STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225390	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parsons Hill Rehabilitation & Health Care Center	1350 Main Street Worcester, MA 01603

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 44222 Based on record review, and interview, the facility failed to ensure that residents and/or their representatives were informed and given necessary information to make health care decisions including the risks and benefits of psychotropic (any drug that affects behavior, mood, thoughts, or perception) medications prior to their use for one Resident (#205) out of a total sample of 29 residents. Specifically, for Resident #205, the facility failed to obtain informed consent from the Resident with notification of the risks and benefits for the use of Clonidine (antihypertensive medication that can also be prescribed for anxiety) prior to administering the medication to the Resident. Findings include: Review of the facility policy titled Psychotropic Medication Informed Consent - Massachusetts Only, dated February 2016, included: -Informed written consent shall include the following information: the purpose for administering the psychotropic medication, the prescribed dosage and, any known effect or side effect of the psychotropic medication. -Documentation of informed consent for prescribing psychotropic medication including but not limited to, drugs that treat Depression, anxiety disorders, or attention deficit/hyperactivity disorder. Resident #205 was admitted to the facility in March 2025 with diagnoses including Major Depressive Disorder and Anxiety Disorder. Review of Resident #205's March 2025 Physician's orders included: -Clonidine HCl Oral Tablet 0.1 mg (milligram), Give 1 tablet at bedtime for anxiety. Ordered 3/10/25, started 3/11/25. Review of Resident #205's March 2025 Medication Administration Record (MAR) indicated that the Clonidine medication was administered as ordered. Review of Resident #205's Minimum Data Set (MDS) Assessment, dated 3/14/25, indicated Resident #205: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points. -was receiving antianxiety medication. Further review of Resident #205's clinical record failed to indicate any evidence that the purpose, dosage, risks, or benefits of the medication were discussed with the Resident prior to the administration of Clonidine for anxiety. During an interview on 3/20/25 at 12:15 P.M., the Assistant Director of Nurses (ADON) and Unit Manager (UM) #1 said that they were unable to locate an Informed Consent for Psychotropic Medication for the administration of Clonidine for anxiety in the Resident's record, but there should be one. During an interview on 3/20/25 at 2:11 P.M., the Director of Nursing (DON) said that an Informed Consent for Psychotropic Medication administration should have been completed for the Clonidine prescribed for anxiety for Resident #205, but the Informed Consent had not been done.

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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. 45429 Based on interview, 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 (#130) out of three applicable residents, out of a total sample of 29 residents. Specifically, for Resident #130, 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 #130 was admitted to the facility in February 2024. Review of Resident #130's medical record indicated: -Resident #130 was not self-responsible and had a legal Guardianship established 4/26/23. -Resident #130 received Medicare Part A Skilled Services beginning on 1/13/25. -Resident #130's last covered day of Medicare Part A Skilled Services was 2/19/25. -The facility staff emailed the NOMNC form to the Guardian. -The facility staff person did not mail a paper copy of the NOMNC form to the Guardian. -The Resident remained in the facility after his/her Medicare Part A Skilled Services ended. Review of Resident #130's NOMNC form indicated: -Medicare Part A Services ended on 2/19/25. -Facility staff person called the Resident's Responsible party on 2/17/25 at 3:00 P.M. to notify them that the Resident's last day of coverage for Medicare A Skilled Services was on 2/19/25. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	-Facility staff person emailed the NOMNC form on 2/17/25 to the Guardian. Further review of the NOMNC form and Resident #130's clinical record failed to indicate that a paper copy of the NOMNC form was mailed to the Resident's Guardian. During an interview on 3/24/25 at 8:10 A.M., MDS Nurse #2 said that she had not mailed a paper copy of the NOMNC form to Resident #130's Guardian. MDS Nurse #2 also said that she was not aware that she needed to mail the NOMNC form to the responsible party and that she had emailed the form instead.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44337 Based on observation, and interview, the facility failed to provide a safe and homelike environment for one Resident (#3) out of a total sample of 29 residents, and for residents on one Unit (Burncoat) out of five Units. Specifically, the facility failed to: -repair a hole located in the wall behind the headboard of Resident #3's bed. -enclose exposed pipes (from a water fountain removal) protruding from a wall in a hallway on the Burncoat unit, placing residents at potential risk of injury. Findings include: Resident #3 was admitted to the facility in December 2019, with diagnoses including Dementia and Schizophrenia. Review of a Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3 was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of three out of a total possible score of 15. On 3/19/25 at 9:34 A.M., the surveyor observed Resident #3 sitting on the edge of his/her bed eating breakfast. The surveyor also observed a large hole in the wall behind the headboard of Resident #3's bed. During an interview on 3/20/25 at 10:08 A.M., Nurse #2 said that Resident #3 was moved into his/her present room a few weeks ago. Nurse #2 said that the hole in the wall behind the headboard in Resident #3's room was made by the resident who was previously in the room. Nurse #2 also said