STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225388	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alliance Health at Baldwinville	51 Hospital Road Baldwinville, MA 01436

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to follow professional standards of practice for food storage and environmental cleaning of the facility's main kitchen.Specifically, the facility failed to ensure that:-food items were properly dated, stored, and/or discarded timely in the main kitchen-clean and sanitary surfaces were maintained in the walk-in refrigerator, walk-in freezer, and food preparation areas, placing the facility residents at risk for contamination and foodborne illnesses. Findings include: Review of the facility policy titled, Food Storage, dated 9/1/25, included but was not limited to the following: >Prepared foods in the refrigerator shall be kept covered, labeled and dated. >Food left at room temperature for several hours (2 to 3) cannot be considered safe and therefore shall be discarded. >Never hold left over poultry, . or meat products more than 48 hours at refrigeration temperatures. Anything held longer than 48 hours should be discarded. Review of the facility policy titled, Cleaning Schedules, dated 9/1/25, included the following: >Each Dining Services Department will have a planned program to assure consistent, effective sanitation practices. >Cleaning will be done daily, weekly, monthly, or as needed within the dietary department. All assignments will follow the proper procedures listed in this manual. >The supervisor on duty will be responsible for assigning the cleaning duties for the day to appropriate staff. >Both day and evening supervisors will be responsible to make sure the department is clean before the end of their respective shift. >The Food Service Supervisor must follow up on why cleaning duties were not accomplished. On 12/30/25 at 7:39 A.M., the surveyor observed the following during the initial kitchen walk through: >In the dry food storage room: -A one-gallon sized, clear plastic bag containing 20 pieces of toasted bread, labeled as toast, dated 12/19/25. -Dried yellow, brown and white substances on the floor under the food storage racks. >In the reach-in refrigerator: -A clear plastic cup with a straw through the lid containing a coffee-colored liquid and ice, unlabeled and undated. >In the walk-in refrigerator: -A sealed, zip-lock, one-gallon sized, clear plastic bag labeled as Italian sausage, and dated 12/17/25. -A covered, clear plastic container half filled with a gelatinous yellow substance, unlabeled and undated. -The refrigerator fan casing was covered with a thick layer of dust that was also coating the ceiling above the fan. -Hard chunks of yellow and brown debris under the food storage racks with torn pieces of clear packing tape and cardboard box fragments. >On the shelving unit below the steam table service area: -One opened and uncovered box of cream of wheat cereal. -Three silver metal sheet pans coated with dry white and brown crumb-like material.During an interview at the time Dietary Staff #1 said that the one-gallon sized plastic bag of toast was out-of-date and should have been discarded by 12/22/25. Dietary Staff #1 said that the clear plastic cup in the reach-in refrigerator belonged to staff, probably contained coffee, did not know how long it had been in the refrigerator and that staff should not keep personal food items in the reach-in refrigerator. Dietary Staff #1 said that the italian sausage should only be kept for three days after defrosting and was not dated appropriately when it was removed from the freezer. Dietary Staff #1 said that the clear plastic container half-filled with a gelatinous yellow substance smelled like vanilla pudding and would need to be discarded because it was not labeled or dated appropriately. Dietary Staff #1 said dating and labeling foods were important to prevent illness to the residents. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/25 at 11:54 P.M., the Food Service Director (FSD) said that he had not yet developed cleaning assignments for the dietary department. The FSD said that the walk-in refrigerator fan and ceiling was dirty and needed to be cleaned because the dust could blow into the resident's food products in the refrigerator. The FSD said that the open box of cream of wheat cereal should have been covered. The FSD said that the dirty floors in the walk-in refrigerator, dry storage room and the silver sheet pans below the steam table were dirty and should have been cleaned to prevent attracting pests into the main kitchen.