #40's November 2024, December 2024, and January 2025, Documentation of Fluids Intake, completed by the Certified Nurses Aides (CNAs), indicated that Resident's #40 exceeded the daily 1200 ml fluid intake limit on the following dates: -11/2/24: 1620 ml -11/16/24, 12/7/24 and 12/28/24: 1230 ml -11/25/24: 1350 ml -11/26/24, 1/2/25 and 1/14/25: 1220 ml -11/27/24: 1320 ml -12/21/24, 12/27/24 and 1/1/25: 1340 ml (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/4/25: 1460 ml -1/5/25 and 1/13/25: 1520 ml -1/10/25: 1420 ml During an interview on 1/14/25 at 12:38 P.M., Resident #40 said that he/she was on a fluid restriction and was not compliant with it at times. During an interview on 1/14/25 at 2:30 P.M., Nurse #11 said Resident #40 was non-complaint at times with the 1200 ml fluid restriction ordered by the Medical Doctor. During an interview on 1/14/25 at 3:24 P.M., Nurse #6 said Resident #40 was on fluid restriction because he/she was on dialysis. Nurse #6 said the MAR indicated the fluids she can administer with the Resident's medications and if the Resident was consuming too much fluids, she would need to notify the Provider. Nurse #6 further said that consuming too much fluids could put the Resident at risk for fluid overload and CHF (Congestive Heart Failure). During an interview on 1/15/25 at 7:04 A.M., Nurse #12 who worked the 11:00 P.M. to 7:00 A.M. shift, said the Resident's fluid restriction amounts were broken down by fluids provided with meals and fluids provided by Nursing on the specified shift. Nurse #12 said she only administers the fluid amounts for medications indicated for Nursing on her shift (120 mls). Nurse #12 said she had been asking facility staff for assistance on how to document and total the Resident's 24-hour fluid totals but had not received any information and was still unsure how to do this. Nurse #12 further said Resident #40 was independent and could obtain fluids on his/her own if he/she needed it. On 1/15/25 at 8:10 A.M., the surveyor observed Resident #40 sitting on his/her bed, eating his/her breakfast meal. The breakfast fluids included on the Resident's meal tray were a glass of orange juice, a glass of milk, and a cup of coffee (fluids approximately five ounces each totaling approximately 15 oz [444 mls]). On 1/15/25 at 8:40 A.M., the surveyor observed an empty breakfast tray on the Resident's bedside table with no remaining fluids on the breakfast tray. The Resident was not observed to be in the room. During an interview on 1/15/25 at 10:15 A.M., the Physician Assistant (PA) said Resident #40 was placed on fluid restriction because he/she was retaining fluids in his/her upper and lower extremities. The PA said Resident #40 had a diagnosis of End Stage Renal Failure and had horrible issues with edema. The PA said she expected that the 1200 ml fluid restriction for Resident #40 was being implemented by the facility staff and she had not received notification from the facility that the Resident's fluid restriction was not maintained. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 12:10 P.M., the surveyor and the Director of Nursing (DON) reviewed Resident #40's clinical record. During an interview at the time, the DON said that the Nurses document in the MAR that the Resident achieved the total amount of fluids ordered or allowed per shift and for the 24-hour totals for the fluid restriction. The DON said the notation (check mark made by the nursing staff) indicated that the Resident did not go over the prescribed 1200 ml fluid restriction amount. The DON further said there were no fluid intake amount totals recorded in the clinical record to indicate what Resident #40 consumed during a 24-hour period and the notation of a check on the MAR only indicated that Nursing staff are acknowledging the fluids amount ordered every shift, and total for the day that was given, and that the Resident did not go over the ordered limits. The DON said that Resident #40 was their own person and could ask for fluids when they want. Upon reviewing the CNA documentation of fluid intake for Resident #40, the DON said that she was wondering if the CNA's were confused with the fluid intake documentation because there were several days that indicated the Resident consumed more than the 1200 mls prescribed. The DON said she had not received communication from the Nurses that Resident #40 was exceeding the 1200 ml fluid restriction order. 50563 2. Review of the facility policy titled Weight Assessment and Intervention, revised March 2019, indicated the following: -weights will be recorded in each individual's medical record. -any weight change of 5 pounds (lbs) or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the physician and dietician. Resident #12 was admitted to the facility in March 2023 with diagnoses including Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #12 had moderate cognitive impairment as evidenced by a BIMS score of 12 out of a possible score of 15. Review of Resident #12's weight documentation in the Electronic Medical Record (EMR) indicated: -10/1/24: weight of 122.2 lbs -11/1/24: weight of 121 lbs -no December 2024 weight -1/1/25: weight of 106 lbs (15 lbs weight loss from 11/1/24) -1/2/25: weight of 106 lbs Review of Resident #12's medical record indicated no documentation of Physician or Dietician notification of weight loss greater than 5 lbs for the Resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 10:51 A.M., Certified Nurses Aide (CNA) #4 said she was the lead CNA on the unit. CNA #4 showed the surveyor a weight book (binder that contained a one-page flowsheet of the weights of every resident for each month) on the unit used by the CNAs to communicate weights to the Nurses who enter them into the medical record. The surveyor and CNA #4 reviewed the December 2024 weight flowsheet and CNA #4 said the December 2024 weight for Resident #12 indicated on the weight flowsheet was 109.1 lbs. CNA #4 said if a re-weight was done it would be written on the weight flowsheet but she did not see that this had occurred. During an interview on 1/9/25 at 11:23 A.M., Nurse #1 reviewed the EMR weight documentation for Resident #12 which now indicated a weight of 109 lbs that was documented by Nurse #3. Nurse #1 said that the Dietician review weights and that is how she would be aware of any loss. During an interview on 1/9/25 at 2:53 P.M., the Administrator said that Nurse #3 had entered the December 2024 weight into the EMR earlier that day (1/9/25). During a telephone interview on 1/9/25 at 3:30 P.M., the Dietician said that weights are not always entered into the EMR by staff. The Dietician said she was not aware of Resident #12 having a weight of 109 lbs in December 2024. The Dietician further said she had asked the Director of Nursing (DON) weekly during risk meetings for a weight on Resident #12 but had not received one. During a telephone interview on 1/9/25 at 11:05 A.M., Nurse Practitioner (NP) #1 said that she follows Resident #12 and is very familiar with him/her. NP #1 said she was not made aware by the facility the Resident had weight loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42690 Based on observation, record review, and interview, the facility failed to provide respiratory care and services consistent with professional standards of practice for one Resident (#4) out of a total sample of 20 residents. Specifically, the facility failed to ensure that the correct oxygen flow rate was administered to Resident #4 as ordered by the Physician. Findings include: Review of the facility policy titled Oxygen Administration, revised October 2010, indicated the following in part: -Verify that there is a physician's order for this procedure. -Review the physician's orders or facility protocol for oxygen administration. -Review the residents care plan to assess for any special needs of the resident -Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered period. Resident #4 was admitted to the facility in March 2023 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and dependence on supplemental oxygen. Review of Resident #4's January 2025 Physician orders indicated the following: -Oxygen at 1.5 LPM (liters per minute- flow rate of oxygen delivery) per nasal cannula every shift for shortness of breath, start date 11/7/24. Review of Resident #4's COPD Care Plan, initiated 3/13/23, indicated to give oxygen therapy as ordered by the Physician. On 1/7/25 at 10:51 A.M., the surveyor observed Resident #4 was receiving oxygen via nasal cannula. The oxygen concentrator (device that concentrates oxygen from environmental air and delivers it to a patient in need of supplemental oxygen) was set at 2 LPM. On 1/13/25 at 3:39 P.M., the surveyor and Certified Nurses Aide (CNA) #6 observed Resident #4 who was seated in a wheelchair and receiving oxygen via a portable oxygen tank. CNA #6 said that the oxygen was set to 2 LPM. During an interview on 1/13/25 at 4:03 P.M., Nurse #5 said that she just went in to check the oxygen and adjusted it from 2 LPM to 1.5 LPM per the Physician order. Nurse #5 said that she was not aware of why the liter flow was set to 2 LPM, that she set it to 1.5 LPM. Nurse #5 said the Resident does not touch the portable tank or the oxygen concentrator.