that she was unaware whether maintenance had been notified of the hole in the wall in Resident #3's room. Nurse #2 said when staff have maintenance concerns they enter the concern into the maintenance log book at the nurses station or call down to the Maintenance staff and leave a voice message. Nurse #2 said she was unsure if the maintenance staff were aware of the hole in the wall behind Resident #3's bed. On 3/20/25 at 10:10 A.M., the surveyor observed exposed pipes protruding from a wall in the hallway of the Burncoat Unit. The surveyor further observed a resident standing in the hallway grab onto the exposed pipes and Nurse #2 had to redirect the resident away from the exposed pipes. During an interview at the time Nurse #2 said that maintenance staff had removed a drinking fountain from the hallway leaving the exposed pipes protruding from the wall. Nurse #2 said the exposed pipes protruding from the wall were not safe and she was afraid a resident might fall onto the exposed pipes and get hurt.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50320 Based on interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) Assessments for two Residents (#49 and #67) out of a total sample of 29 Residents. Specifically: 1. For Resident #49, the facility coded the Resident as utilizing an external catheter during the observation period for the MDS assessment, when he/she did not utilize an external catheter. 2. For Resident #67, the facility failed to accurately code that the Resident was utilizing an antidepressant medication (Trazodone) during the observation period for the MDS assessment. Findings include: 1. Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual version 1.19.1 dated October 2024 indicated the following: -Examine the resident to note the presence of any urinary or bowel appliances. -Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances. -Check next to each appliance that was used at any time in the past 7 days. -Select none of the above if none of the appliances . were used in the past 7 days. Resident #49 was admitted to the facility in August 2023 with diagnoses including Human Immunodeficiency Virus, Chronic Viral Hepatitis, and Opioid Dependence with Unspecified Opioid Induced Disorder. Review of Resident #49's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was coded as having an external catheter (non-invasive device used to manage urinary incontinence). Review of Resident #49's clinical record failed to indicate any evidence that the Resident was utilizing an external catheter. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 3/20/25 at 1:36 P.M., the surveyor and MDS Coordinator #1 reviewed Resident #49's MDS assessment dated [DATE]. MDS Coordinator #1 said Resident #49 does not use an external catheter and the MDS was coded incorrectly. MDS Coordinator #1 said this had happened in the past on the previous MDS dated [DATE], due to the Certified Nurses Aides (CNAs) incorrectly checking off continence not rated due to use of external catheter on the CNA documentation. The surveyor and MDS Coordinator #1 reviewed the CNA documentation dated 2/18/25 - 3/20/25 and use of a specific external catheter was checked off by a CNA on 2/23/25. MDS Coordinator #1 said this was the reason why Resident #49's MDS was coded for use of an external catheter on his/her 2/25/25 MDS. MDS Coordinator #1 said the MDS would need to be corrected to reflect that Resident #49 does not use an external catheter. 45429 2. Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual version 1.19.1 dated October 2024, indicated the following: -high risk drug classes use an indication: check if the resident is taking any medications by pharmacological classification. -Review the residents medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day look back period. -Check if there is an indication noted for all antidepressant medications taken by the resident any time during the observation period. Resident #67 was admitted to the facility in February 2019 with diagnoses including Post Traumatic Stress Disorder (PTSD) and Anxiety Disorder. Review of the Resident's MDS assessment dated [DATE], did not indicate that Resident #67 was taking an antidepressant medication. Review of Resident #67's March 2025 Physician's orders indicated that the Resident had an order for Trazodone 50 milligrams (mg), give 0.5 mg tablet via G-tube in the evening related to suicidal ideations, start date 3/4/21. Review of the Resident's March 2025 Medication Administration (MAR) indicated Resident #67 received Trazadone daily, as prescribed by the Physician. During an interview on 3/25/25 at 9:00 A.M., MDS Nurse #3 said that Resident #67's MDS should have been coded for the antidepressant Trazodone, and it was not coded.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on record review, and interview, the facility failed to coordinate vision care services for one Resident (#129) out of a total sample of 29 residents. Specifically, for Resident #129, the facility failed to schedule vision care appointments and ensure that the Resident was seen and received appropriate treatment to maintain vision abilities, when the Resident consented to and requested vision care services. Findings include: Review of the facility policy titled Consultant Services, dated April 2015, included: -identify and facilitate consultant services to meet the resident's needs, to ensure optimum care for each resident/patient through consultant services. -once the consultant is identified by the MD (medical doctor) and after the family has been notified and given the permission for the consult, the staff will call the consultant to notify him/her of the request and document response in medical record. Resident #129 was admitted to the facility in April 2024 with diagnoses including Complete Traumatic Amputation at level between Knee and Ankle Left Lower Leg and Adjustment Disorder with Anxiety. Review of Resident #129's current March 2025 Physician's orders included an order dated 4/8/24 for Consults: -Ophthalmic care as needed. Review of the Resident's clinical record included a Request for Service for Eye Care Services signed by the Resident, and dated 4/30/24. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points. During an interview on 3/19/25 at 10:18 A.M., Resident #129 said that he/she was still waiting to see the eye doctor. Resident #129 said that he/she needed glasses for distance and reading. Resident #129 further said that he/she has worn glasses his/her whole life, but none since coming to the facility. During an interview on 3/24/25 at 1:06 P.M., the Director of Nursing (DON) said that she was unaware that Resident #129 had signed a consent for Visual Consultant Services on 4/30/24. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/24/25 at 2:45 P.M., the Assistant Director of Nurses (ADON) said that Resident #129 had not been seen by the Vision Consultants over the last year, but should have been. The ADON showed the surveyor a list of eight dates over the past year that the Vision Consultants had been in the facility since the Resident signed the consent for vision services but he/she had not been seen by the Vision Consultants.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51571 Based on observation, interview, and record review, the facility failed to provide necessary care and services relative to enteral feeding (also known as tube feeding, is the delivery of nutrients directly into the stomach), for one Resident (#116), out of a total sample of 29 residents. Specifically, for Resident #116, the facility failed to label and date enteral feeds and fluids being administered to the Resident via Gastrostomy Tube (G-tube - tube placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) as required, to ensure the enteral nutrition administration was consistent with Physician orders and that the product had not exceeded the expiration date. Findings include: Review of the facility policy titled Nursing Policy & Procedure Manual: Enteral Feeding, dated 4/15, indicated the following: -Label formula and administration set with: >Date >Time >Resident's name >Nurse initials Resident #116 was admitted to the facility in January 2023, with diagnoses including Gastrostomy Status, Dysphagia Oropharyngeal Phase, and Mild Protein Calorie Malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #116: -cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points. -received nutrition via a feeding tube. -received over 51 percent (%) of their calories via tube feed. -received fluid intake via a feeding tube and received over 501cc (cubic centimeters) of fluid for hydration per day. Review of Resident #116's March 2025 Physician's orders indicated: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Enteral Feed order: At bedtime, Jevity 1.5 @100 ml/hr (milliliters per hour) up [start] at 10:00 P.M. down [end] at 11:00 A.M., initiated 1/14/25. -Administer 220 ml of H20 (water) every 6 hours via G-Tube every 6 hours, initiated 1/14/25. -Flush feeding tube with 60 ml of water before and after Tube Feed cycle, two times a day, initiated 10/7/24. -Flush G-Tube with 30 ml of H20 before and after medication administration every shift, initiated 11/26/23. On 3/19/25 at 12:19 P.M., the surveyor observed Resident #116 lying in bed and an enteral feeding pump on a pole positioned next to the bed. The surveyor also observed two graduated clear bags hanging on the pole above the enteral feeding pump. One clear bag contained approximately 50 ml beige colored liquid, and the second bag contained approximately 500 ml clear liquid. The enteral feeding pump was observed connected to the Resident and set to infuse at 100 ml/hr. The surveyor did not observe a label, date, or content identifiers on the two bags hanging on the enteral feeding pump pole and being administered to the Resident. On 3/20/25 at 8:32 A.M., the surveyor observed Resident #116 lying in bed and watching television. The surveyor observed that the enteral feeding pump was set to infuse at 100 ml/hr. The surveyor observed two graduated clear bags hanging on the feeding pump pole, one bag contained a beige liquid, and the second bag contained a clear liquid. The two bags did not have a label, a date, or the time they were hung. During an interview at the time, Resident #116 said that the 11:00 P.M. -7:00 A.M.(night) shift Nurses set up his/her enteral feeding, and that the time works best for him/her. On 3/21/25 8:01 A.M., the surveyor and Nurse #1 observed Resident #116 lying in bed with the enteral feeding pump running. During an interview at the time, Nurse #1 said that she works the 7:00 A.M. to 3:00 P.M.(Day) shift and Resident #116's enteral feed is hung by the 11:00 P.M. to 7:00 A.M. shift. Nurse #1 said she takes the enteral feeding down around 11:00 A.M. when the total amount of feeding is completed. Nurse #1 said that the rate of enteral feeds and water flushes are programmed by a Nurse into the enteral feeding pump and Resident #116 received Jevity 1.5 at 100 ml/hr with automatic water flushes set at 220 ml every 6 hours. The surveyor and Nurse #1 observed approximately 300 ml of beige liquid remaining in one of the graduated plastic bags, which Nurse #1 identified as Jevity 1.5 calorie product, and the bag of clear liquid was identified as water for water flushes. The surveyor observed the screen on the feeding pump machine indicated 696 ml of the beige liquid had been administered to Resident #116. Nurse #1 said that the water bag and Jevity bag were not labeled or dated and should have been. Nurse #1 said that typically when an enteral feeding bag and the water flush are administered, both bags should be labeled with the Resident name, date, time, formula administration set and the initial of the Nurse who hung the enteral feed and the water flushes bags. During an interview on 3/21/25 at 11:12 A.M., the Director of Nursing (DON) said that the expectation for the Resident's enteral feeds, is that the nursing staff should have used a sticker which is provided to label the enteral feed and the water flushes with the Resident's name, date, time, formula administration set by the Physician and the initials of the Nurse who hung the enteral feed bags.