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review, the facility failed to ensure that it was appropriate and safe for medications to be self-administered for one Resident (#68) out of a total sample of 18 residents. Specifically, the facility failed to assess Resident #68 for the self-administration and safe and proper storage of two topical medications, placing the Resident at risk of inappropriately self-administering the medications and not storing the medications in his/her room in a safe and secure manner.Findings include: Review of the facility policy titled Medication: Self Administration, with revision date of 4/28/25, included but was not limited to: Residents may administer their own medications, if requested, once the Facility's interdisciplinary team determines that the practice is safe. >The resident must meet the following criteria: >A score of 13 or greater must be obtained on the Brief Interview of Mental Status (BIMS) exam. >The resident must pass the Self-Administration Medication Assessment. >The above assessment must be completed with results documented in the medical record and updated on a quarterly basis. >If the results indicate the person is capable of self-administration, the physician must be notified to obtain an order for such. >Medications must remain secured at the nursing station except for limited medications, i.e., respiratory hand-held inhalers, Nitroglycerine sublingual tablets or sprays. >Self-administration of medication should be addressed in the care plan with an established plan for continuing to monitor ability to self-administer drugs .if the resident becomes unable to carry out safely.Resident #68 was admitted to the facility in September 2025 with diagnoses including Cognitive Communication Deficit.Review of the Minimum Data Set (MDS) Assessment, dated 12/18/25, indicated Resident #68: >had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 11 out of a possible total of 15.>required supervision/touching assistance for toileting, showering, upper body, lower body, footwear application and personal hygiene. On 12/30/25 at 10:45 A.M., the surveyor observed Resident #68 lying in bed with two tubes of one-ounce Diphenhydramine Zinc Acetate (topical analgesic/anti-itch medication) cream and one tube of 30-gram Nystatin (antifungal topical cream) 100,000 units/gram cream within the Resident's reach on the over the bed table. The surveyor failed to observe any facility staff in the immediate area. During an interview at the time, Resident #68 said the creams were used whenever he/she felt an itch to his/her skin. Resident #68 further said that his/her hands, groin and abdomen get itchy sometimes, so he/she rubbed the creams on the itchy areas. Resident #68 said he/she was unaware of how often the creams should be used. Review of Resident #68's medical record included: -A Physician's order for Nystatin cream 100,000 unit/gram; one application topical to groin and scrotum twice a day, start date 9/24/25. -No evidence of a Physician's order for Diphenhydramine Zinc Acetate cream. -No evidence that a self-administration for medication assessment had been completed. -No evidence that a Physician's order for self-administration of medications had been obtained. -No evidence of a Person-Centered Care Plan relative to self-administration of medications and with an established plan for continuing to monitor ability to self-administer drugs. On 12/30/25 at 2:57 P.M., the surveyor observed Resident #68 lying in bed with two tubes of one-ounce Diphenhydramine Zinc Acetate cream and one tube of 30-gram Nystatin, 100,000 units/gram cream within the Resident's reach on the over the bed table. The surveyor did not observe any facility staff in the immediate area. On 12/31/25 at 10:16 A.M., the surveyor observed Resident #68 lying in bed with two tubes of one-ounce Diphenhydramine Zinc Acetate cream and one tube of 30-gram Nystatin, 100,000 units/gram cream within the Resident's reach on the over the bed table. The surveyor did not observe any facility staff in the Resident's room at the time. During an interview on 12/31/25 at 10:19 A.M., Unit Manager (UM) #1 said Resident #68 had two tubes of one-ounce Diphenhydramine Zinc Acetate cream and one tube of 30-gram Nystatin 100,000 units/gram cream within the Resident's reach on the over the bed table. UM #1 said Resident #68 did not have a self-administration of medication assessment, a Physician's order for self-administration of the medications, or a care plan for self-administration of the medications. UM (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 further said Resident #68 should not have the medications left at his/her bedside because the Resident had not been assessed to know if he/she knew how and when to safely use the medications. During an interview on 12/31/25 at 10:46 A.M., the Director of Nursing (DON) said that medications should not be kept at Resident #68's bedside without a self-administration assessment because the Resident may not know how to apply the medications according to the Physician's orders to the right location and the right frequency. The DON said unsecured medications at the bedside were a concern because other residents, wandering residents, staff, vendors from the lab or X-ray and visitors could also have access to the medications.