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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. 47646 Based on observation, record review, and interview, the facility failed to ensure that care and services for pain management consistent with professional standards of practice were provided for one Resident (#9) out of a total sample of 20 residents. Specifically, the facility failed to provide pain management interventions as ordered for Resident #9 when the Resident reported pain and was dependent on staff to receive as needed and scheduled pain medication and non-pharmacological measures to treat his/her pain. Findings include: Review of the facility policy titled Pain - Clinical Protocol, revised March 2018, indicated but was not limited to the following: -Assessment and Recognition 1. The physician and staff will identify individuals who have pain or are at risk for having pain. a. This includes reviewing known diagnosis and conditions that commonly cause pain; for example, diabetic neuropathy. b. It also includes a review for any treatments that the resident is currently receiving for pain, including complementary and non-pharmacologic treatments. -Treatment/Management 2. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. -Monitoring 1. The staff will reassess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain. Resident #9 was admitted to the facility in July 2023 with diagnoses including Diabetes and diabetic neuropathy. Review of the Minimum Data Set (MDS) assessment, dated 12/13/24, indicated Resident #9: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. -had received scheduled pain medication. -did not receive as needed (PRN) pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/13/25 at 2:35 P.M., Resident #9 was observed lying flat in bed and said that he/she had a lot of pain in his/her hands and feet. Resident #9 also said that he/she was on pain medication, but the pain medication really doesn't help. Resident #9 said he/she has told the Nurses about the pain. Review of Resident #9's care plan indicated but is not limited to the following: Focus: Resident #9 has acute pain/chronic pain, revised 7/6/23 Interventions: (date initiated 7/6/23) -Anticipate need for pain relief and respond immediately to any complaint of pain or non-verbal sign of pain. -Encourage Resident to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain. -Evaluate effectiveness of pain interventions. -Review for compliance, alleviating of symptoms, dosing schedules and Resident satisfaction with results, impact on functional ability and impact on cognition. -Monitor/record pain characteristics PRN (as needed): >Quality (e.g. sharp, burning) >Severity (1 - 10 scale) >Anatomical location >Onset >Duration (e.g. continuous, intermittent) >Aggravating factors >Relieving factors Review of Resident #9's Physician orders indicated but was not limited to: -Lyrica (medication to treat nerve pain) Oral Capsule 100 mg (milligram) by mouth at bed time for pain, dated 6/20/24. -Tylenol Extra Strength Oral Tablet 500 mg, give two tablets by mouth two times a day, should not exceed 3, 000 mg in a 24 hour period, dated 10/17/23. -Tylenol Extra Strength Oral Tablet 500 mg, give two tablets by mouth every 6 hours as needed (PRN) for pain. Do not exceed three grams daily, dated 7/12/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's December 2024 and January 2025 Medication Administration Record (MAR) indicated that he/she received the scheduled Lyrica and Tylenol medications as ordered. Further review of the January 2025 MAR indicated that Resident #9 did not receive any Tylenol as needed (PRN) for pain. Further review of Resident #9's December 2024 and January 2025 MARs indicated an order to monitor for pain every shift: -attempt non-pharmacological interventions for pain management such as relaxation, light touch, exercise, music, etc. every shift, start date 7/5/23. During an interview on 1/14/25 at 2:08 P.M., the Director of Nursing (DON) said that every shift the Nurses monitor the Residents' pain by rating it on a scale of zero to ten (0 - 10) with zero being no pain and ten being the worst. The DON said a rating of zero to three (0 - 3) indicates mild pain, four to six (4 - 6) indicates moderate pain, and over seven (>7) indicates moderate to severe pain. The DON said any rating over seven is significant. Review of Nursing documentation for December 2024, indicated Resident #9 was monitored 93 times for pain using a scale of 0 - 10 to rate pain. Results of monitoring indicated the Resident rated his/her pain as follows: -pain level of 8 - 3 times -pain level of 7 - 22 times -pain level of 4 - once -pain level of 5 - once -pain level of 3 - 7 times -pain level of 2 - 6 times Review of Nursing documentation for January 2025, indicated Resident #9 was monitored 40 times for pain. Results of monitoring indicated the Resident rated his/her pain as follows: -pain level of 7 - 9 times -pain level of 4 - once -pain level of 3 - four times -pain level of 2 - once -pain level of 1 - 2 times (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nursing Progress Notes, and December 2024 and January 2025 MARs for Resident #9 failed to indicate any intervention of PRN pain management or non-pharmacological measures as ordered by the MD to address pain ratings. Further review of the Nursing Progress Notes failed to indicate that the Physician was notified when the Resident reported having severe pain. Review of Resident #9's Psychiatrist Progress Note dated 10/9/24, indicated but was not limited to: >Plan/Recommendations: -Recommend referral to medical team pt's concerns for worsening numbness/weakness hands and painful feet. Review of the medical record failed to indicate a referral was made to the medical team regarding numbness, weakness or pain as recommended by the Psychiatrist in October or November. He/she was not seen by the Physician until 12/19/24. Review of Resident #9's Psychiatrist Progress Note dated 12/18/24, indicated but was not limited to: -Patient reports worsening, painful, debilitating neuropathy. -Findings/Assessment: >Resident #9 carries a diagnosis of diabetic neuropathy causing pain poorly controlled. >Pt (patient) spending more time isolated in bed. >Pt continues to be bothered by worsening neuropathy. >Previously he/she received benefit from acupuncture for chronic fatigue. -Plan/Recommendations: >Consider referring Pt for acupuncture to help with painful neuropathy. Review of the medical record failed to indicate a referral was made for acupuncture to help with painful neuropathy for Resident #9 . Review of Resident #9's Physician Progress Note dated 12/19/24, indicated but was not limited to: -Chief Complaint: >This is MD (Medical Doctor) follow-up on DM (Diabetes)/neuropathy and chronic conditions. >Resident #9 reports doing well however pain due to neuropathy with pain level is 8 out of 10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>He/she currently uses Lyrica. >Eating, drinking and sleeping are ok. -Plan: >Diabetes with peripheral neuropathy, Monitor - Pt followed by neuro (Neurology) for this. >Continue Lyrica 100 mg at night. >Continue Tylenol 1000 mg BID (twice a day) and 500 mg q6h prn (every six hours as needed). Not to exceed three grams in 24 hours. >He/she has tried Gabapentin (Neurontin - anticonvulsant medication used to treat peripheral neuropathy) in the past without any effect. >He/she does not believe neuro would have any other modalities for him/her. >Obtain neuro appointment if Pt wishes. >Today Pt reports pain level is 8 out of 10. Monitor and adjust medications as needed. Review of medical record indicated Resident #9 was last seen by a Neurologist in June 2024, with the following recommendations: -current dose of Lyrica, 100 mg at night. -Physical Therapy for gait training. -Occupational Therapy for hand strengthening. During an interview on 1/14/25 at 12:10 P.M., Certified Nurses Aide (CNA) #4 said she is caring for Resident #9 today and knows him/her well. CNA #4 said the Resident complains about pain to his/her hands and feet a lot and she reports this to the Nurse. CNA #4 said the Resident requires limited assistance with his/her activities of daily living (ADLs) and he/she walks to the bathroom. CNA #4 said Resident #9 sleeps most of the day. During an interview on 1/14/25 at 12:15 P.M., Nurse #15 said that he is caring for Resident #9 today. Nurse #15 said he does not know the Resident well and has taken care of him/her twice. Nurse #15 said that the Resident did not report any pain today. During an interview on 1/14/25 at 12:23 P.M., Resident #9 was observed lying flat in bed and said that he/she is in constant pain to his/her hands, feet and toes, and the pain medication doesn't help. Resident #9 said his/her pain is usually an 8 on a scale of 0 - 10, the pain is really bad. He/she said the pain has gotten worse over the past few months. Resident #9 said he/she has had acupuncture in the past and would like to try it for the pain. Resident #9 said there is a Tylenol as needed (PRN) order for pain, but it doesn't help so he/she doesn't ask for it. Resident #9 said that he/she tells the Nurses about his/her pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/14/25 at 2:08 P.M., the DON said when a resident rates pain at a level of 7 or 8, its moderate to severe and she would call it significant pain. The DON said she would expect the Nurse to contact the Provider and intervene with the pain. The DON said she was not aware of Resident #9's pain. The DON further said she used to see the Resident up and walking around, but now she thinks about it, she has not seen him/her up and walking in the hallway in a while. The DON said she did not know about the Psychiatrist's recommendation for acupuncture, she thinks it would be a good idea to help the Resident's pain. The DON said the MD and/or NP review and sign the Psychiatrist's documentation and usually agree with and implement all of the recommendations, not sure what happened to this one.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview, and record review, the facility failed to provide appropriate medical care and Physician supervision for one Resident (#12) out of a total sample of 20 Residents. Specifically, for Resident #12, the facility failed to ensure that the Provider was aware of the Resident's weight loss and management of his/her nutritional status. Findings include: Review of the facility policy titled Weight Assessment and Intervention, revised March 2019, indicated the following: -weights will be recorded in each individual's medical record. -any weight change of 5 pounds (lbs) or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the physician and dietician. Resident #12 was admitted to the facility in March 2023 with diagnoses including Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #12 had moderate cognitive impairment as evidenced by a BIMS score of 12 out of a possible score of 15. Review of Resident #12's weight documentation in the Electronic Medical Record (EMR) indicated: -10/1/24: weight of 122.2 lbs -11/1/24: 121 lbs -no December 2024 weight -1/1/25: 106 lbs -1/2/25: 106 lbs Review of Resident #12's Medical Record indicated no documentation of Physician notification or interventions for a weight loss greater than 5 lbs. During an interview on 1/9/25 at 10:51 A.M., Certified Nurses Aide (CNA) #4 showed the surveyor a weight book on the unit used by the CNAs to communicate weights to the Nurses. The Nurses then enter the weights into the medical record. The surveyor and CNA #4 reviewed the December 2024 weight flowsheet and CNA #4 said the December 2024 weight for Resident #12 indicated on the flowsheet was 109.1 lbs. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/9/25 at 11:05 A.M., Nurse Practitioner (NP) #1 said she was not made aware of the December 2024 and January 2025 weights of 109 lbs and 106 lbs, but had she been informed she would have ordered something like Ensure (nutrition supplement).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37400 Based on observation, interview, and record review, the facility failed to ensure that the facility menus were followed for resident meals. Specifically, the facility failed to: -ensure the daily menus posted reflected the actual meals provided and that breakfast meals were posted on the daily menus and match the approved menus. -notify residents when menu items were substituted. -ensure residents who required pureed meals were notified of what their meals were and not provided with leftover food items from previously served meals. -provide the residents with adequate alternate options for menu items. Findings include: Review of facility menus, provided to the survey team on 1/7/25 indicated the following dinner menu for 1/7/25 and 1/8/25: -Dinner for 1/7/25: fish kiev, buttered noodles, herbed green beans, breadstick, diced pears -Dinner for 1/8/25: beef chili, broccoli cuts, corn bread, margarine, apple pie On 1/7/25 at 5:11 P.M., the surveyor observed the dinner provided to the residents which consisted of breaded chicken, mashed potatoes and mixed vegetables. On 1/8/25 at 5:09 P.M., the surveyor observed the dinner meal provided to the residents which consisted of sliced hot dogs mixed with beans, carrots and vanilla pudding. The vanilla pudding was in a disposible dessert cup. During an interview with a resident, he/she said the food was horrible, but he/she will eat the pudding. Review of the Food Committee Meeting Notes, from October 2024 and November 2024 (no notes were provided for December 2024) indicated the following: -new menu cycle (Fall/Winter) started -request for accommodation of low sodium diet, one resident received items like kielbasa, sauerkraut -concerns that portions provided were not enough or not what was on diet plan (large portions) (continued on next page)

