STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225392	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Health and Rehabilitation Center LLC	215 Bicentennial Highway Springfield, MA 01118

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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 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 observations, interviews and record review the facility failed to follow professional standards of practice for food safety to prevent the potential spread of foodborne illness in the main facility kitchen and on three (Unit #2, #3 and #4) of three unit kitchenettes.Specifically, the facility failed to:1.Implement control measures for monthly cleaning of the facility's ice machine located in the main kitchen, and proper storage of the ice scoop, increasing the risks for residents to develop foodborne illnesses and infections.2. ensure that food items were properly stored in the kitchenettes on Unit #2, #3 and #4 and that Unit #2 and Unit #3 kitchenettes were maintained in safe, clean, and sanitary conditions. Findings include: 1. Review of the facility's policy titled Ice, revised October 2022, indicated the following:-Ice will be prepared and distributed in a safe and sanitary manner.-The exterior of the ice machine will be cleaned weekly.-Ice bins will be cleaned monthly and as needed.-Ice scoops will be cleaned and stored in a separate container that limits exposure to dust and moisture retention. Review of the Indigo NXT Ice Machine Installation, Operation and Maintenance Manual, dated May 2022, indicated the following:-You are responsible for maintaining the ice machine in accordance with the instructions in this manual.-Clean the area around the ice machine as often as necessary to maintain cleanliness and efficient operation.-Wipe surfaces with a damp cloth rinsed in water to remove dust and dirt from the outside of the ice machine.-De-scale and sanitize the ice machine every six months for efficient operation.-The remedial de-scaling procedure de-scales all components in the water flow path and is used between bi-yearly detailed de-scaling and sanitizing procedure.-Ice machine de-scaler is used to remove lime scale and mineral deposits.-Ice machine sanitizer disinfects and removes algae and slime. On 12/3/25 at 7:25 A.M., the surveyor observed the following in the facility's main kitchen:-The ice machine with the lid closed.-The ice scoop was stored on the top of the ice machine (not in a separate container).-The Ice Machine Cleaning Log was posted on the outside of the ice machine.-The Ice Machine Cleaning Log indicated boxes for each month of the year.-The Cleaning Log indicated the last time the ice machine was cleaned was on 9/7/25.-The boxes on the Cleaning Log for the months of October 2025, November 2025, and December 2025 were blank.The surveyor placed their hand on the top of the ice machine (where the ice scoop was stored) and slid their fingertips approximately six inches along the top of the machine. When the surveyor removed their hand dry, brown, dusty debris was observed on their fingertips. During an interview on 12/3/25 at 8:20 A.M., the Food Service Director (FSD) said that the ice machine observed by the surveyor in the main kitchen was new and that the facility had received it a few months ago. The FSD said the ice scoop was stored on top of the ice machine because when the ice machine was delivered, it did not come with a separate bin for storing the ice scoop. The FSD also said that the ice machine's ice bin was supposed to be cleaned monthly and that the outside of the ice machine was supposed to be cleaned as needed to ensure that it was free of dust and dirt. During an interview on 12/5/25 at 10:15 A.M., the District FSD said that the ice machine was supposed to be cleaned monthly. The District FSD said that monthly cleaning included emptying the ice bin, cleaning the flap (door that covers the ice bin), gasket, and the ice bin. The District FSD said monthly cleaning targeted the ice bin, flap and gasket because those areas were breeding grounds for bacterial growth and could cause (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	illness. The District FSD said the ice machine in the facility's main kitchen was the only ice machine in the facility and that keeping the ice machine clean was important to reduce the risk of illness for the residents. During an interview on 12/9/25 at 8:59 A.M., the FSD said the ice from the ice machine in the main kitchen was used to keep medication carts and beverage carts drinks cold and was also used for resident consumption. 2. Review of the facility policy titled Food Receiving and Storage, revised 2014, included but was not limited to the following: -Foods shall be .stored in a manner that complies with safe food handling practices. -Food Services, or other designated staff, will maintain clean food storage areas at all times. -Uncooked and raw animal products will be stored in drip proof containers. -Food items and snacks kept on the nursing units must be maintained as below: >All food items to be kept below 41 degrees Fahrenheit (F) must be placed in the refrigerator located in the nourishment kitchens (kitchenette) labeled with use-by date within 3 days. >All foods belonging to residents must be labeled with the resident's name, the item and the use by date. >Beverages must be dated when open and discarded after twenty-four (24) hours. >Other opened containers must be dated and sealed or covered during storage. Review of the facility's policy titled Environment, revised 9/2017, included but was not limited to the following: -All food preparation areas, food service areas .will be maintained in a clean and sanitary condition. >All food contact surfaces will be cleaned and sanitized after each use. On 12/9/25 at 8:23 A.M. through 8:33 A.M., the surveyor observed the following in facility kitchenettes:Unit #2 kitchenette: In the refrigerator: >McDonald's plastic cup containing a straw and clear liquid that was unlabeled and undated. >Two raw hamburger patties dated 9/6/25, unlabeled in the refrigerator (not in a leak proof container). In the microwave oven: >Flaking rusted areas on the inside of the oven door and on the inner