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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. 45429 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 (#91), out of a total sample of 29 residents. Specifically, for Resident #91, the facility failed to ensure that the oxygen concentrator was set at 2 liters per minute (LPM) as ordered by the Physician, when the Resident was observed with the oxygen concentrator set at 1.5 LPM. Findings include: Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for oxygen therapy. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease (COPD) that oxygen administration may lead to an increase in PaCO2. -Equipment maintenance and supervision: >All oxygen delivery equipment should be checked at least once daily . >Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. Review of the facility policy titled Oxygen Concentrators, undated, indicated the following: -Verify the Physician's order and review the patient's chart. -Adjust the liter flow in accordance with the Physician's order by rotating the flow selector knob on the flow meter located on the front panel of the unit. Resident #91 was admitted to the facility in April 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and chronic respiratory failure. Review of Resident #91's most recent Minimum Data Set (MDS) Assessment, dated 1/13/25, indicated: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #91 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points. -Resident #91 received oxygen therapy. Review of Resident #91's COPD Care Plan, last revised 2/10/25, indicated: -give oxygen 2 liters (via) nasal cannula continuously as the Resident has shortness of breath when lying flat, per Resident interview. Review of Resident #91's March 2025 Physician orders indicated the following: -oxygen continuously via nasal cannula at 2 liters a minute. -every shift check pulse ox (SpO2 - measure of oxygen in the blood as a percentage of the maximum oxygen the blood could carry) and Liters Per Minute (LPM), start date 11/11/24. On 3/19/25 at 12:39 P.M., the surveyor observed that Resident #91 was receiving oxygen via nasal cannula while lying in bed and the oxygen concentrator attached to the nasal cannula was set at 1.5 LPM. During an interview at the time, Resident #91 said that the oxygen concentrator should be set to 2 LPM. On 3/20/25 at 7:47 A.M., the surveyor observed Resident #91 lying in bed and receiving oxygen via nasal cannula with the oxygen concentrator set at 1.5 LPM. On 3/24/25 at 7:54 A.M., the surveyor observed Resident #91 receiving oxygen via nasal cannula while lying in bed and the oxygen concentrator was set to 1.5 LPM. During an interview on 3/24/25 at 9:44 A.M., Nurse #3 said that Resident #91 should have been receiving oxygen via nasal cannula at 2 LPM per the Physician's orders. The surveyor and Nurse #3 went into Resident #91's room and observed the oxygen concentrator was set at 1.5 LPM. Nurse #3 was observed to adjust the oxygen concentrator to 2 LPM and exit the Resident's room. During an interview on 3/24/25 at 12:43 P.M., the Director of Nursing (DON) said the oxygen that Resident #91 had been receiving via nasal cannula should reflect the liters per minute as prescribed by the Physician.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 51571 Based on record review, and interview, the facility failed to provide care and services consistent with professional standards of practice related to renal dialysis (procedure to remove waste products and excess fluid from the body when the kidneys stop functioning properly) for two Residents (#93 and #147), out of a total sample of 29 residents. Specifically, the facility failed to communicate and maintain ongoing documentation with the dialysis center to ensure that the dialysis center and the facility received the most current information pertaining to Resident's #93 and #147. Findings include: Review of the facility policy titled Hemodialysis, dated April 2015, included but was not limited to: -Communication between the facility and the hemodialysis center will occur using a communication book/sheet that consists of: >vital signs >Copy of MAR (Medication Administration Record) >any change of condition from last hemodialysis treatment -Documentation will be completed prior to dialysis treatment. -The communication book/sheet will be reviewed upon return from dialysis. 1. Resident #93 was admitted to the facility in February 2023, with diagnoses including Chronic Kidney Disease Stage 4, Hypertensive Emergency, and Anemia in Chronic Kidney Disease. Review of Resident #93's Care Plan for Hemodialysis, initiated 2/20/23, indicated: -Goal: To tolerate dialysis without complications, revised 12/9/24. -Intervention: Complete Hemodialysis Communication form in Hemodialysis Communication book. Include vital signs and anything noteworthy since last appointment, initiated 7/26/23. Review of the most recent Minimum Data Set (MDS) Assessment, dated 2/14/25, indicated Resident #93: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points. -received Dialysis treatment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #93's March 2025 Physician's orders indicated: -Dialysis Days: Tuesday, Thursday, and Saturdays, at 10:30 A.M., initiated 12/15/23. -Hemodialysis pick up 9:30 A.M., with pick up scheduled Tuesday, Thursday, and Saturdays, initiated 1/23/25. Review of Resident #93's Dialysis Communication Book failed to provide evidence of any communication sent to the Dialysis Center from the facility for any dialysis days in January 2025, February 2025, or March 2025. Review of the Resident #93's clinical record failed to provide any evidence of ongoing communication by the facility with the dialysis center. During an interview on 3/19/25 at 9: 21 A.M., Resident #93 said that he/she went to the dialysis center three times a week on Tuesday, Thursday, and Saturday and had not missed any dialysis treatments. Resident #93 said that dialysis treatments were going well. On 3/20/25 at 8:50 A.M., the surveyor observed Resident #93's dialysis communication book/binder at the nurses station which contained copies of blank facility daily dialysis communication forms. The dialysis communication form required the Resident's face sheet, pre-weight, labs, medications administered, vital signs, allergies, and if the Resident had eaten a meal prior to leaving for dialysis treatment to be completed for dialysis center communication. The surveyor failed to find any evidence in Resident #93's dialysis communication book/binder that the dialysis communication forms were completed