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Westfield Gardens Nursing and Rehab	37 Feeding Hills Road Westfield, MA 01085

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/9/25 from 1:30 P.M. to approximately 3:00 P.M., the survey team conducted a resident council meeting with nine residents and the following was discussed: -the daily menus were posted near the nursing station and the majority of the residents in the meeting said most residents did not know what the menu was for the day. During an interview on 1/9/25 at 3:19 P.M., the Administrator said the facility menus provided to the survey team shortly after entrance were the actual facility approved menus and the daily menus posted outside of the nursing station on the units were the menus indicating what was going to be served for that day. The Administrator further said sometimes the menu changes based on food items not being delivered/available from the vendor and if there were questions, the Food Service Director (FSD) would be the person to talk to. On 1/9/25 at 3:47 P.M., the surveyor observed the daily menu for lunch and dinner posted outside of the [NAME] Unit and the following was posted: -Lunch: roast turkey, cornbread stuffing, broccoli and jello -Dinner: ham steak, mashed potatoes, mixed vegetables and peaches -the breakfast menu was not posted Review of the facility approved menus indicated the following meals were to be provided for 1/9/25: -Breakfast: cold cereal of choice, egg and hash brown bake, wheat toast, fresh banana -Lunch: chicken vegetable stew over noodles, dinner roll, pineapple tidbits -Dinner: kielbasa, mashed potatoes, sauerkraut, chocolate brownie -Bedtime (HS) snack: graham crackers and beverage of choice The surveyor conducted a test tray on 1/9/25 at 5:18 P.M., and the following meal items were provided: -thick slice of ham -cooked elbow macaroni -mixed vegetables -a dessert was not provided On 1/9/25 from 4:15 P.M. through 4:55 P.M., the surveyor observed the dinner service in the facility kitchen: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-meal trucks had trays, each tray contained a resident meal ticket. The resident meal ticket included the resident name, date, meal, unit and room number, diet, allergies/dislikes and preferences. There were no food/fluid items or amounts of the food items listed on the meal tickets. -Dietary Aide #4, who was cooking the dinner meal, was observed to put disposable dessert dishes of pudding, peaches and jello on the resident meal trays. The amounts of the desserts were observed to be of varying amounts, some of the dessert dishes were mostly full while others had less. -the steam table contained the following food items: >a pan of elbow pasta, >a pan of mixed vegetables, >a pan of regular ham >a pan of ground ham, >a small pan of mashed potatoes, >a small pan of reddish colored sauce. -During an interview on 1/9/25 at 4:20 P.M., Dietary Aide #4 said fruit in the dessert dishes should be the same amount which was four ounces (oz), but she noticed that there were some portions that are not the same. Dietary Aide #4 said the FSD coordinated with the day cook for the menus, and the dinner meal for that night was ham, elbow macaroni, mixed vegetables and peaches. Dietary Aide #4 said sometimes menu items have to be substituted because they run out of certain food items, for example there was not enough mashed potatoes so she made elbow macaroni for the regular diets and the mechanical soft (ground) diets were going to receive the mashed potatoes. Dietary Aide #4 said the alternate offered was always grilled cheese and she was not aware of any other alternates. Dietary Aide #4 said she did not document when she makes substitutions for menu items, she just decides what to serve. -During an interview on 1/9/25 at 4:28 P.M., Dietary Aide #5, who had set up the unit beverage carts for the dinner meal, said she usually included hot water, coffee, creamers, thickened drinks, juice, regular and Lactaid milk for the beverage cart. Dietary Aide #5 said there was no Lactaid milk, so it was not provided. -the surveyor observed Dietary Aide #4 take covered plates out of the reach-in refrigerator at 4:24 P.M., 4:29 P.M., 4:34 P.M, 4:48 P.M. and 4:50 P.M., and put them in the microwave (to reheat) and then remove and uncover the plates, and put them on individual resident trays. -During an interview on 1/9/25 at 4:50 P.M., Dietary Aide #4 said the food she was reheating in the microwave was the pureed food from lunch that she was serving as the pureed meal for dinner for the residents. When the surveyor asked what the pureed meal was that was being served, Dietary Aide #4 said she did not know what the meal was for lunch that was being served. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/9/25 at 4:34 P.M. and 4:51 P.M., the FSD said the disposable dessert dishes containing peaches were 4 oz., which was the serving size, and that some of the dessert dishes with peaches did not have correct portion amounts, some were less. The FSD said the menu provided to the survey team was what was supposed to be served to the residents, but it was not in the same sequence [sic] of what was actually being served to the residents. The FSD said sometimes they have issues with their vendor and do not receive items. The FSD further said the pureed meal served at dinner that night was the leftover meal which was served at lunch. When the surveyor asked what the residents on pureed diets were served for lunch, the FSD said the residents on pureed diets would have received the dinner meal from the previous night. The FSD further said that instead of wasting the food, they puree it for the next hot meal. The FSD said he did not have a reason for doing this except it was the way it had always been done. The FSD said he could see why doing this could be a problem because the residents who were on a pureed diet were not receiving what the other residents were receiving for the meal. When the surveyor asked if the residents receiving the pureed food would know what they were actually receiving, he said they would not. The FSD said he was unable to provide the surveyor with a weekly menu that the residents in the facility have actually been served and that he posts the daily menu for lunch and dinner the day of and then discards the old menus. During a follow-up interview on 1/9/25 at 5:59 P.M., the FSD said he was unable to provide the surveyor with menus of what had been served to residents in the previous weeks or months. The FSD further said the residents were not notified of the meals until the day he posts them, and he did not include the breakfast meal. The FSD said he did not have a set menu and did not utilize substitution logs when menu items are changed. The FSD further said there are no PAR levels (Periodic Automatic Replacement: an inventory control system indicates the levels of inventory that should be in stock in order to fulfil demand) for food items in the kitchen and that he based his ordering on what he decided for the menu, and that this menu was not shared with the residents. The FSD said he was only allowed to use one food vendor and that there were times when he did not receive items that were ordered. The FSD said they ran out of Lactaid milk, so he asked the Administrator to pick up Silk Milk (plant-based soy milk) but they did not have Silk Milk. When the surveyor asked if Silk Milk was equivalent to Lactaid milk, the FSD said they were both lactose-free, so he thought it was fine. The FSD said the corporation who owns the facility provides the approved menu and that he had a budget of $6.99 per patient/per day which included meals and snacks. Review of the facility approved menu indicated the following lunch menu for 1/10/25: -tuna noodle casserole, California blend vegetables, chocolate pudding. On 1/10/25 at 11:45 A.M., the surveyor observed the following lunch meal being served to the residents: -meatloaf, mashed potatoes and spinach. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/14/25 at 9:33 A.M., the Registered Dietitian (RD) said it was her understanding that the FSD used the corporate menu and made adjustments/substitutions for food items that he knew the residents did not like and may also make substitutions when items did not come in from their vendor. The RD said there were no substitution logs that she was aware of and she would expect that if items were substituted, it would be replaced with something that was equivalent to what was supposed to be served. When the surveyor asked about the review/approval of the menus served, the RD said the menus were from their corporate company. The RD said the menus for the day were posted near the nursing station and discussed during morning meeting. The RD said residents can observe the posted menus or ask what the menu was. When the surveyor relayed observations of the varying amounts observed for desserts, the RD said she could not speak to that but there were utensils to provide the correct dessert amounts and that some of the residents may request smaller portions so that may be why there are smaller amounts in some of the dessert cups. The RD further said the residents will always have concerns about the facility food. The RD further said the facility should not be using leftover food from a previous meal to provide to the residents on a pureed diet, that this was something that the facility did years ago and she did not realize it was still occurring. The RD said the pureed meals provided to the residents should be the same meal as indicated on the menu that is served to the other residents. The RD said it should not be regular practice to use leftover meals as the pureed meal for residents. Review of the facility approved menu indicated the following lunch menu for 1/14/25: -Meatloaf, mashed potatoes, broccoli cuts, dinner roll and mandarin oranges. On 1/14/25 at 12:32 P.M., the surveyor observed the following lunch meal served to the residents: -kielbasa, mashed potatoes, sauerkraut and applesauce. Review of the facility approved menu indicated the following breakfast and lunch menu for 1/15/25: -Breakfast: cold cereal of choice, hard cooked eggs, white toast, fresh banana -Lunch: chicken and biscuits, marinated green bean salad, chocolate chip bar On 1/15/25 at 8:11 A.M., the surveyor observed the following breakfast served to the residents: -french toast, scrambled eggs and cold cereal (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/15/25 at 10:37 A.M., Dietary Aide #2, who was also a regular cook, said the lunch today was chicken parmesan, noodles, green beans and pineapple. Dietary Aide #2 said he goes by the menus posted on the cook's book, looks in the refrigerators to see what was available and makes a plan for breakfast and lunch. Dietary Aide #2 said he knows what the residents like, sees what's available and makes menus that way. Dietary Aide #2 said he knows the meals provided to residents have to have a meat source, starch and a vegetable. Dietary Aide #2 showed the surveyor the menu he said they were using at the time which was titled Spring/Summer Menu with dates listed from May to September 2023 (and not the weekly Fall/Winter 2024-2025 menus provided to the survey team during entrance). Dietary Aide #2 said that the Spring/Summer Menu was the menu to be used, but breakfast listed for yesterday (1/14/25) and today (1/15/25) was not what was served. Dietary Aide #2 further said pancakes were served on 1/14/25 (Spring/Summer Menu indicated: cream of wheat, scrambled eggs with ham, wheat toast) and French toast and scrambled eggs was served on 1/15/25 (Spring/Summer Menu indicated: cheese grits, pancakes, banana). Dietary Aide #2 further said tomorrow (1/16/25), he would be serving waffles (Spring/Summer Menu indicated: oatmeal, scrambled eggs and muffin). During an interview on 1/15/25 at 11:21 A.M., the surveyor and the FSD reviewed the concerns relative to the resident menus and the FSD said he understood the concerns. Please Refer to F804