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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. Based on observations, interview, and record review, the facility failed to ensure that activities of daily living (ADL's - activities related to personal care which includes washing, dressing, and personal hygiene [combing hair, applying makeup, washing/drying face and hands, and shaving]) were provided for one Resident (#84) of one applicable resident, out of a total sample of 18 residents. Specifically, the facility staff failed to assist Resident #84 with facial hair removal when the Resident required assistance for ADL care of personal hygiene due to weakness and impaired cognitive and communication skills. Findings include: Resident #84 was admitted to the facility in February 2024 with diagnoses including senile degeneration of brain, cognitive communication deficit, unspecified mental disorder due to unknown psychological condition, and muscle weakness. Review of the Person-Centered ADL Care Plan, last edited on 11/17/25, included but was not limited to the following: -Problem: Resident #84 required ADL assistance due to weakness. -Approach: Resident #84 required set-up with supervision assistance for grooming. Review of the Person-Centered Cognitive Loss/Dementia Care Plan, last edited on 11/13/25, included but was not limited to the following: -Problem: Resident #84 had impaired cognitive and communication skills: Short Term Memory deficit, poor insight, poor judgement. -Approach: Staff to provide cues, prompting, demonstration if unable to complete a task independently. Review of the Certified Nurse Aide (CNA) Care Kardex (a brief overview of a Resident's care needs), last updated 11/11/25 indicated Resident #84: -was confused. -required cues and supervision of another person at wheelchair level in bathroom sink level for grooming. Review of the Nurse Aide Behavioral Flow sheets from December 2025 through 1/5/26 indicated Resident #84: -had not demonstrated resistance to care. Review of the Minimum Data Set (MDS) Assessment, dated 11/13/25, indicated Resident #84: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of one out of a total possible score of 15. -had not demonstrated rejection of ADL care. -required substantial/maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort) for personal hygiene. On 12/30/25 at 9:25 A.M., the surveyor observed Resident #84 seated in a wheelchair in the Unit One hallway. The Resident was dressed in a shirt, pants, and shoes, with facial hair strands present to the upper lip and chin. On 12/30/25 at 3:02 P.M., the surveyor observed Resident #84 lying in his/her bed with eyes closed, and facial hair remained on his/her upper lip and chin. On 12/31/25 at 3:44 P.M., the surveyor observed Resident #84 was dressed in a sweater, pants and socks, lying on his/her bed with his/her eyes closed. The Resident was observed with facial hair present to his/her upper lip and chin. On 1/5/26 at 7:44 A.M., the surveyor observed Resident #84 seated in a wheelchair at his/her bedside dressed in a sweater, pants and shoes. The surveyor further observed that Resident #84 now had thick facial hair strands present to his/her upper lip, chin and bilateral cheeks. During an interview on 1/5/26 at 9:00 A.M., Certified Nurses Aide (CNA) #1 said she was familiar with Resident #84 and was assigned to provide care to the Resident. CNA #1 said Resident #84 liked to get out of bed early and therefore the night shift (11:00 P.M.- 7:00 A.M.) CNA gets the Resident out of bed and provides morning care each day for washing, dressing and grooming. CNA #1 said morning care for washing, dressing and grooming for the day had been completed for Resident #84 by the night shift CNA. CNA #1 further said Resident #84 does not refuse care and could wash his/her own face when handed a washcloth but was dependent for removal of facial hair. CNA #1 said residents should be assisted to remove facial hair with daily morning care and that Resident #84 was unable to shave him/herself due to forgetfulness and poor recall. At the same time, the surveyor and CNA #1 observed Resident #84's facial hair. CNA #1 said that the facial hair to the Resident's lip, chin and cheeks was long, appeared to be several days of growth, and should have been removed during morning care by the night shift CNA. CNA #1 said when the night shift was unable to remove facial hair during morning care that the day shift (7:00 A.M.-3:00 P.M.) or evening shift (3:00 P.M.