as required by the facility. Further review of Resident #93's clinical record failed to indicate that dialysis communication forms were completed for January 2025, February 2025, and March 2025. During an interview on 3/20/25 at 9:02 A.M., the Unit Manager (UM) #2 said that Resident #93 has dialysis treatments three times a week on Tuesday, Thursday, and Saturday. UM #2 said that there is no daily dialysis communication from the facility to the dialysis center when Resident #93 goes for dialysis. UM #2 said that the dialysis communication binder for Resident #93 contains dialysis communication from the dialysis center to the facility after treatment is completed. The surveyor and UM #2 reviewed the dialysis communication binder, and UM #2 said that nursing staff only complete the dialysis communication form if there was an issue before the Resident goes for dialysis treatments. During an interview on 3/20/25 at 11:22 A.M., the Assistant Director of Nurses (ADON) said that the Nurses should be communicating vital signs and weights prior to each dialysis appointment, and they have not been providing this information. 45429 2. Resident #147 was admitted to the facility in January 2025 with diagnoses including End Stage Renal Disease (ESRD) and Adult Failure to Thrive. Review of Resident #147's Care Plan for Hemodialysis, initiated 2/6/25, indicated the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal: to tolerate dialysis without signs of complications. -Intervention: monitor intake and output. -If Resident has decreased urinary output, increased confusion, fever, changes in usual mental status, poor skin turgor, Resident may be dehydrated. Review of Resident #147's most recent Minimum Data Set (MDS) Assessment, dated 2/25/25, indicated: -staff assessment for mental status had been completed as the Resident had been transferred out to the hospital. -short-term memory was okay. -cognitive skills for daily decision making coded as modified independence with some difficulty only in new situations. -receiving dialysis treatment. During an interview on 3/19/25 at 9:36 A.M., Resident #147 said that he/she went to the dialysis center three times a week on Monday, Wednesday, and Friday. Review of Resident #147's March 2025 Physician's orders indicated: -Dialysis days Monday, Wednesday, Friday at 4:00 P.M., pick up time 3:15 P.M. -Check dialysis book after treatment for any new recommendations or issues, update Physician or Nurse Practitioner(NP) if needed. -Ongoing assessment of Resident prior to dialysis. Review of Resident #147's dialysis communication book failed to provide evidence of any communication sent to the dialysis center from the facility for any dialysis days in January 2025, February 2025, or March 2025, except for 1/29/25 and 2/14/25. Review of Resident #147's clinical record failed to provide any evidence of ongoing dialysis communication between the facility and the dialysis center. During an interview on 3/20/25 at 9:02 A.M., UM #2 said that there was no dialysis communication on dialysis days from the facility to the dialysis center. UM #2 also said that the dialysis communication book for the Resident contains information from the dialysis center. UM #2 said the facility only complete a hemodialysis communication sheet for the Resident if there is an issue prior to the Resident leaving for dialysis. During an interview on 3/20/25 11:22 A.M., the ADON said that the Nurses should have been communicating Resident #147's vital signs and weights prior to each dialysis appointment, and they had not been communicating the information.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51571 Based on interview, and record review, the facility failed to ensure that recommendations made by the Consultant Pharmacist during a monthly Medication Regimen Review (MRR) were implemented as required for three Residents (#116, #122, and #49), out of a total sample of 29 residents. Specifically, the facility failed to: 1. For Resident #116, act upon the Consultant Pharmacist recommendations dated 10/19/24 and 11/23/24, to discontinue a Multivitamin and Calcium tablets to reduce polypharmacy (use of multiple medications at once, often exceeding what's clinically necessary) when the recommendations were reviewed and agreed upon by the Physician. 2. For Resident #122, act upon the Consultant Pharmacist recommendations dated 10/19/24 and 1/16/25, to update the Physician's order for Vitamin D3 50,000 IU (international units) monthly, when the recommendations were reviewed and agreed upon by the Physician. 3. For Resident #49, act upon the Consultant Pharmacist recommendations to obtain orders and complete a Thyroid Stimulating Hormone (TSH) level and ensure Physician review of the recommendations. Findings include: Review of the facility policy titled Policy and Procedure: Consultant Services, initiated April 2015, indicated: -A note should be recorded on the consultant form by any health care consultant who sees the resident/patient at the request of the MD (medical doctor) or the family. The consultant should document findings and recommendations on this form. -The charge nurse will then notify the attending physician of findings, and he/she can then order the specific treatment as outlined by the consultant. 1. Resident #116 was admitted to the facility in January 2023, with diagnoses including Gastrostomy Status, Dysphagia Oropharyngeal Phase, and Mild Protein Calorie Malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #116 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a total possible score of 15. Review of the Consultant Pharmacist Recommendation to Prescriber Forms dated 10/19/24 and 11/23/24, indicated: -In an effort to reduce polypharmacy: Evaluate the continued use of these vitamins/supplements and consider discontinuing multivitamin and Calcium. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Pharmacist recommendation had been reviewed and agreed to by the Physician. Review of Resident #116's March 2025 Physician Orders indicated the following: -Multivitamin Tablet, give 1 tablet via G-tube in the morning for preventative maintenance, initiated 11/26/23. -Calcium Carbonate Tablet, give 500 mg via G-tube in the morning for preventative maintenance, initiated 11/26/23. Review of Resident #116's Medication Administration Record (MAR) from 10/1/24 to 3/20/25, indicated that the Resident was administered multivitamin and Calcium daily. Review of Resident #116's Clinical Record failed to indicate that the Consultant Pharmacist Recommendations which had been agreed to by the Physician, had been implemented prior to the survey start. Further review of Resident #116's March 2025 MAR indicated the Physician's orders for Calcium Carbonate tablet 500 mcg via G-Tube and multivitamin tablet, 1 tablet via G-Tube were discontinued on 3/21/25 (153 days after the initial Consultant Pharmacist recommendation on 10/19/24). 