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37400 Based on observation, interview, and record review, the facility failed to ensure that food provided to residents was palatable and of appropriate temperatures on one unit (Willow) of two units observed. Findings include: During the initial pool process, conducted on 1/7/25, the residents had the following concerns relative to the facility food provided: -one Resident reported he/she had numerous food concerns about breakfast. The portions served were too small, he/she had told numerous staff and no one from the kitchen has come to speak with him/her. The Resident reported he/she would like more eggs and oatmeal in the morning. -six Residents said the food was terrible, not good or could be better. -one Resident requested more fruit on the menu. -one Resident said the supper meal was particularly bad. -one Resident, who was observed to have numerous food/beverage items purchased outside of the facility, said the food was not good, the hot food was not hot and the food served was limp and could blow in the wind. The Resident further indicated no one from the facility had talked to him/her about preferences since he/she was admitted . During an interview on 1/7/25 at 7:38 A.M., the Food Service Director (FSD) said he had not had any concerns about food and had received no grievances for about eight months. The FSD said they have a food committee that meets monthly and any concerns that are brought up in food committee were addressed. On 1/9/25 from 1:30 P.M. to approximately 3:00 P.M., the survey team conducted a resident council meeting with nine residents and the following was discussed: -staff stand around when the meal carts are delivered to the units and the food trays are not passed timely. -eight of the residents said temperature of the food was a concern. -hot food was often cold. -they were provided fruit and pudding for dessert for most meals, do not get whipped topping on desserts and would like to. -some of the food was burnt when served. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-some of the vegetables were hard, like the broccoli cuts- they were mostly stalks. -more variety of eggs in the morning, they always receive scrambled eggs. -sometimes the beverage cart was not passed during the meal or beverages sit too long prior to being passed and the cold drinks were not cold and the hot drinks were not hot. -three residents said there was too much gravy served on the food. -the orange juice provided was watered down. During an interview on 1/9/25 at 3:50 P.M. with Nurse #1, Nurse #5 and Nurse #6 the following was discussed: -the residents have expressed they do not like the meals. -there have been numerous resident complaints about the food and nothing changes. Review of the Food Committee Meeting Notes, from October 2024 and November 2024 (no notes were provided for December 2024) indicated the following: -some reports of food temperature concerns -concerns about the orange juice being watery -concerns that portions provided were not enough or not what was on diet plan (large portions) -concerns about receiving broccoli stalks -receiving repetitive foods like apples multiple days in a row -concerns about food being too overcooked On 1/9/25 at 4:15 P.M., the surveyor requested test trays for the dinner meal to be placed on the [NAME] and Oak meal trucks for the dinner meal. On 1/9/25 at 5:18 P.M., the surveyor obtained one of the two test trays and the following was observed: -thickly sliced ham - 103.6 degrees Fahrenheit (F): not hot and did not contain much flavor -elbow macaroni - 104.0 degrees F: room temperature, no flavor -mixed vegetables - 93.7 degrees F: cool to taste -no dessert was provided (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 1/9/25 at 5:59 P.M., the FSD said the hot food should be 135 degrees or higher and the cold food should be 40 degrees or less, and had not done tests trays for a long time. During a follow-up interview on 1/15/25 at 11:21 A.M., the FSD said he was aware that residents had temperature concerns about the meals previously and was hoping it was resolved. The FSD said the food carts they utilize in the kitchen were old, have gaps and no insulation and thought this could be contributing to the temperature issues with the meals.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 37400 Based on observation, interview, and record review, the facility failed to ensure that resident preferences were obtained and implemented by the facility kitchen for four Residents (#1, #56, #117 and #20) and resident council participants. Specifically, the facility failed to: -For Resident #1, provide food that accommodated the Resident's preferences. -For Resident #56, provide food and drink that accommodated the Resident's preferences. -For Resident #117, provide food that accommodated the Resident's preferences. -For Resident #20, provide food that accommodated the Resident's preferences. -provide food items that were appropriate and accommodated resident allergies, intolerances and preferences. -provide appealing substitutes of similar nutritive value. Findings include: During the initial pool process, conducted on 1/7/25, the residents had the following concerns relative to the facility food provided: -Resident #1 reported he/she had numerous food concerns about breakfast. The portions served were too small, he/she had told numerous staff and no one from the kitchen has come to speak with him/her. The Resident reported he/she would like more eggs and oatmeal in the morning. -Resident #56, who was observed to have numerous food/beverage items purchased outside of the facility, said the food was not good, the hot food was not hot and the food served was limp and could blow in the wind. The Resident further indicated no one from the facility had talked to him/her about preferences since he/she was admitted . Review of the Food Committee Meeting Notes, from October 2024 and November 2024 (no notes were provided for December 2024) indicated the following: -some reports of not receiving beverages during meals -request for more dessert items like frosted cake and ice cream -request for accommodation of low sodium diet, one resident received items like kielbasa, sauerkraut (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-concerns about the orange juice being watery -concerns that portions provided were not enough or not what was on diet plan (large portions) -concerns about receiving broccoli stalks -requests for more fresh vegetables -receiving repetitive foods like apples multiple days in a row On 1/9/25 from 1:30 P.M. to approximately 3:00 P.M., the survey team conducted a resident council meeting with nine residents and the following was discussed: -four residents said sometimes there was an alternate food option offered of grilled cheese. -six residents said they receive food items they were not supposed to receive. -food preferences were not always obtained from the residents. -there were facility nursing staff that purchase snacks and/or bring in snacks for them that they like, and unless certain staff were working, snacks at bedtime were not routinely offered to them. -one resident said he/she was allergic to eggs and had received them for meals. -one resident said he/she did not want to receive pork products and was receiving them. -would like more of a variety of vegetables and fresh salads During an interview on 1/9/25 at 3:50 P.M. with Nurse #1, Nurse #5 and Nurse #6 the following was discussed: -the limited snacks available are packaged peanut butter cookies and chocolate chip cookies and pudding. -many residents have difficulty with chewing and swallowing, were diabetic, have food preferences, and the snacks provided at the facility were limited. -the residents are not provided pies, cakes, other baked goods with meals unless it was a special occasion. The residents are mostly provided pudding or fruit. -the residents have asked about alternate meal choices because one meal option is offered, and have been told that peanut butter and jelly sandwiches were available as an alternate which may not be appropriate for some of the residents. On 1/9/25 at approximately 4:00 P.M., the surveyor observed the following in the facility kitchenette: -two drawers full of prepackaged peanut butter crackers (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a drawer full of prepacked chocolate chip cookies -in the refrigerator: *tray of plastic dessert cups containing varying amounts of pudding *various pitchers of apple juice and several bottles of other juices *numerous containers of nutritional supplements During an interview on 1/9/25 at 5:59 P.M., the Food Service Director (FSD) said resident preferences are obtained by either himself or the Registered Dietitation (RD) for new admissions usually within 24 hours. The FSD said once the preferences are obtained, the information was entered into their computer system (where the meal tickets are generated) under likes/dislikes. The FSD said there was no formal documentation relative to when resident preferences were obtained. The FSD said he nor the RD attend resident care plan meetings. The FSD said unless a resident had a concern about the meals and was vocal about the concern, menu/meal preferences would not routinely be obtained. During interviews on 1/14/25 at 9:33 A.M. and 3:45 P.M., the RD said she worked part-time in the facility on Tuesdays. The RD said she had attended the Resident Food Committee Meetings and there had been no concerns or complaints expressed by residents during these meetings. The RD said residents were able to make their needs known, and if they have concerns or preference changes, they can ask to speak with her or notify the FSD. The RD said resident preferences were obtained on admission by herself or the FSD and then on an as needed basis if a resident or staff indicate concerns or changes, and that these preferences were entered into the computer and indicated on the resident meal tickets or resident care plans. The RD said resident preferences were not obtained during her quarterly reviews. The surveyor reviewed the concerns expressed at the resident council meeting and the RD said residents will always have concerns about the food, and that there were plenty of snacks available to provide to the residents including peanut butter crackers, cookies, pudding, milk and juice. The RD said the snack items provided were appropriate for all diet consistencies. The RD said that residents could purchase their own snacks, have family provide food items or utilize the vending machines located in the facility for snacks. The RD said that the residents had decided on the types of snacks that the facility was going to provide about two years ago and said this (preference) had not been revisited since then. The RD further said she would follow-up with the specific resident who requested food preference changes and that the resident who was allergic to eggs should not be receiving them. During a breakfast observation on 1/15/25 from 8:07 A.M. through 8:44 A.M., the surveyor observed the following: -breakfast meals were being distributed on the [NAME] Unit. -Resident #117 received his/her breakfast tray at 8:11 A.M. At 8:37 A.M., the surveyor observed the Resident's breakfast tray included scrambled eggs, french toast and cold cereal. The Resident had taken a few bites of the french toast and had consumed most of the cold cereal. The scrambled eggs remained untouched. During an interview at the time, Resident #117 said he/she does did not eggs and the french toast was cold. Review of the Resident's meal ticket did not indicate any preferences or dislikes (this area was left blank). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 8:34 A.M., Resident #20 was observed lying in bed, and without a breakfast meal tray. During an interview at the time, Resident #20 said he/she received scrambled eggs and french toast for breakfast today and he/she did not eat eggs. Resident #20 said the staff removed the tray and that he/she was waiting for another breakfast meal. Review of Resident #20's meal ticket for breakfast indicated no allergies, large portions, and no eggs. -At 8:48 A.M., the surveyor inquired about Resident #20's breakfast as he/she had not received a different meal choice as yet. Certified Nurses Aide (CNA) #9 said another breakfast for Resident #20 had been requested a while ago. CNA #9 said the Resident's meal ticket indicated he/she did not like eggs and he/she received them today. CNA #9 said she would go to the kitchen to follow-up on the requested breakfast tray for Resident #20. During an interview on 1/15/25 at 11:12 A.M., the FSD said Resident #117 was recently admitted and preferences should have been obtained by the RD. The FSD said when the RD obtains resident preferences, she typically writes them on a sticky note, he enters the information into the computer for the meal tickets and then the notes made for resident preferences were discard. The FSD said he was made aware of what occurred with Resident #20's breakfast meal.