cabinet casing. Unit #3 kitchenette: In the upper left sided kitchenette cabinet: >Uncle Ben's Street Food microwaveable meal, with use a by date of 10/10/25. >One uncovered container of unwrapped peppermint herbal tea bags, with a use by date of 7/2/21. >One open and undated gallon of spring water, approximately 1/4 full. In the refrigerator freezer: >A thick layer ice covering the floor of the freezer casing that contained blue, brown and yellow particles. Unit #4 kitchenette: On the left side of the food service area, below the microwave oven: >An area of splattered, dried, brown substance on the countertop, inside the top drawer and down the length of the cabinet surfaces. Inside the microwave oven: >Red/brown substance containing rice pieces that was crusted along the floor of the microwave casing. Inside the refrigerator: >One covered bowl containing a pale yellow, soft product with a resident name, dated 12/5/25. >One covered bowl of red liquid, unlabeled and dated 12/5/25. >One clear produce bag containing green grapes with a resident's name, undated. During an interview on 12/9/25 at 8:59 A.M., the Food Service Director (FSD) said the Dietary Aides clean, restock and discard outdated food/liquids for all facility kitchenettes twice a day at 6:30 A.M., and 4:30 P.M. The FSD said cleaning and restocking should include the refrigerator, freezer, microwave, cabinets and surfaces and cleaning involved the use of a sanitizer product and clean rags twice a day. The FSD further said all facility staff were responsible to clean up food and liquid spills when they occur and there was no scheduled defrosting or preventative maintenance for the unit refrigerators/freezers at this time. The FSD said all food brought in from outside sources should be labeled with the date received and the resident's name and prepared food and liquids that are three days after being placed in the refrigerator should be discarded during the 6:30 A.M. rounds by Dietary staff. On 12/9/25 at 9:48 A.M. through 9:58 A.M., the surveyor and the District Manager of Dining Services observed all the Unit kitchenettes. During an interview at the time, the District Manager of Dining Services said all the findings observed by the surveyor were a concern but fixable. The District Manager of Dining Services said all facility staff are responsible to ensure that food items and beverages were labeled with a resident's name, dated, and discarded on time and all stored food items should be covered. The District Manager of Dining Services said prepared foods and open liquids should be discarded on day three of morning rounds by the Dietary department and she had a concern with foods that were kept after the best by date. The District Manager of Dining Services said microwave rust could chip off and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	flake into resident's food and then be consumed. The District Manager of Dining Services further said frozen blue, brown and yellow particles in the freezer could be food or plastic pieces and raw meat should be stored in a leak proof container and not be in the unit kitchenettes. The District Manager of Dining Services also said all staff should be cleaning up spills and food debris between Dietary Aide visits on the units and expired foods could cause illness for the facility's vulnerable population. During an interview on 12/9/25 at 1:54 P.M., the Administrator said the rusty microwave had been reported during morning rounds a few weeks ago but was unable to recall the exact date. The Administrator said the microwave should have been taken out of use when the concern had been identified. During an interview on 12/9/25 at 2:00 P.M., the Infection Preventionist (IP) said that all food items should be covered, labeled and dated and surfaces kept clean in all of the unit kitchenettes. The IP said that outdated foods and dirty surfaces could cause illness like Salmonella (bacteria that can cause foodborne illness) to the residents in the facility.

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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. Based on observations, interviews, and records review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections in the facility main laundry area, and on one unit (Unit #2) out of three resident units.Specifically, the facility failed to:1. Ensure that laundry personnel in the main facility laundry room wore the indicated Personal Protective Equipment (PPE-items such as gowns and gloves worn by staff to decrease the spread of infections) when sorting dirty laundry and linens soiled with feces.2. Ensure that facility staff followed appropriate hand hygiene standards on Unit #2 when: -Certified Nurse Aide (CNA) #1 failed to perform handwashing procedure while entering and exiting individual resident rooms with Enhanced Barrier Precautions (EBP) signage posted and clearly visible at the doorway of the resident rooms. -CNA #1 failed to perform handwashing procedure after the removal of gloves and after providing high contact resident care. Findings include: 1. Review of the facility policy titled Personal Protective Equipment Guidelines, revised 12/12/12, included but was not limited to: >Personal Protective Equipment (PPE: items such as gowns and gloves worn to prevent the spread of infection) was provided to our employees at no cost to them. Training is provided in the use of the appropriate PPE for the tasks or procedures that employees will perform. The facility is responsible to clean, maintain, and/or dispose of PPE. Home laundering is not permitted. -Employees of other companies working in the facility must wear PPE when occupational exposure may occur. -Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or other potentially infectious materials (OPIM) pose a hazard to the eye, nose or mouth. -Remove immediately or as soon as feasible any garment contaminated by blood or OPIM, in such a way as to avoid contact with outer surface. Review of the facility policy titled Laundry Handling Practices, revised 12/12/12, included but not limited to: >Proper handling of linen and laundry will reduce the likelihood of recontamination. -Use Standard Precautions (basic infection practices used in healthcare