2. Resident #122 was admitted to the facility in November 2023, with diagnoses including Alcohol Abuse, Hyperlipidemia, and Chronic Viral Hep C (Hepatitis C). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #122 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. Review of the Consultant Pharmacist Recommendation to Prescriber Forms dated 10/19/24 and 1/6/25, indicated: -Resident is receiving Vitamin D3 1000 IU daily. In order to save nursing med pass time and enhance Resident convenience, consider change to the following: monthly administration. If no change is indicated, note medical necessity of current therapy in progress note. -The Pharmacist recommendation had been reviewed and agreed to by the Physician. Review of Resident #122's March 2025 Physician's orders indicated: -Vitamin D3 Oral Tablet (Cholecalciferol), give 25 mcg (micrograms) by mouth in the morning for supplement, initiated 3/6/24. Review of Resident #122's Medication Administration Record (MAR) from 11/1/24 to 3/20/25, indicated that the Resident was administered Vitamin D3 Oral tablet 25 mcg daily. Review of Resident #122's Clinical Record failed to indicate that the Consultant Pharmacist Recommendations which had been agreed to by the Physician, had been implemented prior to the survey start. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #122's March 2025 MAR indicated a Physician's order for Vitamin D3 50,000 IU, to be administered monthly, was initiated 3/20/25 (152 days after the initial Pharmacist Recommendation had been made on 10/19/24). During an interview on 3/21/25 at 12:54 P.M., the Director of Nursing (DON) said that the Pharmacy Recommendations for Resident's #116 and #122 were signed by the Physician and should have been implemented, but the pharmacy recommendations had not been implemented. During a follow-up interview on 3/25/25 at 7:30 A.M., the DON said that she is responsible for sorting all the Pharmacy Recommendations for Residents. The DON said she puts all the Pharmacy Recommendations in an envelope for the Charge Nurses on the units. The DON said the Charge Nurses are responsible for ensuring that the Pharmacist Recommendations were given to the Physicians for review, and for updating the Resident records. 50320 3. The Food and Drug Administration (FDA) Highlights of Prescribing Levothyroxine Tablets for Oral Use, dated December 2017, indicated: -In adult patients with primary hypothyroidism, monitor serum TSH (Thyroid Stimulating Hormone) levels after an interval of 6 to 8 weeks after any change in dose. -In patients on a stable and appropriate replacement dose, evaluate clinical and biochemical response every 6 to 12 months and whenever there is a change in the patient's clinical status. Resident #49 was admitted to the Facility in August 2023 with diagnoses including Human Immunodeficiency Virus, Chronic Viral Hepatitis, and Opioid Dependence with Unspecified Opioid Induced Disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #49: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 points. Review of Resident #49's clinical record indicated the Resident had a Physician's order for Levothyroxine Sodium (medication used to treat hypothyroidism [condition where the thyroid gland does not produce enough thyroid hormone]), oral tablet 150 micrograms (mcg), give one tablet by mouth in the morning for preventative maintenance, effective 8/25/23. Review of Resident #49's Medication Administration Records (MAR) for December 2024 and January 2025 through March 2025, indicated the Resident was administered the Levothyroxine medication as ordered by the Physician. Review of Resident #49's Medication Regimen Review completed by the Consultant Pharmacist on 12/18/24, indicated: -laboratory test for TSH to help assess the efficacy and potential side effects of continued use of Levothyroxine. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the medical record failed to provide evidence that the TSH lab test was obtained or that the recommendation was reviewed with Resident #49's Physician. During an interview on 3/24/25 at 1:56 P.M. the DON said the Pharmacy Recommendation was reviewed in December 2024, but the TSH level had not been completed as recommended. The DON said the laboratory test for the TSH level should have been completed.

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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. 50320 Based on observation, and interview, the facility failed to adhere to infection control standards of practice, increasing the risk of contamination and the spread of infection to other residents within the facility. Specifically, the facility failed to ensure that housekeeping staff on the Greendale Unit adhered to appropriate Personal Protective Equipment (PPE) use and hand hygiene when cleaning resident rooms. Findings include: Review of the Facility policy titled Hand Hygiene, dated April 2015, indicated: >Alcohol hand sanitizer should be used: -after removing gloves -before entering the residents' rooms -before exiting the residents' rooms Review of the facility clinical competency for putting on (donning) and removing (doffing) PPE indicated: >sequence for removal of PPE: -Remove PPE at the doorway of the room. -after all PPE has been removed, perform hand hygiene. -perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE. On 3/24/25 at 9:18 A.M. through 9:22 A.M, the surveyor observed the following on the Greendale Unit: -Housekeeper #1 walked down the unit hallway with gloved hands, carrying two clear trash bags with refuse in both bags. -Housekeeper #1 opened the soiled utility room by entering the code on the locked door with the same gloves in place. -Housekeeper #1 disposed of the two trash bags in the soiled utility room, exited the soiled utility room and remained wearing the same gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Housekeeper #1 walked back down the hallway to her utility cart located outside of a resident room, removed a broom from the cart and entered the resident's room without removing the used gloves. -Housekeeper #1 exited the resident's room with gloved hands, carrying a trash bag in the hallway to the soiled utility room. -Housekeeper #1 handed the trash bag to another staff member standing in the doorway of the soiled utility room