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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. 37400 Based on observations, interviews and record review, the facility failed to maintain a clean and sanitary environment in the facility's main kitchen increasing the potential risk of food related illnesses. Specifically, the facility failed to ensure that: -Kitchen surfaces and equipment were clean and free of dust and debris. -Temperatures were obtained prior to meal service to ensure food was safe to be served to residents. -Food was thawed appropriately to minimize risk of food related illness. -Food items were labeled and dated when stored. -The dish machine temperatures were within appropriate ranges for use. Findings include: Review of the Manufacturer's Guidelines for the AM Select Dishwasher, dated February 2005, indicated the following relative to the facility dishmachine: -High Temperature Dishmachine: Wash Temperature 150-165 degrees Farenheit Review of the Food and Drug Administration (FSD) Food Code, dated 2022, indicated the following: -Thawing. Time/Temperature Control for Safety Food shall be thawed: (A) Under refrigeration that maintains the food temperature at 5 degrees Celsius (41 degrees Fahrenheit) or less, or (B) Completely submerged under running water: (1) At a water temperature of 21 degrees Celsius (70 degrees Fahrenheit) or below ., -Microwave Cooking: foods cooked in a microwave oven shall be: (A) Rotated or stirred throughout or midway during cooking to compensate for uneven distribution of heat; (B) Covered to retain surface moisture; (C) Heated to a temperature of at least 74 degrees Celsius (165 degrees Farenheit) in all parts of the food; (D) Allowed to stand covered for 2 minutes after cooking to obtain temperature equilibrium. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Time/Temperature Control for Safety Food, Hot and Cold Holding: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, Time/Temperature Control for Safety Food shall be maintained: (1) At 57 degrees Celsius (135 degrees Farenheit) or above .or (2) At 5 degrees Celsius (41 degrees Farenheit) or less. Review of the facility policy titled Cleaning and Sanitation of Food Service Areas, dated July 2023, indicated the food service staff will maintain the sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. The policy indicated: -the Food Service Manager will record all cleaning and sanitation tasks needed for the department -tasks will be designated to the responsibility of specific positions in the department -all staff will be trained on the frequency of cleaning necessary -a cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed -the following items will be cleaned as follows: >all small equipment, utensils and appliances: after every use >counters: after every use >toasters: after every use >kitchen cabinets and drawers: twice monthly >shelves: monthly >clean behind and under major equipment: monthly >ice machine: monthly Review of the facility policy titled Counter Space Cleaning, dated July 2023, indicated counter space will be wiped and sanitized prior to and following food preparation and meal service, and as needed. Review of the facility policy titled Toaster Cleaning, dated July 2023, indicated the toaster will be cleaned after each use. Review of the facility policy titled Ice Machine & Equipment Cleaning, dated July 2023, indicated the ice machine and equipment (scoops) will be cleaned regularly to maintain a clean and sanitary condition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/7/25 at 7:25 A.M., the surveyor observed the following during the initial kitchen walk-through: -shelves with clean pots/pans, coffee pots, pitchers were visibly dirty and had debris present. -toaster was caked with dark, black colored crumbs covering the bottom. -two air conditioners which were on and running, had visible dust on the vents. The air conditioners were located in food preparation areas and air was blowing over kitchen equipment and utensils. -an open box containing wrapped turkey breasts was left out on a kitchen counter. During an interview immediately following the observation, Dietary Aide #1, who was cooking that morning, said the toaster was frequently used and was not sure how often it was supposed to be cleaned. Dietary Aide #1 said the wrapped turkey breasts were thawing. During an interview on 1/7/25 at 7:38 A.M., the Food Service Director (FSD) said there was no current cleaning schedule utilized by the kitchen. The surveyor relayed observations of unclean air conditioners, toaster, and shelving. The FSD said the toaster should be cleaned once weekly and shelving in the kitchen should be dust free and cleaned once every two weeks. The FSD said there was no schedule for cleaning the air conditioners. During an interview on 1/8/25 at 3:21 P.M., the Administrator said she was made aware of some sanitation concerns from the FSD after the initial walk through. The Administrator said she had some concerns about the kitchen cleanliness and was trying to have a contract company come in to do a power washing, but this did not occur prior to survey. On 1/9/25 from 4:15 P.M. through 4:50 P.M., the surveyor observed the following during the dinner meal service: -upon entry into the kitchen the surveyor observed panned food in the steam table. The steam table water was observed in multiple sections and were not covered (allowing the steam to escape from the steam table). During an interview at the time, Dietary Aide #4 said she put the food in the steam table about 10-15 minutes prior. Dietary Aide #4 said she obtained the temperature of the food when it was taken out of the oven, but never records the temperatures. Dietary Aide #4 said the meat should be 160 degrees or higher and that the vegetables should be between 140 and 150 degrees. Dietary Aide #4 said she did not take the temperature of the elbow macaroni or the sauce that was going to be served. Dietary Aide #4 said she was a fill-in cook, and that she had previously cooked about 10 times. -4:23 P.M., Dietary Aide #4 started to plate the resident meals for dinner. -The surveyor observed Dietary Aide #4 take a covered plate out of the reach in refrigerator, put them in the microwave to reheat and then removed, uncovered and placed them on resident trays at the following times: 4:24 P.M., 4:29 P.M., 4:34 P.M, 4:48 P.M. and 4:50 P.M.,. The surveyor did not observe Dietary Aide #4 obtain temperatures of the reheated food items prior placing them on the resident meal trays. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview at 1/9/25 at 4:50 P.M., Dietary Aide #4 said the food she was reheating in the microwave was the pureed food from lunch that she was serving as the pureed meal for dinner. When the surveyor asked what the pureed meal that was being served, Dietary Aide #4 said she did not know what the meal was for lunch that was being used. Review of the Daily Temperature Logs To Be Taken By The [NAME] On Duty Forms from 12/1/24 through 1/9/25 indicated the following: -no temperatures were obtained for the dinner meals on 12/2/24, 12/3/24, 12/4/24, 12/5/24, 1/2/25, 1/7/25 and 1/9/25 -no temperatures were documented as obtained for all meals served on 12/18/24, 12/23/24, 12/24/24, and on 1/6/25 During an interview on 1/9/25 at 4:34 P.M. and 5:59 P.M., the FSD said there was no cleaning schedule utilized, that the kitchen was an old kitchen and it was difficult to keep it clean. The FSD said temperatures of food should be taken prior to meal service and documented. The FSD said food items should be thawed in the refrigerator or under cool running water. The FSD said temperatures of the food should be taken prior to meal service and documented and that unless it was documented, there would be no way to know what the food temperatures were for that meal/day. The FSD said the steam table could be used to hold food for up to an hour, but the unused or partially used steamtable wells should be covered so that the heat in the steam table was maintained. The FSD said if the steam table was open, the hot air would not stay in steam table to keep the food hot. The FSD said he was aware he had reusable dessert dishes, but did not think he had enough for all of the residents, but understood serving food items in disposable dishware regularly was not appropriate. On 1/15/25 at 9:26 A.M., the surveyor observed Dietary Staff #3 run the dishwasher two times per the surveyor's request. The following was observed: -Observation #1: wash temperature rose to 149 degrees Fahrenheit. Dietary Staff #3 said that the temperature usually comes up to about 163 degrees Fahrenheit. -Observation #2: wash temperature rose to 150 degrees Fahrenheit. On 1/15/25 at 9:31 A.M., the surveyor and Dietary Staff #2 reviewed the Dish Machine Temperature Log for January and noted: -For breakfast, lunch and dinner on 1/1/25 through 1/7/25 there were 16 occasions (out of 21 occasions) when the wash temperature never rose above 149 degrees Fahrenheit and was as low as 142 degrees Fahrenheit. -For dinner on 1/9/25 through 1/14/25, there was no documenation of what the wash and rinse temperatures were. During an interview at the time, Dietary Staff #2 said that he was away during that time, so could not speak to what happened. Dietary Staff #2 said that if he had any issues, he would report it verbally to maintenance or use the TELS System (system in which the maintenance department receives work orders). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of the Dish Machine Temperature Log indicated the following on the bottom of the form: -The wash temperature must be at least 160 degrees . -If the temperature is not at the proper temperature DO NOT USE THE MACHINE - notify your supervisor for instructions. On 1/15/25 at 9:33 A.M., the surveyor requested the dishwasher be run for a third observation. The wash temperature was observed rising to 155 degrees Fahrenheit. Immediately following the observation, Dietary Aide #2 said that the wash cycle was not coming up to the temperature that it should, which was around 160 degrees Fahrenheit. During an interview on 1/15/25 at 9:41 A.M., the Director of Maintenance (DOM) said that he had not been made aware that the wash temperatures had not been coming up to the expected wash temperature and would expect that the staff would notify him when they were not, so that he could call the company to come in and service the dishwashing machine. The surveyor and the DOM reviewed the January 2025 wash temperature log. The DOM said that the temps were not high enough and the wash temperature usually goes up to 160 degrees Fahrenheit. The DOM said that he was told by the dishwasher's company representative that if the wash temperature did not come up to the expected temperature, but the final rinse did, that the facility staff should not worry because it is the final rinse where the sanitation occurs. On 1/15/25 at 10:21 A.M., the DOM provided the manufacturer's specification (guidelines) and said that the wash temperature is expected to be from 150-165 degrees Fahrenheit. The surveyor and the DOM reviewed the January 2025 wash temperature log again and found 16 wash temperatures in January 2025 did not come up to 150 degrees Fahrenheit. The DOM said that he would have expected staff to let him know when the wash temperature did not come up to at least 150 degrees Fahrenheit and they did not. During a follow-up kitchen walk through on 1/15/25 at 10:37 A.M., the surveyor observed the following: -shelves with clean pots/pans, coffee pots, pitchers were visibly dirty and had debris present. -ice machine (that was in use) had black, brown discoloration on the internal parts. -in the reach-in freezer: >two large unopened clear packages of uncooked meat ribs, unlabeled and undated. >two large unlabeled and undated uncooked beef wrapped in clear plastic wrap. During an interview on 1/15/25 at 11:06 A.M., the FSD said the ice machine did not look clean inside. The FSD said maintenance does the internal cleaning. The FSD said the unlabeled and undated meat items in the reach-in freezer were spare ribs and pork butt and they were not labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/15/25 at 12:41 P.M., the DOM said the ice machine was part of a preventative maintenance program and was supposed to be cleaned by a contract company every six months. The DOM said the last time the ice machine received preventative maintenance was approximately eight months ago and it was overdue. The DOM said he looked at the inside of the ice machine, and it was not clean and should not be used until it was cleaned.