for all patient's, at all times, to prevent the spread of infections from both known and unknown sources) in the handling of all soiled laundry. Wear protective gloves and other appropriate PPE when having contact with contaminated laundry. -Handle contaminated laundry as little as possible, with minimal agitation. Review of the facility policy titled Standard Precautions, dated 3/8/20, included but was not limited to: -Standard precaution includes a group of infection prevention practices that apply to all residents regardless of the suspected or the confirmation infection status. These practices include the use of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves, gowns, masks, eyewear, or face shields. The choice of PPE is dependent upon the anticipated exposure. It also includes equipment or personnel items that have been handled by a resident and thus require PPE to avoid potential transmission of pathogens. <All resident blood, body fluids, excretions and secretions other than sweat will be considered potentially infectious. <Standard precautions will be used on all residents. -Appropriate PPE (personal protective equipment) will be utilized using the guidelines below. Hand hygiene should take place before and after donning any PPE. <Mask and eyewear (or face shields) - should be worn during procedures that are likely to generate droplets/splashing or blood or body fluids. <Gown/Aprons (fluid resistant) - should be worn when there is potential for soiling clothing with blood/body fluids. <Hand washing/hand hygiene - should take place after glove removal and must take place according to policy and procedure regardless of the employee's perception of how his or her hands are. On 12/4/25 at 1:02 P.M., the surveyor observed the following with Laundry Personnel #1 and #2 in the facility main laundry room: -No evidence of PPE supplies present in the dirty linen sorting room. During an interview at the time, Laundry Personnel #1 said laundry staff kept PPE that were not stored in the dirty linen sorting room. Laundry Personnel #1 said he did not know where PPE should be stored. -The surveyor observed a non-operational sink in the dirty linen sorting room. There was a blue cloth, a plastic wrapper inside the sink, a small red and white box labelled drywall screws and a paint brush on the countertop and brown dust in and around the edges of the sink. -No evidence of a paper towel dispenser or trash container was located near the hand washing sink in the dirty linen sorting room. -An empty box labeled hand gloves was observed on a large table in the dirty linen sorting room with individually bagged linens and clothing in a clear plastic bag. During an interview at the time, Laundry Personnel #2 said that PPE was not available in the dirty linen sorting room but was located down the hallway in the clean linen room. Laundry Personnel #2 further said that laundry personnel typically use the sink located in the washing room to perform hand hygiene prior to sorting dirty linens. On 12/4/25 at 3:00 P.M., the surveyor observed Laundry Personnel #2 in the dirty linen sorting room and a large grey bin next to Laundry Personnel #2 with linens that included towels soiled with feces. Laundry Personnel #2 was not observed to be wearing a gown or face shield at the time. The surveyor failed to observe evidence of available PPE supplies in the dirty linen sorting room. During an interview at the time Laundry Personnel #2 said that she should have worn PPE such as a gown and eye protection when sorting the dirty linens to prevent transferring germs and pathogens into her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clothing and/or splashes from the towels soiled with fecal matter. During an interview on 12/4/25 at 3:13 P.M., the Director of Nursing (DON) said that laundry personnel should don PPE when sorting soiled linens in the dirty linen sorting room to prevent the transfer of pathogens on staff clothing and transmission of pathogens to staff. The DON also said that the dirty room in the main laundry department should have appropriate supplies of PPE and a functional sink with paper towel and trash container for staff use. 2. Review of the facility policy titled Hand Hygiene, dated 3/8/20, included but was not limited to: >It is the policy of this facility that staff will perform hand hygiene as a means of cleaning hands by using either soap and water, (hand washing) or antiseptic hand rub (Alcohol-based hand Rub - ABHR). -To decrease the risk of transmission of infection. <Alcohol based hand sanitizers are the most effective product for reducing the number of germs on the hands and is the preferred method of cleaning the hands in most clinical situations. <Soap and water are appropriate for use whenever hands are visibly dirty, before eating, and after using the restroom. -Guidelines for decision of use ABHR or Soap and water during routine patient care: <Immediately before touching a patient. <After touching a patient or the patient's immediate environment. <After contact with blood, body fluids or contaminated surfaces. -Immediately after glove removal. On 12/4/25 at 11:30 A.M., the surveyor observed the following: -CNA #1 entered and exited individual resident rooms with Enhanced Barrier Precautions (EBP-measures using protective barrier gowns and gloves as an infection control intervention designed to reduce transmission of multi-drug-resistant organisms [MDRO] during high contact resident care) signage posted outside the rooms without performing hand hygiene prior to or upon exit from the residents' rooms. -CNA #1 entered a resident room with EBP signage posted, without performing hand hygiene, assisted the resident with incontinent care and exited the room. -CNA #1 was observed to assist another resident with EBP signage posted, along with a second staff member to transfer into a wheelchair using a mechanical lift, then exited the room after the resident was transferred without performing hand hygiene. During an interview on 12/4/25 at 11:55 A.M., CNA #1 said that she did not complete hand hygiene because she was just entering and exiting the rooms and was not providing any ADL care for the residents. CNA #1 said she thought she used the ABHR, but she might not have. CNA #1 said she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have used the ABHR to clean her hands when entering and exiting resident rooms to prevent the spread of infection. During an interview on 12/4/25 at 1:33 P.M., Unit Manager (UM) #2 said that staff should use ABHR when entering and exiting a resident's room. UM #2 said that staff might unintentionally touch a doorknob and/or the bathroom stall while in the residents' room and might not be aware. UM #2 further said that the use of ABHR when staff enter and exit a resident room prevents the spread of germs and infections.