-11:00 P.M.) CNAs should shave the Resident's facial hair. CNA #1 said that removal of facial hair was important so that Resident #84 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would not get embarrassed at group activities and shaving would provide the Resident with dignity. During an interview on 1/5/26 at 9:20 A.M., the Director of Nursing (DON) said that Resident #84's facial hair should be removed by the night shift during morning care. The DON said that she would have concerns for the Resident to be embarrassed due to the presence of his/her facial hair. The DON said the facility did not have a policy relative to the delivery of ADL care or removal of facial hair for the residents in the facility. During an interview on 1/5/26 at 9:51 A.M., the Staff Development Coordinator (SDC) said that all CNA staff are educated and evaluated for competency during orientation relative to bathing, dressing and grooming. The SDC said the facility did not have policy on ADL care or facial hair removal because it was a standard of practice for ADLs. The SDC said shaving and removal of facial hair was a part of the grooming process for all residents in the facility. The SDC said if a CNA staff member was unable to remove Resident #84's facial hair during morning care the CNA should try again later that same day or the next day.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews, and record review, the facility failed to provide care and services consistent with professional standards of practice for indwelling urinary catheters (a soft, flexible tube that drains urine from the bladder into a drainage bag) for one Resident (#58) of three applicable residents, out of a total sample of 18 residents.Specifically, for Resident #58, the facility staff failed to ensure that the Resident's urinary drainage bag was positioned off the floor to decrease the risk of contamination and increasing the Resident's risk for indwelling urinary catheter infections. Findings include: Review of the facility's policy titled Catheter Care of Indwelling Urinary, revised 8/5/23, indicated the following:ˆ >Always keep the drainage bag below the level of the resident's bladder and off the floor. Resident #58 was admitted to the facility in October 2025 with diagnoses including obstructive and reflux uropathy. Review of the Minimum Data Set (MDS) Assessment, dated 11/6/25 indicated Resident #58: -did not demonstrate rejection of care. -had an indwelling urinary catheter. -required substantial/maximum assistance for showering, toileting and dressing below the waist. Review of Resident #58's Physician's orders indicated the following: -Foley (type of indwelling urine catheter) catheter care every shift (11:00 P.M. - 7:00 A.M., 7:00 A.M. - 3:00 P.M., and 3:00 P.M. - 11:00 P.M.), effective 10/30/25. -May change Foley catheter as needed for leakage/blockage, effective 10/20/25. -Change catheter drainage bag monthly, effective 11/26/25. On 12/30/25 at 9:25 A.M., the surveyor observed Resident #58 sitting in a wheelchair in the dining area with his/her Foley catheter drainage bag connected under his/her wheelchair seat. The surveyor further observed the urinary catheter drainage bag touching the dining area floor without a protective barrier in place. On 12/30/25 at 2:46 P.M. and 12/31/25 at 9:37 A.M., the surveyor observed Resident #58 lying in bed with his/her eyes closed and his/her Foley catheter drainage bag touching the floor without a protective barrier in place. During an interview on 12/31/25 at 1:28 P.M., Certified Nurse's Aide (CNA) #1 said that she was assigned to provide care to Resident #58. CNA #1 said that Resident #58 did not manipulate or handle his/her own urinary drainage bag. The surveyor and CNA #1 observed Resident #58 lying in bed with his/her Foley catheter drainage bag on the floor without a protective barrier. CNA #1 said that the Resident's Foley catheter drainage bag should not be touching the floor and should be in a protective privacy bag. CNA #1 said when the Foley catheter drainage bag touches the floor it can cause infections to Resident #58. During an interview on 12/31/25 at 1:32 P.M., the Infection Preventionist (IP) said that the Resident's Foley catheter drainage bag should be kept off the floor. The IP said that keeping the Resident's drainage bag off the floor was important because germs on the floor could get into the Resident's drainage bag and cause the Resident an infection.