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51571 Based on observation, record review, and interview, the facility failed to maintain complete and accurate medical records for four Residents (#40, #33, #118 and #12), out of a total sample of 20 Residents. Specifically, the facility failed to: 1. For Resident #40, accurately document the total 24 hour fluid measurements as ordered by the Physician when Resident #40 was identified as having a fluid restrictions order of 1200 milliliters (ml) per day. 2. For Resident #33, ensure the MOLST (Medical Order for Life Sustaining Treatment) form was accurate and completed to ensure that the Resident's wishes were honored. 3. For Resident #118, ensure the Medical Provider Progress Notes were located in the clinical record. 4. For Resident #12, ensure that Provider Progress Notes written by the Nurse Practitioner (NP) were included and accessible in the Resident's medical record. Findings include: 1. Resident #40 was admitted to the facility in October 2022, with diagnoses including End Stage Renal Disease, Dependence on Renal Dialysis and Chronic Systolic Heart Failure. Review of the Facility Policy titled Intake, Measuring and Recording, established date 2001, and last revised October 2010, indicated the following: The purpose of this procedure was to accurately determine the amount of liquid a resident consumes in a 24-hour period. -Verify that there was a physician's order for this procedure and/or that the procedure is being performed per facility policy. -At the end of your shift, total the amount of all liquids the resident consumed. -Record all fluid intake on the intake and output record. -Report other information in accordance with facility policy and professional standards of practice. Review of the Facility Policy titled Charting and Documentation, established date 2001, and last revised July 2017, indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. -The assessment data and /or any unusual findings obtained during the procedure/treatment. Review of Minimum Data Set (MDS) Assessment, dated 1/3/25, indicated that Resident #40: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. -received dialysis while in the facility. -received a therapeutic diet while in the facility Review of Resident #40's Comprehensive Person-Centered Care Plan, initiated 10/15/24 and last revised 1/14/25, indicated: -1200 milliliter (ml) Fluid Restricted - 480 ml Nursing, 720 ml dietary (240 ml per meal), initiated 1/14/25 -approx. 600 ml on the 7:00 A.M. to 3:00 P.M., 480 ml on the 3:00 P.M. to 11:00 P.M, and 120 ml on the 11:00 P.M. to 7:00 A.M. Prefers 1/2 cup coffee and 1/2 cup gingerale with meals, initiated 1/14/25 -monitor intake and output, initiated 3/7/23. Review of Resident #40's January 2025 Physician orders indicated the following: -Fluid intake for 11:00 P.M. to 7:00 A.M. = 120 ml every night shift. Order active 3/20/23. -Fluid intake for 3:00 P.M. to 11:00 P.M. = 480 ml every evening shift. Order active 3/20/23. -Fluid intake for 7:00 A.M. to 3:00 P.M. = 600 ml every day shift. Order active 3/20/23. -Total and record last 24-hours of fluid intake. Notify medical team if over 1200 ml every shift. Order active 7/26/23. During an interview on 1/14/25 at 11:30 A.M., Certified Nurses Aide (CNA) #5 said Resident #40 was on fluid intakes because he/she was on dialysis. CNA #5 said any fluids the Resident consumed during meals were charted in the Resident's record. CNA #5 said that the intakes were divided throughout the day for the Resident on each shift. CNA #5 said the Resident did not ask for extra fluids. During an interview on 1/14/25 at 2:30 P.M., Nurse #11 said the Resident's fluids intakes were entered into the electronic medical record by the CNA's and that she documents the fluids intakes she gives the Resident with medication administration. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/14/25 at 3:16 P.M., CNA #7 said that she informs the Nurse of the fluid amounts consumed by the Resident and documents this amount at the end of her shift. CNA #7 said the Resident's medical record or meal ticket will indicate the fluid restriction amounts allowed. During an interview on 1/14/25 at 3:24 P.M., Nurse #6 said fluid intake amounts are documented on the Medication Administration Record (MAR), and include the total fluid amounts allowed the Resident can have for each shift and the Nurses sign that it was administered with a check mark. Nurse #6 said that she usually asks the CNA's the total amount of fluids the Resident consumed for the shift. Nurse #6 said there was no way to figure out the actual fluid amounts consumed by Resident #40 because there was no way to document this information on the MAR. During an interview on 1/15/25 at 7:04 A.M., Nurse #12 said the Resident's fluid intakes amounts are on the MAR for each shift. Nurse #12 said she has been asking the facility about how to document the 24-hour total for fluids intake amounts for Resident #40, and no one has been able to assist her with how to do this. During an interview on 1/15/25 at 12:10 P.M., the Director of Nursing (DON) said that the Nurses sign off on the MAR that the Resident achieved the total amount of fluids ordered or allowed per shift and for the 24-hour totals for the fluid restriction, and that the Resident did not go over the prescribed fluid amount. The DON further said there were no totals recorded in the clinical record to indicate what the Resident actually consumed during a 24-hour period. The DON said the check box on the MAR only indicated that Nursing staff were acknowledging that the fluids amount ordered were given, and that the Resident did not go over the ordered limits of fluids. 37400 2. Resident #33 was admitted to the facility in October 2024 with diagnoses including Type 2 Diabetes and Protein-Calorie Malnutrition. Review of the MOLST form, located in the electronic medical record and signed by Resident #33 on 10/11/24, indicated: -Section A indicated the Resident wanted to be resuscitated (chest compressions and rescue breathing if his/her heart stops) -Section B indicated the Resident did not want intubation (DNI: the insertion of a tube into a patient's airway to provide artificial means for breathing) and ventilation (DNV: treatment to help a person breathe when they find it difficult or are unable to breathe on their own. A mechanical ventilator pushes airflow into the patient's lungs to help them breathe) -Sections A through C of the form indicated treatment decision were only valid if the Sections D and E indicating the Patient or Patient Representative and Clinician (Physician or Practitioner) legally printed their names, and their signatures and the date were obtained. -Section E where the Clinician was to print their name, sign and date was left blank. Review of the Resident's clinical record indicated: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-an Interdisciplinary Care Plan Meeting Note dated 10/21/24 indicating the Resident was a full code status (all medical measures will be taken to maintain and resuscitate life including intubation and ventilation) -Advanced Directive Care Plan, initiated on 10/13/24 and revised 11/29/24 which indicated the Resident was a Do Not Resuscitate (DNR: the patient did not want chest compressions and rescue breathing if his/her heart stops) -A Provider Note, dated 12/17/24 indicating the Resident's code status was Do Not Intubate. -January 2025 Physician's Orders indicating the Resident was a full code status. During an interview on 1/14/25 at 11:50 A.M., the surveyor and the Director of Nursing (DON) reviewed Resident #33's medical record. The DON said the MOLST form indicated the Resident did not want intubation and ventilation and was signed and dated by the Resident. The DON further said the Physician did not sign/date Section E on the MOLST form as required, therefore the wishes of the Resident were not valid, and he/she would be considered a full code status. The DON said the current Physician's orders indicated the Resident was a full code status and that the Advanced Directives Care Plan was not accurate. The DON further said the MOLST form should not have been filed in the Resident's clinical record until it was signed and dated by the Physician so that the Resident's wish to not have intubation and ventilation could be honored. 3. Resident #118 was admitted to the facility in December 2024 with diagnoses including COVID-19 infection, Urinary Tract Infection (UTI), repeated falls, dehydration, Chronic Kidney Disease, and Adult Failure to Thrive. Review of the clinical record on 1/7/25 at 11:37 A.M., indicated: -the Resident experienced a clinical change and was transferred to the hospital on 12/30/24 and was readmitted to the facility on [DATE]. -no MOLST form or indication of code status for Resident #118. -no documented evidence of Medical Provider (Physician or Nurse Practitioner) progress notes since admission and readmission. During an interview on 1/8/25 at 4:50 P.M., Nurse #4 said the Medical Providers dictate their progress notes, they are sent to the facility and should be uploaded into the Resident's clinical record. On 1/8/25 at 5:53 P.M., the surveyor was provided with Medical Provider notes dated 1/3/25 onward. There were no Medical Provider notes prior to 1/3/25. Review of the Resident's clinical record on 1/9/25 at 10:36 A.M., indicated a MOLST form signed by the Resident and the Medical Provider on 12/27/24 and 12/30/24 respectively. Further review of the clinical record indicated numerous Medical Provider progress notes from the Resident's original admission the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 12:19 P.M., Nurse #3 said there was an issue with resident information being uploaded into their clinical records. Nurse #3 said the Receptionist was the person designated to do this task, but she also booked resident transportation and had other tasks she was responsible for in addition to uploading the resident record information. Nurse #3 said the delay in uploading resident information into the clinical record had been an issue for quite some time and it was important to have the information available in the resident's clinical record. Nurse #3 said the Medical Provider notes and the MOLST form for Resident #118 should have been uploaded into the clinical record prior to survey. Nurse #3 said the information for Resident #118 had been uploaded on 1/8/25 and 1/9/25 after the surveyor inquiry. 50563 4. Resident #12 was admitted to the facility in March 2023 with diagnoses including Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #12 had moderate cognitive impairment as evidenced by a BIMS score of 12 out of a possible score of 15. Review of Resident #12's Medical Record indicated no Physician Progress notes in the last 120 days. During an interview on 1/9/25 at 5:00 P.M., Medical Records staff said there were no Physician Progress Notes in the Resident's Medical Record after September 2024. During a telephone interview on 1/9/25 at 11:05 A.M., Nurse Practitioner (NP) #1 said she had progress notes for October 2024, November 2024 and December 2024 in her records.