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to provide necessary care and services in a timely manner, consistent with Residents' needs and choices, to improve the Resident's ability to carry out activities of daily living (ADLs) relative to mobility for one Resident (#10) out of a total sample of 21 residents. Specifically, the facility failed to respond to Resident #10's request to be assessed for the use of a walker and the ability to walk when: -The Resident used a wheelchair for mobility. -The Resident reported improved abilities to move his/her legs. -The Resident requested therapy services to address his/her ability to stand and use a walker. Findings include: Review of the facility policy titled Functional Impairment - Clinical Protocol, dated 2001 and revised September 2012, indicated the following: - . periodically during a resident's stay, .staff will assess the resident's physical condition and functional status. - Staff will monitor . the resident's functional progress, both while receiving therapy and in general while on the unit. Review of the facility's ADL Policy, dated 12/22/21 and reviewed December 2022, indicated the following: -The facility will ensure a resident is given the appropriate treatment and services to . improve his or her ability to carry out the ADLs. -Care and services for ADLs included mobility. Resident #10 was admitted to the facility in May 2020 with diagnoses including Chronic Pain Syndrome, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Lymphedema, Muscle Wasting and Atrophy, and Abnormality of Gait and Mobility. Review of the Minimum Data Set (MDS) Assessment, dated 8/23/24, indicated Resident #10: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. -required partial/moderate assistance to complete sitting to standing. -required partial/moderate assistance to complete transfers to and from the bed/chair/toilet. Review of Resident #10's clinical record indicated the Resident's most recent Physical Therapy intervention had been provided from 9/25/24 through 11/22/24 and was discontinued 11/26/24. Review of the Physical Therapy Discharge summary, dated [DATE], indicated Resident #10: -required partial/moderate assistance for transfers to and from the bed and chair. -goal for marching in place was discontinued due to the Resident's inability to clear his/her foot in standing. -status for walking was not applicable. Review of Resident #10's Care Plan Conference Record, dated 9/4/25, indicated the Resident inquired about Rehabilitation Services, standing, and use of a walker. Review of Resident #10's Social Service Progress Note, dated 9/4/25, indicated the following:-A care plan meeting was held with the Resident on 9/4/25.-The Resident expressed interest in restarting Physical Therapy. Review of Resident #10's ADL Care Plan, revised 9/4/25, indicated: . initiate Rehab (Rehabilitation) Screen PRN (as needed). Review of the MDS Assessment, dated 11/24/25, indicated Resident #10: -was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15 total possible points. -had no upper extremity and lower extremity range of motion impairments. -used a motorized wheelchair independently. -performed transfers to and from the bed/chair/toilet with supervision or touching assistance. -did not receive any Rehabilitation Therapies during the observation period for the MDS Assessment. Review of Resident #10's clinical record failed to indicate any evidence the Resident had been assessed by Rehabilitation Services since the Resident's inquiry on 9/4/25. On 12/3/25 at 10:58 A.M., the surveyor observed Resident #10 mobilizing through the hallway in a motorized wheelchair without any assistance from staff. During an interview on 12/3/25 at 11:05 A.M., Resident #10 said he/she had problems with his/her legs due to weakness and Lymphedema which had caused him/her difficulty moving his/her legs on his/her own. Resident #10 said that he/she felt he/she had made improvements with his/her legs and could now lift them up into bed on his/her own. Resident #10 said that he/she was feeling stronger than he/she had in the past and that he/she wanted to try standing with a walker and eventually see if he/she could walk. Resident #10 said that he/she was not currently able to walk and (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required the use of his/her motorized wheelchair for independence with mobility. Resident #10 further said, I don't want to keep sitting in this chair. Resident #10 also said that he/she had inquired about having therapy several months prior and did not know why it was taking so long to be seen by someone from the Rehabilitation Department. During an interview on 12/4/25 at 12:20 P.M., the Rehabilitation Director said Resident #10 had not used a walker or walked for a very long time. The Rehabilitation Director said that although residents' statuses could change over time, use of a walker was not appropriate and safe for Resident #10. The Rehabilitation Director said if a resident required an assessment that involved gait training, the assessment would be completed by the Physical Therapist. The Rehabilitation Director said that Resident #10 had not been assessed by the Physical Therapist since the Resident's request on 9/4/25. During an interview on 12/4/25 at 1:50 P.M., the Rehabilitation Director said she had spoken with the Resident following the surveyor's inquiry and that the Resident felt he/she was stronger now and would be able to stand with a walker. The Rehabilitation Director said that the Resident expressed the desire to work on standing and progress to walking. The Rehabilitation Director said