and returned to her utility cart, removed her dirty gloves and disposed of the dirty gloves in the trash bag on the cart. -Housekeeper #1 re-entered the same resident room without performing hand hygiene. During an interview at the time, Housekeeper #1 said she should have removed her gloves before she left the resident's room and should not be wearing the gloves in the hallway. Housekeeper #1 said she did not remove her gloves because the trash bag was wet. Housekeeper #1 said she should not have gloves on leaving a resident room and she should wash her hands before entering and exiting a resident room. During an interview on 3/25/25 at 8:18 A.M., the Infection Preventionist (IP) said Housekeeper #1 should not be walking in the hallway with gloves on. The IP further said Housekeeper #1 should not be going from room to room with the same gloves on, and not performing hand hygiene upon entering and exiting a resident's room. The IP said all the staff are educated on proper PPE use annually and given a competency exam. The IP said Housekeeper #1 should have known the right procedure for hand hygiene and proper use of PPE. The IP said Housekeeper #1 was not completing PPE or hand hygiene the proper way, based on the training provided by the facility.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on observation, and interview, the facility failed to implement an effective pest control program on three Units (Tatnuck, Greendale, and [NAME]) out of five units observed, and impacting nine Residents (#42, #97, #144, #53, #21, #85, #49, #119 and #63) on the three Units. Specifically, the facility failed to implement effective pest control measures when: -live mice were observed in Resident's rooms by the survey team for the duration of the survey. -Exterminator services were suspended when bi-weekly Exterminator visits were indicated in the facility's pest control plan and the pest control issues related to mice in the facility was not resolved. -Residents in Resident Council meetings reported ongoing mice activity. Findings include: During an interview and observation by surveyor #1 on 3/19/25 at 9:14 A.M., on the Greendale Unit, Resident #42 said that he/she saw mice nightly, in the halls and in his/her room. Surveyor #1 observed no sticky pads or mouse traps in the Resident's room. During an interview and observation by surveyor #4 on 3/19/25 at 9:19 A.M., on the Tatnuck Unit, Resident #97 said that he/she saw mice all day, everyday and he/she had to store any food in his/her room in locking plastic bins. At the same time, surveyor #4 observed a mouse crawling under the Resident's bed along the wall, behind a nightstand in the corner of the room and returned back in the same direction a moment later. Surveyor #4 did not observe any mouse traps in the Resident's room. During an interview by surveyor #2 on 3/19/25 at 9:20 A.M., on the [NAME] Unit, Resident #144 said that there were mice in the facility. During an interview by surveyor #2 on 3/19/25 9:34 A.M., on the [NAME] Unit, Resident #53 said that there were mice in the facility. During an interview by surveyor #1 on 3/19/25 at 9:47 A.M., on the Greendale Unit, Resident #21 said that he/she sees one or two mice a night when things quiet down. Resident #21 further said the building has not had sticky traps in more than a month and usually three to four mice would be caught with the sticky traps. During an interview and observation by surveyor #2 on 3/19/25 at 9:56 A.M., on the [NAME] Unit, Resident #85 said that there were mice in the facility and surveyor #2 observed a silver mouse trap in the Resident's room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation by surveyor #3 on 3/19/25 at 10:08 A.M. on the Tatnuck Unit, Resident #49 said that he/she sees mice and mice droppings in his/her room all the time. Surveyor #3 observed three black pieces of debris that looked like rodent droppings against the wall outside of the bathroom door in the Resident's room. Surveyor #3 did not observe any mouse traps in the Resident's room. During an interview by surveyor #1 on 3/19/25 at 10:08 A.M., on the Greendale Unit, Resident #119 said that he/she saw mice two to three times a week. During an interview on 3/19/25 at 9:48 A.M., the Regional Maintenance Director (RMD) said that he assessed Resident #97's room and that there is usually a mouse trap in the Resident's room. During an interview on 3/20/25 at 7:43 A.M., the RMD said that the facility is contracted with an Exterminator Company for visits every other week. The RMD said that he has a specific communication process with the Exterminator, and he utilizes a request log book which is located at the facility front desk and accessible for all staff or residents to note any observations of rodents or pests. The RMD said that there is a maintenance request log book on all of the units and he and his maintenance staff round daily to review any requests in the log books and that he is available by phone as well for any immediate issues. The RMD further said that he conducts additional rounds weekly to check for room cleanliness and that the facility has discussed concerns with clutter in resident rooms, resident food storage, and increased food and spills in the evenings when housekeeping were not available. During an interview on 3/20/25 at 8:21 A.M., the Exterminator said that he had not been in the facility since his last contracted visit in December 2024 and he was unsure if another staff from his agency had serviced the facility. The Exterminator said that he primarily uses Tin Cats as mouse trap boxes and those traps are in each resident room in addition to other traps around the perimeter of the facility. During an interview on 3/20/25 at 8:33 A.M., the front desk Receptionist said that she recognizes the Exterminator as he will review the Exterminator communication book at the front desk for any requests. The Receptionist said that she had not seen the Exterminator since December, until today. During an interview on 3/20/25 at 9:05 A.M., the RMD provided the Maintenance Weekly Rounding Logs for the Greendale, Tatnuck, and [NAME] Units, which failed to indicate any logged concerns relative to rodents or pests from December 2024 to current day for Resident's #42, #97, #53, #85, #49, and #119 rooms. The RMD said if there were observed issues or pest sightings reported by staff or residents during the weekly rounding, he would notify the Director of Nursing (DON) and the Administrator. During an interview on 3/20/25 at 9:28 A.M., the Exterminator said he had completed the consulting visit and that he usually has a total of roughly 156 tin cat traps in the facility, typically one per each resident room, and that there were about three dozen traps missing from his count. The Exterminator said the missing tin can traps would be replaced with bait stations and glue boards. During an interview and observation on the Tatnuck Unit on 3/20/25 at 10:07 A.M., Resident #63 asked if surveyor #4 wanted to see a mouse and said there was a mouse in his/her room. Surveyor #4 observed a sticky trap placed next to Resident #63's bed and nightstand with one live mouse caught in the trap. Resident #63 said that staff had just put the sticky trap in place that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225390	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parsons Hill Rehabilitation & Health Care Center	1350 Main Street Worcester, MA 01603