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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. 42741 Based on observation, interview, and record review, the facility failed to implement an infection control program that ensured residents in the facility were provided with a safe, sanitary, and comfortable environment aimed to prevent the development and transmission of communicable diseases and infection for three Residents (#48, #60, and #118) out of a total sample of 20 residents and on one Unit (Willow Unit) out of two units observed. Specifically, the facility failed to: 1. for Resident #48, conduct on going surveillance for a communicable disease when the Resident was diagnosed with Shingles (a viral infection the causes painful rash). 2. ensure a glucometer on the [NAME] Unit was disinfected appropriately after use and prior to storing. 3. ensure that staff donned (put on) the appropriate personal protective equipment (PPE) during a medication and tube feed administration for a resident on Enhanced Barrier Precautions (EBP- infection control measures that use gowns and gloves to reduce the spread of multidrug resistant organisms [MDROs]).performed hand hygiene and PPE (personal protective equipment). 4. for Resident #60, ensure that staff donned appropriate PPE prior to performing high-contact wound care when the Resident was on Enhanced Barrier Precautions (EBP). 5. for Resident #118, ensure staffed donned appropriate PPE to enter the Resident's room when the Resident was on isolation/droplet precautions (precautions used when a person is suspected of having a communicable disease spread by respiratory droplets). Findings include: Review of the facility policy titled Surveillance for Infections, revised 7/2017, indicated the following: -The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions and to prevent future infections. -Gathering Surveillance Data >The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. 1. Resident #48 was admitted to the facility in December 2024. (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 #48's Nursing Note dated 12/30/24, indicated Resident #48 was presenting with a rash on his/her right side in the area of his/her rib cage. The rash appeared reddened, raised, some areas with blisters, and some scabbed over areas. The Resident reported the rash was very painful and itchy. Contact Precautions (precautions used to prevent the spread of infectious diseases that are transmitted through contact) were implemented. Review of Resident #48's Nursing Note dated 12/31/24, indicated he/she was started on Acyclovir (antiviral medication used to treat Shingles) and was diagnosed with Shingles. Review of Resident #48's December 2024 and January 2025 Physician's orders indicated Resident #48 received Acyclovir to treat his/her Shingles from 12/31/24 through 1/8/25. During an interview and record review on 1/15/25 at 9:59 A.M., the Director of Nursing (DON) who was filling in for the Infection Preventionist (IP) who was not available during the survey said the IP tracks all infections in the facility to look for trends, to make sure infections are contained, and are not spreading, and to ensure that treatments ordered are working or if education needs to be provided to staff to help reduce infections. The DON further said the IP utilizes a line listing (form used that includes but is not limited to date of infection onset, use of antibiotics, pertinent labs/x-rays, changes in treatment) information to track infections. The surveyor and the DON reviewed the January 2025 line listing which indicated no documentation that Resident #48 was being monitored for his/her Shingles infection. The DON said Resident #48 should have been followed on the January 2025 line listing to monitor for changes in his/her condition and the IP should be updating the line listing twice weekly when she was in the facility, and it did not appear the January 2025 line listing was complete. At the time of survey exit on 1/15/25 at 5:00 P.M., the facility was unable to provide the December 2024 line listing for review. 50563 2. Review of the facility policy titled Obtaining a Fingerstick Glucose Level, revised October 2011, indicated the following: -Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. During a Medication Administration observation on 1/8/25 at 3:55 P.M. with Nurse #10, the surveyor observed the following: -Nurse #10 complete a fingerstick blood glucose using a glucometer on a resident. -Nurse #10 take the glucometer with the used test strip attached to it and place it into the storage bin on top of supplies stored in the bin (clean gauze, lancets, test strips and alcohol prep pads) without cleaning and disinfecting the glucometer or removing the used test strip. -Nurse #10 perform hand hygiene, don a glove and clean and disinfect the glucometer with appropriate disinfectant wipes and then place back into the storage bin on top of the same contaminated supplies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #10 set up to enter another room to complete a fingerstick blood glucose on another resident using the same glucometer and supplies from the same storage bin, at which time the surveyor intervened. During an interview on 1/8/25 at 5:59 P.M., Nurse #10 said that once used on a resident the glucometer is considered dirty or contaminated. Nurse #10 further said that she should have cleaned and disinfected the glucometer before placing it on top of clean supplies to prevent contamination. During an interview on 1/9/25 at 8:06 A.M., Nurse #3, who was covering for the DON, said the expectation is that a Nurse would not put a used glucometer with a test strip into the storage bin until the test strip was removed and the glucometer cleaned and disinfected. 3. Review of the facility policy titled Enhanced Barrier Precautions, dated August 2022, indicated the following: -enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drub resistant organisms (MDROs) to residents. -EBPs employ targeted gown and glove use during high contact care activities when contact precautions do not otherwise apply. >gloves and gown are applied prior to performing high contact resident care activity. -Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: >device care or use (.feeding tube .) During a Medication Administration observation on 1/8/25 at 4:09 P.M., the surveyor observed Nurse #10: -prepare medication and tube feed to be administered to a resident via his/her Gastric Tube (G-tube). -perform hand hygiene, don gloves, did not don a gown, gather supplies and enter the resident's room where an EBP sign was observed outside the door. -auscultated for placement of the G-tube. -checked for residual. -flushed and administered medications. -set-up tube feed pump and hooked up to the resident's G-tube. -disposed of used supplies or stored them appropriately. -doffed gloves and performed hand hygiene before leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview immediately following the observation on 1/8/25 at 4:40 P.M., the surveyor and Nurse #10 reviewed the EBP sign outside the door of the resident's room. Nurse #10 said that the sign indicated a gown was to be worn for care of the G-tube. Nurse #10 further said she should have worn a gown during the medication and tube feed administration but did not. 4. Review of the facility's clinical competency titled Putting on (Donning) Personal Protective Equipment (PPE) / Taking Off (Doffing) PPE, dated 2/4/21, indicated the following: -Removes gloves and gown just before exiting patient/resident room. Review of the facility policy titled Handwashing/Hand Hygiene, revised January 2019, indicated the following: -use an alcohol-based hand rub alternatively, or soap (antimicrobial or non-antimicrobial) and water for the following situations: >before handling clean or soiled dressings, gauze pads, etc. -before moving from a contaminated body site to a clean body site during resident care. Resident #60 was admitted to the facility in November 2024 with diagnoses including a Stage 3 Pressure Ulcer of the Sacral Region. Review of Resident #60's Minimum Data Set (MDS) Assessment indicated: -the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of a possible score of 15. -had a Stage 3 pressure ulcer on admission. During a wound care observation for Resident #60 on 1/9/25 at 9:30 A.M., the surveyor observed Nurse #9: -perform hand hygiene, don gown and gloves, pick up supplies and enter the Resident's room. -cleanse a table, place a barrier down and set up supplies on the table. -assist Resident into position. -use wound cleanser and gauze to clean the sacral wound and then pat it dry. -open collagen matrix dressing, cut it to size and then place the dressing on the wound bed without removing gloves. -covered the dressing with bordered foam dressing. -assisted the Resident to a comfortable position. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-gather trash in the trash bag and exit the room without doffing gown and gloves and proceeded to the soiled utility room to dispose of the trash. -return to the room with soiled gown and gloves still in place. -doff gown and gloves and then perform hand hygiene. During an interview immediately following the observation on 1/9/25 at 9:35 A.M., Nurse #9 said she should have changed her gloves and performed hand hygiene between cleansing the wound and handling and applying clean dressing to the wound because the wound is considered dirty before she cleaned it. Nurse #9 further said that she should have doffed the gown and gloves before exiting the Resident's room but did not. During an interview on 1/9/25 at 9:42 A.M., Nurse #3, who was covering for the Director of Nursing, said that the expectation during wound care was that the Nurse should change gloves between cleaning the wound and handling and applying a clean dressing. Nurse #3 further said that the expectation relative to PPE is that the gown and gloves should have been doffed before exiting the room. 37400 5. Resident #118 was admitted to the facility in December 2024 with a diagnosis of COVID-19 infection. During the facility entrance on 1/7/25 at approximately 7:15 A.M., the survey team was notified that one resident in the facility was positive for COVID-19 infection. Review of the facility policy titled Isolation- Categories of Transmission Based Precautions, revised September 2022, indicated Transmission-based precautions (TBP) are initiated when a resident develops signs and symptoms of a transmissible infection, arrives for admission with symptoms of an infection, or has a laboratory confirmed infection, and is at risk of transmitting the infection to other residents. The policy also included the following: -Droplet precautions are implemented for individuals documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing, talking, or by performance of procedures such as suctioning. -masks are worn when entering the room. -gloves, gown and goggles are worn if there was a risk of spraying respiratory secretions. Review of Resident #118's clinical record indicated the following: -Nursing Note dated 12/30/24, indicated the Resident had a change in condition, the Provider was updated and the Resident was transferred to the hospital for evaluation. -Nursing Note dated 1/3/25, indicated the Resident was readmitted to the facility with a diagnosis of COVID-19 infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 9:50 A.M. through 9:58 A.M., the surveyor observed the following: -the door to Resident #118's room was closed. -Signage was posted outside of the room which indicated: >Stop. Droplet Precautions. Everyone must: clean their hand including before entering and when leaving the room. >Make sure their eyes, nose and mouth are fully covered before room entry. >Remove face protection before room exit. -A bin containing personal protective equipment (PPE) including masks (N95 and surgical), gowns, gloves and face shields were observed outside of the Resident's room. -the call light in the Resident's room was initiated. -at 9:54 A.M., Certified Nurses Aide (CNA) #8 was observed donning a gown, gloves and N95 mask and entered the Resident's room. CNA #8 did not put on eye protection. -at 9:58 A.M. CNA #8 exited the room with PPE. During an interview at the time, CNA #8 said she entered the Resident's room to respond to the call light. CNA #8 said she did not put on eye protection because she was not providing care. CNA #8 said Resident #118 was requesting medication when she went in to attend to the call light. CNA #8 said she was familiar with the Droplet Precautions signage and that it indicated to put on a gown, gloves, mask and eye protection. CNA #8 said Resident #118 was on Droplet Precautions because he/she was positive for COVID-19 infection. On 1/9/25 at 10:07 A.M. through 10:15 A.M., the surveyor observed the following: -Resident #118's call light was initiated. -at 10:13 A.M., CNA #1 was observed donning a gown and surgical mask and entered the Resident's room. CNA #1 did not have an N95 mask, gloves or eye protection in place. -at 10:15 A.M., CNA #1 opened the door to the Resident's room with gown and surgical mask on. Nurse #14 was observed outside of the Resident's room. During an interview at the time, when the surveyor indicated the Droplet Precaution signage posted outside of the Resident's room, CNA #1 said he answered the Resident's call light and that he/she was requesting water and medications. At this time, Nurse #14 provided verbal education to CNA #1 about the PPE requirements prior to entering Resident #118's room which included gown, gloves, N95 mask and eye protection.