that a Physical Therapy Evaluation was now scheduled for the following date (12/5/25). During an interview on 12/5/25 at 2:40 P.M., the Physical Therapist (PT) said that he had not been alerted to the Resident's request to be assessed for the use of a walker and potential for walking until 12/4/25 (following the surveyor's inquiry). The PT said he was going to assess the Resident that same day to determine whether the Resident would benefit from Physical Therapy services. Review of the Physical Therapy Evaluation, dated 12/5/25, indicated Resident #10: -was being evaluated after being referred for gait training. -referral was prompted because the Resident verbalized interest in pursuing goals to be able to ambulate on the unit. -stated, I want to be able to move around with a walker. -was able to ambulate two feet with moderate assistance. -A treatment plan was developed for the Resident to receive Physical Therapy services. -Goals were developed and included but were not limited to gait training. -rehabilitation potential was good. During an interview on 12/9/25 at 8:45 A.M., the Social Worker (SW) said if a resident expressed a desire for rehabilitation services during a care plan meeting, the SW would verbally notify the Rehabilitation Director. The SW said that there was no formal communication in place to alert the Rehabilitation Director when a resident requested rehabilitation services. During an interview on 12/9/25 at 9:30 A.M., the Rehabilitation Director said when a staff member referred a resident for rehabilitation services, the staff member was supposed to complete a written Rehabilitation Referral Form, and that the referral forms were kept on all units. The Rehabilitation Director said she had never received a written rehabilitation referral relative to Resident #10's 9/4/25 request. The Rehabilitation Director said that Resident #10 was evaluated by the PT on 12/5/25 (three months after the Resident's request for rehabilitation services) and would now be receiving Physical Therapy services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one Resident (#14) out of a total sample of 21 residents was provided assistance with personal hygiene care and services. Specifically, the facility failed to ensure that Resident #14 was offered and/or provided grooming assistance timely for nail care when the Resident required total dependence of staff for hygiene, bathing, and dressing. Findings include: Review of the facility policy for Activities of Daily Living (ADLs - basic self-care tasks that individuals perform daily to maintain their health and well-being), last reviewed 12/2022, indicated:-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. -The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. -the facility will provide care and services for the following activities of daily living:a. Hygiene- bathing, dressing, grooming, and oral care b. Mobility- transfer and ambulation, including walkingc. Elimination- toileting and incontinent care 1. Resident #14 was admitted to the facility in June 2024 with diagnoses including Parkinson's Disease, Dementia, left hand contracture and lack of coordination. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #14:-was unable to complete the Brief Interview of Mental Status (BIMS) examination and had severely impaired cognitive skills for daily decision making. -had no behaviors. -required substantial/maximal assistance with personal hygiene including grooming needs. Review of Resident #14's ADL care plan, last revised 9/25/25, indicated:-the Resident will receive assistance with ADLs due to impaired mobility.-goal: Resident will remain clean and free of body odor, well-groomed and well-nourished with assistance. -grooming: Resident required assisted care of one staff for all grooming. Review of Resident #14's November 2025 and December 2025 Nursing Progress Notes failed to indicate that the Resident had refused care relative to grooming and/or personal hygiene. Review of Resident #14's December 2025 Medication Administration Record (MAR) failed to indicate that the Resident exhibited any documented behaviors from 12/1/25 to 12/8/25. Review of Resident #14's Visual/Bedside Kardex Report dated 12/8/25, indicated that the Resident requires assisted care of one staff for all grooming. Review of Resident #14's Task List Report dated 12/8/25 and initiated 6/12/24, indicated that the Resident receives personal hygiene/grooming from a Certified Nurse's Aide (CNA) every day and every shift. On 12/3/25 at 9:03 A.M., the surveyor observed Resident #14 sitting up in bed. The surveyor observed that the Resident's fingernails were approximately 1/8 inch long and had a dark brown substance and food debris underneath the fingernails on both hands. During an interview on 12/3/25 at 2:33 P.M., Resident #14's Healthcare Proxy (HCP) said that he/she visits the Resident once a week in the facility and was concerned that the Resident's fingernails were long and dirty and would like his/her fingernails to be cleaned and trimmed because it is unhygienic. On 12/4/25 at 1:09 P.M., the surveyor observed Resident #14 sitting up in bed watching television while eating lunch with his/her hands. The surveyor observed that the Resident's fingernails remained untrimmed and had a dark brown substance and food debris underneath the nails of both his/her hands. On 12/8/25 at 8:41 A.M., the surveyor and Nurse #4 observed Resident #14 sitting up in bed eating breakfast with his/her hands. The surveyor and Nurse #4 further observed that the Resident's fingernails had a dark brown substance and food debris underneath the fingernails. During an interview at the time, Nurse #4 said that the Resident's fingernails were dirty, had not been cleaned and should have been cleaned daily because it could potentially become an infection control concern for the Resident. On 12/8/25 at 8:52 A.M., the surveyor and CNA #2 observed Resident #14 sitting up in bed eating breakfast in his/her room. During an interview at the time, CNA #2 said that the Resident's fingernails were dirty, did not appear to have been cleaned and should have been. CNA #2 also said that Resident's fingernails should be groomed daily or when they are observed to be soiled.