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interviews and record review, the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC: notice issued to a resident who is receiving benefits under Medicare Part A when all covered services end) was accurately issued for one Resident (#95) out of three applicable residents, out of a total sample of 18 residents. Specifically, for Resident #95, the facility failed to ensure that a paper copy of the NOMNC was provided to the Resident's responsible party as required. Findings include: Review of the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) Centers for Medicare and Medicaid Services (CMS-10123), indicated the following: -Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of electronic notice delivery. -The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. Resident #95 was admitted to the facility in June 2025. Review of Resident #95's medical record indicated: -Resident #95 was not responsible for him/herself and had a Healthcare Proxy (HCP) that was activated on 6/21/25. -Resident #95 received Medicare Part A Skilled Services beginning on 6/17/25.-Resident #95's last covered day of Medicare Part A Skilled Services was 7/3/25.-The facility staff had contacted the HCP over the telephone to inform them of the NOMNC information on 7/1/25 at 11:30 A.M. -The facility staff person did not mail a paper copy of the NOMNC form to the HCP. Further review of the NOMNC form and Resident #95's clinical record failed to indicate that a paper copy of the NOMNC form was mailed to the Resident's HCP. During an interview on 12/31/25 at 4:18 P.M., the Regional Clinical Reimbursement staff member said that the facility refers to the CMS guidelines on how to deliver the NOMNC forms to ensure that they are done properly. During an interview on 12/31/25 at 4:25 P.M., the Social Worker (SW) said that she did not have documentation that the NOMNC was provided to Resident #95's HCP in person or that a paper copy was mailed to the HCP after the NOMNC information had been issued over the telephone.

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and records reviewed, the facility failed to coordinate an assessment with the PASRR program when a significant change in mental status was determined for one Resident (#3) out of a total sample of 18 residents. Specifically, the facility failed to refer Resident #3 to the PASRR program for a Level II Resident Review in a timely manner when the Resident: -Had a previous negative PASRR screening for serious mental illness (SMI). -Experienced aggressive behaviors. -Required in-patient psychiatric hospitalization. -Was newly diagnosed with bipolar disorder. -Required newly prescribed antipsychotic medication to be administered. Findings include: Review of the facility policy titled PASRR Preadmission and Review, dated 4/1/25, indicated the following: -The facility will refer all residents with newly evident or possible SMI, ., or related condition for PASRR assessment at resident review upon admission and significant change in status. -The facility must notify the state mental health authority (DMH PASRR) . promptly after a significant change in status is identified. -If a resident triggers for SMI and demonstrates a Treatment History or Life Impairments, a PASRR Level II request must be made to obtain an abbreviated Level II due to categorical determination or a full Level II evaluation. -If new information is obtained post-admission regarding Treatment History or Life Impairment, a new PASRR for Resident Review is needed and should be submitted for Level II review. -Any resident with significant change in status since their original admission to the facility . should be submitted into the PASRR portal. -If the resident's Level I screening form is in the PASRR portal but appears to require a Level II evaluation or Resident Review that is not in the portal, the nursing facility must contact the appropriate PASRR authority. Resident #3 was admitted to the facility in February 2021 with diagnoses including Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease affecting left non-dominant side, and occlusion and stenosis of Unspecified Cerebral Artery. Review of the PASRR Level I Screening, dated 2/12/21, indicated Resident #3: -did not have a documented diagnosis of mental illness or disorder (MI/D) . that may lead to chronic disability. -had not required any of the listed treatments or interventions, which included one or more psychiatric hospitalizations, that was, or may have been, due to MI/D within the previous two years. -screen for SMI was negative due to no diagnosis or suspicion of SMI. Review of Resident #3's Nursing Progress Note, dated 10/5/23, indicated: -The Resident was verbally abusive to a certified Nurse's Aide (CNA). -The Resident stated, If I had a gun I would shoot you all. Review of Resident 3's Nursing Progress Note, dated 10/6/23, indicated: -The Resident had increasing behaviors over the previous few months which included: -Yelling and throwing items at staff. -Refusing medications and care at times. -The Resident had refused antidepressant medication recommended by the Physician. -The facility was concerned for the Resident's overall well-being with hygiene, skin integrity, and medical health related to declining medications. -The Physician wanted the Resident to be sent to the Emergency Department (ED) for psychiatric evaluation. Review of Resident #3's Physician Progress Note, dated 10/6/23, indicated: -The Physician assessed the Resident for an acute visit. -the Resident had been experiencing escalating behaviors (physically and verbally aggressive toward staff; throwing objects, demeaning, aggressive, racial statements, accusatory). -The Resident was non-compliant with his/her behavior modification plan. -The Resident was not agreeable to go to the ED for evaluation. -Due to risk of harm to staff and other residents, ., the Resident was being involuntarily sent to the ED for psychiatric evaluation via Section 12 (temporary, involuntary restraint and transport of an individual posing a serious risk of harm due to mental illness for psychiatric evaluation). Review of the clinical record indicated Resident #3: -was admitted for acute psychiatric hospitalization on 10/7/23. -was newly diagnosed with bipolar disorder, current episode manic severe with psychotic features on 10/7/23, while in the hospital. -had been ordered for Olanzapine (antipsychotic medication) which was administered to the Resident (continued on next page)

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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 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	during his/her inpatient psychiatric hospitalization stay. -hospital physician recommended the Resident continue taking Olanzapine following his/her inpatient psychiatric hospitalization. -returned to the facility on [DATE]. -had no evidence the Resident had been referred to the PASRR program. Review of Resident #3's Physician Order, dated 10/16/23 and discontinued 4/26/24, indicated: Olanzapine tablet, 10 milligrams (mg) orally at 8:00 P.M. Review of Resident #3's Physician Orders, dated 4/26/24 and last reviewed 11/26/25, indicated the following: -Olanzapine tablet: 10 milligrams (mg), oral, given with 2.5 mg tab; total dose 12.5 mg daily, once a day at 8:00 P.M. -Olanzapine tablet: 2.5 mg, oral, one tablet with 10 mg; total dose daily 12.5 mg, once a day at 8:00 P.M. Review of the Minimum Data Set (MDS) Assessment, dated 10/16/25, indicated Resident #3: -was able to make him/herself understood, and he/she understood others with clear comprehension. -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 total possible points. -demonstrated verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) one to three days during the MDS observation period. -active diagnoses included bipolar disorder. -received antipsychotic medication on a routine basis. -A gradual dose reduction (GDR) of antipsychotic medication was contraindicated. Review of Resident #3's December 2025 Medication Administration Record (MAR) indicated a total dose of 12.5 mg Olanzapine was administered to the Resident daily, as ordered. Review of Resident #3's clinical record on 12/30/25 failed to indicate any evidence the Resident had been referred to the PASRR program when he/she experienced a significant change in mental status, required inpatient psychiatric hospitalization, was newly diagnosed with bipolar disorder, and required the use of antipsychotic medication. On 12/30/25 at 9:03 A.M., the surveyor observed Resident #3 sitting in a wheelchair in his/her room. During an interview at the time, the Resident responded verbally to the surveyor but did not make eye contact with the surveyor. During an interview on 12/31/25 at 1:05 P.M., the Social Worker (SW) said the facility identified and she became aware in May 2025 that Resident #3 had not been referred to the PASRR program for Resident Review in October 2023 as required, after the Resident had an inpatient psychiatric hospitalization, had been newly diagnosed with bipolar disorder, and required antipsychotic medication to be administered. The SW said she did not refer the Resident to the PASRR program for Resident Review until 9/4/25, at which time the Resident's referral was rejected due to a request for additional information. The SW said that at the time of this interview on 12/31/25, she had not yet submitted the additional information requested by the PASRR office for Resident #3.