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Work Order Summary for General Pest Control, dated 12/27/24 indicated: >Service Frequency: Biweekly. >Service type: Regular. >14 dead mice were found at Nurses Station. >8 dead mice found in patient rooms. >20 rodent glue traps were replaced in the facility. Review of the Work Order Summary for General Pest Control, dated 3/20/25 indicated: >Service Frequency: Biweekly. >Service type: Regular. >10 dead mice were found in patient rooms. >Recommend replacing tin cats . >60 rodent glue traps were replaced in the facility. Review of the Resident Council Meeting Minutes dated 1/9/25, indicated the following: -Despite the efforts of the housekeeping staff, mice continue to be an issue in resident rooms. -Clutter, opened containers, food not put away in plastic totes, food/spills on the floor from the evening before etc . -Rounds are done weekly on all the units . -Maintenance has a contract with the Exterminator. He comes every other week and as needed. Review of the Resident Council Meeting Minutes dated 2/13/25, indicated the following: -Despite the efforts of the housekeeping staff, mice continue to be an issue in resident rooms. -This topic was discussed again. It appears some rooms are seeing more mice than others. -Maintenance has a contract with the Exterminator. He comes every other week and as needed. -This too was re-discussed with the residents. They were encouraged to report mice sightings to staff. During an interview on 3/20/25 at 9:00 A.M., the RMD said that he was not aware of any concerns about mice or pests from Resident Council meetings in January 2025 or February 2025. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/25 at 9:02 A.M., the Activities Director (AD) said that she did not initiate any Resident Council response for Maintenance about mice from the January 2025 or February 2025 Resident Council meetings, because the conversation was to minimize concerns with resident's food storage and to communicate that the facility was aware of the issues with mice. During the Resident Council Meeting on 3/20/25 at 1:00 P.M., 8 Residents from the Greendale and [NAME] units attended and indicated the following: -8 out of 8 Residents were concerned about mice in the facility. -Maintenance puts mouse traps in rooms and an Exterminator comes to the facility, but they are not sure how often. -The facility staff provided locked plastic bins to the Residents for storing food in their rooms and educated the Residents on appropriate food storage. -Residents felt the issues with mice are ongoing. During an interview on 3/20/25 at 10:39 A.M., the Administrator said that the facility had a Quality Improvement plan relative to pest control and were working to establish a new contract with a different Extermination company. The Administrator said that services with the current Extermination company were suspended for January 2025 and February 2025, and the services were re-instated on 3/19/25 at 4:00 P.M. Review of the Quality Improvement Plan titled Food and Hoarding, initiated 1/1/22 and last revised 2/1/25, indicated: -Goal was to eliminate Pests and Congestion in Rooms -Action Steps were: >To have extra treatments done by pest company as needed. >Maintenance has also bought and set traps to rid pests from resident rooms. >To keep monitoring rooms on a weekly basis for food and hoarding. >To fill any holes created by pests. September 2024: >Exterminator is still coming [every other week] and checking stations that they supply for building and inside and outside. October 2024: >Exterminator is still on an [every other week] basis and will do any extra service needed. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	November 2024: >Exterminator to check all areas for any pests and Maintenance to do any work that is needed. >Exterminator is still on an [every other week] basis and on call as needed. >Exterminator has added an extra additive with traps to kill the pests faster. -January 2025: >Maintenance has continued to audit all residents rooms weekly and report . to DON. >Maintenance is still checking all units weekly and filling any holes. >Housekeeping was cleaning all rooms on all units. They will continue to monitor and report any problems to Maintenance. -February 2025: >Maintenance is still doing weekly audits of rooms on every unit. >The Administrator has walked around the building to check and we have seen zero mice running around or in traps. >We will continue to keep Exterminator on an [every other week] basis. Review of the January 2025 Quality Improvement Plan (QAPI) Meeting Minutes provided by the facility, indicated: -Maintenance reported an increase in things being chewed through by mice. -[12/27/24] Exterminator added into the traps a new additive. -Maintenance is doing check for holes and/or mouse droppings. -Exterminator pulled out 8 mice the last time he was here, is improvement, added extra bait traps, will put in problems rooms, filling holes to keep mice out, cleaning rooms, and keeping food out as much as we can. Review of the QAPI Meeting Minutes, dated 2/20/25, provided by the facility, indicated: >Administrator continues to work on eradicating pests in the building. >Administrator walking around the building, no mice found in traps. >Exterminator every other week. >Problem rooms identified with housekeeping and maintenance. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/25 at 2:26 P.M., the RMD said when the Exterminator did not come to the facility for the anticipated January 2025 visit, the RMD contacted the Extermination company and was informed that services were suspended due to non-payment of past invoices. The RMD further said Exterminator services were re-instated yesterday 3/19/25 to allow for a visit today.