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	225392	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sixteen Acres Health and Rehabilitation Center LLC	215 Bicentennial Highway Springfield, MA 01118

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to ensure that a Physician ordered pain medication was available to be administered for one Resident (#4) out of a total sample of 21 residents.Specifically, for Resident #4, the facility failed to ensure that Morphine Sulfate (pain medication) was available to be administered to the Resident every four hours as ordered by the Physician, over six consecutive opportunities, for two consecutive days. Findings include:Review of the facility pharmacy policy titled Provider Pharmacy Requirements, effective June 2020, indicated:-The provider pharmacy is responsible for rendering the required services in accordance with local, state and federal laws and regulations; facility policies and procedures; community standards of practice; and professional standards of practice. Review of the facility policy titled Medication and Treatment Orders, reviewed June 2022 indicated:-Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in the state. Resident #4 was admitted to the facility in November 2025 with diagnoses including pressure ulcer of the sacrum, and aphasia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #4 was unable to complete a Brief Interview for Mental Status (BIMS) as evidenced by a score of 99 entered on the MDS assessment. Review of the active Physician orders dated 12/8/25, indicated:-Morphine Sulfate Oral Solution 10 mg (milligrams) per 5 ml (milliliters), Give 10 mg/5 ml via G-tube (gastrostomy tube: a flexible tube placed through the abdomen directly into the stomach used for long term nutrition, fluids and medications) every four hours for [pressure ulcers] pain management. Review of the December 2025 Medication Administration Record (MAR) indicated:-Morphine Sulfate Oral Solution was scheduled to be administered at 1:00 A.M., 5:00 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M.Further review of the December 2025 MAR failed to indicate the scheduled Morphine Sulfate Oral Solution was administered as ordered on:>12/7/25 at 1:00 P.M., 5:00 P.M., and 9:00 P.M.>12/8/25 at 1:00 A.M., 5:00 A.M., and 9:00 A.M. Review of the eMAR (electronic) Medication Administration Record notes documented after the medication was due to be administered indicated the following: -12/7/25 at 2:48 P.M., Morphine Sulfate Oral Solution 10 mg/5 ml medication on order. -12/7/25 at 9:30 P.M., Morphine Sulfate Oral Solution 10 mg/5 ml medication not given, medication not available, waiting for delivery from pharmacy.-12/8/25 at 12:30 A.M., Morphine Sulfate Oral Solution 10 mg/5 ml medication not given, medication not available, waiting for delivery from pharmacy.-12/8/25 at 5:30 A.M., Morphine Sulfate Oral Solution 10 mg/5 ml medication not given, medication not available.-12/8/25 at 9:06 A.M., Morphine Sulfate Oral Solution 10 mg/5 ml, hold pending arrival, may give when available. On 12/4/25 at 8:52 A.M., Resident #4 was observed lying in bed and awake, with the head of bed elevated. Resident #4 was observed to be non-responsive to the surveyor's prompts at conversation. On 12/4/25 at 1:17 P.M., Resident #4 was observed lying in bed and asleep, with visitors present at his/her bedside.On 12/8/25 at 8:07 A.M., Resident #4 was observed lying in bed, eyes closed, with the head of bed elevated. During an interview on 12/8/25 at 10:10 A.M., the surveyor, Unit Manager (UM) #3, and Nurse #2, reviewed Resident #4's December 2025 MAR. UM #3 said that the MAR indicated that Resident #4 had not received Morphine Sulfate Oral Solution as ordered for the past six scheduled doses. Nurse #2 said that the medication had not been administered because it was not available from the pharmacy. Nurse #2 further said when the pharmacy was notified that the Morphine Sulfate medication was needed, the pharmacy staff indicated that the medication would be delivered with the next pharmacy delivery. Nurse #2 also said that pharmacy medication delivery issues are ongoing for Resident #4's Morphine Sulfate Oral Solution. Both UM #3 and Nurse #2 were unsure if the pharmacy medication issues had been reported to the Administrator.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, and interview, the facility failed to ensure that medications were stored according to professional standards of practice for one unit (4th floor) out of three total units. Specifically, for the 4th floor unit, the facility failed to: -ensure that a controlled substance medication was stored in a safe and secure compartment for controlled substances and/or other drugs subject to abuse inside the medication cart, when an Oxycodone tablet was found in a medication cup during a medication cart observation. -ensure that a controlled substance medication that was refused by a resident was appropriately destroyed and not left unlabeled and accessible in the medication cart with the potential of being diverted or accidentally administered to a resident. Findings include: Review of the facility policy titled Storage of Medications, dated 10/1/19, included but was not limited to:>Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medication to the original container. -All medications dispensed by the pharmacy are stored in the container with the pharmacy label.