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 42741 Based on interview, and record review, the facility failed to implement antibiotic monitoring system for one Resident (#118) out of a total sample of 20 residents. Specifically, for Resident #118, who was diagnosed with a urinary tract infection (UTI) and started on antibiotics, the facility failed to ensure their antibiotic surveillance tracking form was updated and maintained to include all pertinent information relative to monitoring Resident #118's infection and use of antibiotics. Findings include: Review of the facility policy titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, revised 12/2016, indicated the following: -Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. -All resident antibiotic regimens will be documented on the facility approved antibiotic surveillance tracking form. Resident #118 was readmitted to the facility post hospitalization in January 2025 with a diagnosis of UTI. Review of Resident #118's January 2025 Physician's orders indicated: -Cefdinir (an antibiotic) one capsule by mouth twice daily for 10 days, start date 1/4/25. Review of Resident #118's January 2025 Medication Administration Record (MAR) indicated that the Cefdinir medication was administered for Resident #118 as ordered from 1/4/25 through 1/14/25. During an interview on 1/15/25 at 9:59 A.M., the Director of Nursing (DON) who was filling in for the Infection Preventionist (IP) who was not available during the survey said the IP tracks any infections in the facility to look for trends to make sure infections are contained and are not spreading. The DON also said that the IP tracks antibiotic use to ensure treatments are working or if other alternatives need to be explored for treatment. The DON further said the IP utilizes a line listing (form used that includes but is not limited to date of infection onset, use of antibiotics, pertinent labs/x-rays, changes in treatment) information to track infections and antibiotic use. The surveyor and the DON reviewed the January 2025 line listing which indicated no documentation for Resident #118's UTI or that antibiotic use was being monitored for the Resident. The DON said Resident #118 should have been included on the line listing so he/she could be monitored for changes in his/her condition and the line listing should have been updated twice weekly when the IP was in the building, and it did not appear the January 2025 line listing was complete.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on record review, and interview, the facility failed to ensure that one Resident (#60) out of a total sample of five residents reviewed for immunization, was screened for eligibility to receive the recommended pneumococcal vaccination, that the Resident and/or his/her Resident Representative was educated on the benefits and potential side effects of the vaccine, and were offered and administered (if applicable) the vaccine in a timely manner. Specifically, the facility failed to ensure that Resident #60 was offered the Pneumococcal Conjugate Vaccine (PCV-a vaccine that helps protect against diseases caused by pneumococcal bacteria) at the time of admission or shortly thereafter, putting the Resident at risk for developing facility acquired Pneumonia. Findings include: Review of the facility policy titled Infection Control Prevention, Control, and Antibiotic Stewardship, revised 7/22/22, indicated the following: -Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized. -The resident's medical record includes documentation that indicates, at a minimum: >That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. >That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical. Review of the Centers for Disease Control and Prevention (CDC) information sheet titled Pneumococcal Timing Vaccine Timing for Adults, dated 10/24, indicated the following recommendation: -If a patient is over [AGE] years of age and has not had any prior pneumococcal vaccinations administered PCV20 or PCV15 (type of pneumococcal vaccinations currently available). Resident #60 was admitted to the facility in November 2024 and was over the age of 50. Review of Resident #60's medical record indicated no documentation the Resident had any previous Pneumococcal Vaccination and that he/she or his/her Resident Representative had been offered a PCV vaccine to make sure he/she was up-to-date on his/her Pneumococcal Vaccinations. During an interview on 1/7/25 at 4:30 P.M., Nurse #2 said at the time the Resident was admitted to the facility, the Resident's immunization history should have been obtained and the Resident and/or the Resident's Representative should have been offered a Consent/Refusal form to complete which explained whether he/she accepted to have an updated Pneumococcal Vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 4:42 P.M., Nurse #3 said she was unable to find any documentation that Resident #60, or his/her Resident Representative was offered a Pneumococcal Vaccination and information about Pneumococcal Vaccination at the time Resident #60 was admitted to the facility or shortly thereafter.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 42741 Based on record review, and interview, the facility failed to ensure screening for eligibility to receive the recommended COVID-19 vaccination, education on the benefits and potential side effects of the vaccine was provided to the Resident and/or Resident Representative, and COVID-19 vaccines were offered and administered (if applicable) in a timely manner, for two Residents (#4 and #60) out of a total sample of five Residents reviewed for immunizations. Specifically, the facility failed to ensure that: 1. Resident #4's Resident Representative was provided with information about the risks and benefits of COVID-19 immunization and completed a Consent or Refusal form when Resident #4's Health Care Proxy (HCP- person named to make medical decisions when the Resident can no longer make medical decisions as determined by a Physician) was activated, prior to Resident #4 being administered a COVID-19 vaccination. 2. Resident #60 was administered the most recent recommended COVID-19 vaccination in a timely manner after the Resident consented to receive the recommended COVID-19 vaccination. Findings include: Review of the facility policy titled Coronavirus Disease (COVID-19)-Infection Prevention and Control Measures, revised 6/23 indicated the following: -Vaccination Procedures and Reporting. -All staff and residents will be educated on the COVID-19 vaccine they are offered .Education will cover benefits and potential side effects related to receipt of the COVID-19 vaccination. -When a resident or staff member chooses to be vaccinated, a consent form will be initiated. -Documentation of Vaccination for Residents. -Education to the resident/resident representative, including date and time and name of the representative (if applicable). -Date and time the offering of the vaccine took place. -Acceptance or refusal of the vaccine. -If contraindicated for the vaccine, appropriate documentation of such in the medical record . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225383	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westfield Gardens Nursing and Rehab	37 Feeding Hills Road Westfield, MA 01085

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Centers for Disease Control and Prevention (CDC) webpage titled Staying Up to Date with COVID-19 Vaccination (https://www.cdc.gov/covid/vaccines/stay-up-to-date.html), dated 1/7/25, indicated the following: -Everyone ages six months and older should get the 2024-2025 COVID-19 vaccine. 1. Resident #4 was admitted to the facility in March 2023. Review of Resident #4's Physician Determination to Invoke Health Care Proxy (action taken when a Resident is unable to make medical decisions and his/her named HCP now makes the medical decisions for the Resident), indicated Resident #4 HCP was activated on 10/25/23. Review of Resident #4's COVID-19 Vaccine Consent/Refusal dated 12/20/23, indicated Resident #4 completed the COVID-19 Vaccine Consent/Refusal form. Further review of the COVID-19 Vaccine Consent/Refusal form indicated no documentation Resident #4's HCP had been provided with education related to the benefits and potential side effects of the vaccine or that he/she consented or declined vaccination for Resident #4. Review of Resident #4's Immunization Audit Report, indicated Resident #4 was administered his/her most recent COVID-19 vaccination on 12/27/23. 2. Resident #60 was admitted to the facility in November 2024. Review of Resident #60's COVID-19 Vaccine Consent/Refusal form dated 11/8/24 indicated he/she consented to receiving COVID-19 vaccinations. Review of Resident #60's Massachusetts Immunization Information System Report (MIIS-system used to track vaccinations) indicated Resident #60 had last received a COVID-19 vaccination on 1/3/22. Further review of the Resident's medical record indicated no documentation that the Resident had received an updated COVID-19 vaccination after consenting to receive COVID-19 vaccinations. During an interview on 1/8/25 at 3:26 P.M., Nurse #3 said she was unable to find any documentation on why Resident #60 did not receive a COVID-19 vaccination timely after he/she consented to a COVID-19 vaccination. During an interview on 1/8/25 at 5:02 P.M., Nurse #3 said Resident #4's HCP was activated prior to Resident #4 receiving his/her most recent dose of the COVID-19 vaccination. Nurse #3 further said Resident #4's HCP should have been consulted for consent and to provide education prior to administering a COVID-19 vaccination to Resident #4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225383	A. Building B. Wing	01/15/2025

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 50563 Based on observation, and interview, the facility failed to ensure that electrical bed equipment was maintained in a safe operating condition for one Resident (#2) out of a total sample of 20 residents. Specifically, for Resident #2, the facility failed to ensure that the bed remote control remained in safe working condition when the Resident's bed remote control cord that was currently in use was identified to be frayed with exposed electrical wires. Findings include: During an observation on 1/7/25 at 8:37 A.M., the surveyor observed Resident #2 lying in bed with the bed remote control in his/her hand. The cord to the bed remote control was observed to be frayed with multicolored wires visible where the outer protective portion of the cord had separated. During on observation on 1/7/25 at 2:05 P.M., the surveyor observed Resident #2's bed. The Resident was not in the bed. The bed remote control was laying at the foot of the bed and the cord to the remote control remained with a frayed outer protective layer with visible multicolored wires. During an interview on 1/7/25 at 2:17 P.M., CNA #1 said he was a regular staff member and was familiar with Resident #2. The surveyor and CNA #1 observed Resident #2's bed remote control cord. CNA #1 said that the cord had been that way for about a week. CNA #1 further said that the process was to notify maintenance immediately if this type of issue is identified but that he had not notified maintenance. During an interview on 1/7/25 at 2:25 P.M., the surveyor and the Maintenance Director observed Resident #2's bed remote control cord. The Maintenance Director said he had not been made aware of this issue before this afternoon. The Maintenance Director further said that there is concern with this bed remote control cord because of the exposed wires.