-Disposal of any medications prior to the expiration date will be required if contamination or decomposition is apparent. Review of the facility policy titled Controlled Substance Storage, dated 10/1/19, included but was not limited to:>Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. -Schedule II - V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double locked compartment separate from all other medications or per state regulation. -The access system to controlled medications is not the same as the system giving access to other medications (the key that opens the compartment is different from the key that opens the medication cart). -If a key system is used, the medication nurse on duty maintains possession of the key to controlled substance storage area. Back-up keys to all medication storage areas, including those for controlled substances, are kept by the director of nursing (DON) or designee. Review of the facility policy titled Controlled Substance Disposal, dated 10/1/19, included but was not limited to:>Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. -When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record/book on the line representing that dose. -The administrator, nurses and or pharmacists witnessing the destruction ensures that the following information is entered on the individual controlled substance accountability record/book:<Date of destruction<Resident's name <Name and strength of medication<Prescription number<Amount of medication destroyed<Signatures of witnesses -Accountability records for controlled substances that are disposed of/or destroyed are maintained with the unused supply until it is destroyed or disposed of and then stored for 5 years or per applicable law or regulation. On 12/5/25 at 9:53 A.M., during a medication cart observation with Nurse #3 on the 4th floor unit, the surveyor observed the following: -Nurse #3 opened the medication cart and stepped to the side of the medication cart.-The surveyor opened the top drawer of the medication cart to observe the contents of the medication cart. -Nurse (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#3 then picked up an unknown item from the top drawer of the medication cart and held the item behind her back. -When the surveyor asked to see the removed item, Nurse #3 presented a plastic medication cup with a small round white tablet inside the cup. During an interview at the time, Nurse #3 said the round white tablet inside the plastic medication cup was an Oxycodone (opioid analgesic, classified as Schedule II-controlled substance) tablet, that a resident had refused earlier in the day. Nurse #3 said that the Oxycodone tablet should have been destroyed with another Nurse immediately when the resident had refused the Oxycodone tablet, but it was not destroyed. Nurse #3 said ensuring the controlled substance medication was destroyed immediately and appropriately prevents medication errors and accuracy of the controlled substance count. During an interview on 12/5/25 at 12:30 P.M., Unit Manager (UM) #1 said the Oxycodone tablet should have been placed in the sharps container that is sealed for safety to prevent residents and other staff members from gaining access to the medication. UM #1 said when a resident refused to take a controlled substance medication, the expectation for nursing staff was that the Nurse should seek another Nurse and immediately dispose of the medication in the sharps container to ensure other staff members do not have access to the medication for safety. UM #1 said that the risk of the Nurse leaving the controlled substance medication inside the medication cart that was not double locked was that the Nurse might forget the medication and/or administer the medication to another resident. UM #1 said failing to properly destroy the medication can affect the controlled substance medication count. During an interview on 12/5/25 at 2:35 P.M., the Director of Nursing (DON) said when controlled substance medications were refused by residents, the controlled substance medication should be immediately destroyed and disposed of into the sharps container for safety to prevent other residents in the facility and staff members access to the medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility to ensure that medical records were complete and accurate for one Resident (#4) out of a total sample of 21 residents. Specifically, for Resident #4, the facility staff failed to provide documentation that the Provider was notified when the Resident's Morphine Sulfate Oral Solution was not available to be administered as ordered placing the Resident at risk of not having pain appropriately managed. Findings include: Review of the facility policy titled Medication and Treatment Orders, reviewed June 2022 indicated the following:-Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in the state. Review of the facility policy titled Change in Resident's Condition or Status and Notification, reviewed June 2022 indicated the following:-The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician, Physician Assistant (PA) or on-call Physician when there has been a significant change in the resident's medical/mental conditions or status including but not limited to a need to alter the resident's medical treatment significantly. Resident #4 was admitted to the facility in November 2025 with diagnoses including pressure ulcer of the sacrum, and aphasia. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #4 was unable to complete a Brief Interview for Mental Status (BIMS) assessment as evidenced by a score of 99 entered on the MDS assessment. Review of the active Physician orders dated 12/8/25, indicated:-Morphine Sulfate Oral Solution 10 mg (milligrams) per 5 ml (milliliters). Give 10 mg/5 ml via G-tube (gastrostomy tube: a flexible tube placed through the abdomen directly into the stomach used for long term nutrition, fluids and medications) every four hours for pain management [of sacral pressure ulcer]. Review of the December 2025 Medication Administration Record (MAR) indicated that the prescribed Morphine Sulfate Oral Solution was scheduled to be administered at the following times daily: 1:00 A.M., 5:00 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M.Further review of the December 2025 MAR failed to indicate that Resident #4's scheduled Morphine Sulfate Oral Solution was administered as ordered on:-12/7/25 at 1:00 P.M., 5:00 P.M., and 9:00 P.M. (3 doses)-12/8/25 at 1:00 A.M., 5:00 A.M., and 9:00 A.M. (3 doses) Review of the eMAR medication administration record indicated the following notes documented after the missed medication times:-12/7/25 at 2:48 P.M., Morphine Sulfate Oral Solution 10 mg/ 5 ml on order, PA [said] ok [okay] to give on arrival.-12/7/25 at 9:30 P.M., Morphine Sulfate Oral Solution 10 mg/ 5 ml not given, medication not available, waiting for delivery from pharmacy (no documentation that Provider was contacted)-12/8/25 at 12:30 A.M., Morphine Sulfate Oral Solution 10 mg/ 5 ml not given, medication not available, waiting for delivery from pharmacy (no documentation that Provider was contacted)-12/8/25 at 5:30 A.M., Morphine Sulfate Oral Solution 10 mg/ 5 ml not given, medication not available (no documentation that Provider was contacted)-12/8/25 at 9:06 A.M., Morphine Sulfate Oral Solution 10 mg/ 5 ml, hold pending arrival, may give when available, PA aware.Further review of the eMAR Medication Administration documentation and Nursing Progress Notes failed to indicate that the Physician/PA had been notified that Resident #4 had not been administered Morphine Sulfate Oral Solution as ordered on 12/7/25 at 5:00 P.M., and 9:30 P.M., and 12/8/25 at 12:30 A.M., and 5:30 A.M. During an interview on 12/8/25 at 10:10 A.M., the surveyor, Unit Manager (UM) #3, and Nurse #2 reviewed Resident #4's December 2025 MAR and UM #3 said that the MAR indicated that Resident #4 had not received Morphine Sulfate Oral Solution as ordered for the past six scheduled doses. Nurse #2 said that the medication had not been administered because it was not available from the pharmacy. UM #3 and Nurse #2 were unsure if the pharmacy medication issues had been reported to the Administrator. UM #3 further said that she was unsure if the Physician/PA had been notified of the missed medication doses and that there should have been a progress note written or documentation on the MAR that indicated the Physician/PA had been notified of the missed medication doses.

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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 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. Based on interviews, and records review, the facility failed to refer one Resident (#3) out of a total sample of 21 residents to the PASRR office when the Resident experienced a significant change in status assessment.Specifically, the facility failed to refer Resident #3 to the PASRR office when the Resident:-had a previous negative PASRR screening for serious mental illness (SMI).-expressed a wish to commit suicide.-required modification to his/her care plan relative to his/her suicidal statement.-required antipsychotic medication that was previously discontinued to be re-ordered and administered following his/her suicidal statement. Findings include: Review of the facility policy titled PASRR, dated 11/1/21 and last reviewed 2023, indicated the following: -When an individual who resides in a nursing facility has experienced a significant change or the individual is newly identified as having a condition that may impact the individual's PASRR disability status, the appropriateness of the individual's nursing facility placement, or the individual's need for specialized services, the facility must submit an updated PASRR Level I Screening Form to the appropriate PASRR office. -In all instances, the nursing facility must request a resident review from the PASRR office no later than the next business day following the date in which the facility detects that the member: -experienced a significant change; or -is newly identified as having a condition that may impact the individual's PASRR disability status, the appropriateness of the individual's nursing facility placement, or the individual's need for specialized services. Resident #3 was admitted to the facility in March 2023 with diagnoses including Intracranial Injury with loss of consciousness, Depression, and Anxiety. Review of the Level I PASRR Screening, completed 3/9/23, indicated Resident #3: -had a mood disorder. -had severe anxiety/panic. -had not required any of the listed treatments or interventions within the previous two years due to mental illness or disorder (MI/D). -had not experienced limitations in major life activities in at least one of three areas listed (interpersonal functioning, concentration, adaptation to change) due to MI/D either currently or within the previous six months. -had a negative screen for serious mental illness (SMI). -was not indicated for a Level II PASRR evaluation due to no diagnosis or suspicion of SMI. Review of the Minimum Data Set (MDS) Assessment, dated 7/24/25, indicated Resident #3: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15 total possible points. -received antipsychotic medication. -had no upper extremity (shoulder, wrist and hand) range of motion impairments. -required set up and clean up assistance for eating. Review of Resident #3's August 2025 Physician orders indicated the following: -Risperidone Oral Tablet 0.25 milligrams (mg), give one tablet by mouth two times a day for Psychosis, dated 8/3/25. -An order dated 8/14/25 and discontinued 8/21/25, for Risperidone Oral Tablet 0.25 mg, give one tablet by mouth in the evening for Psychosis until 8/21/25. Review of the Behavioral Health Provider Note, dated 9/11/25, indicated Resident #3: -chief complaint was insomnia. -target symptoms included insomnia, inappropriate sexual behaviors, agitation, and aggression. -was being seen for routine follow-up. -had experienced a recent loss of a sibling. -history of suicidal ideation (SI) was unknown. -Risperdal had been recently discontinued. -mood was stable. Review of Resident #3's Clinical Nurses Note, dated 9/16/25, indicated the Resident stated intention to commit suicide with use of a butter knife or by any means necessary. Further review of the Clinical Nurses Note indicated the following: -No sharp objects near Resident. -One to one (1:1) supervision provided. -The Resident was evaluated by a Crisis Clinician. -The on-call Provider ordered 15-minutes checks to be completed for the Resident and to transfer the Resident to the emergency department if suicidal ideations continued. Review of Resident #3's Physician order, dated 9/17/25, indicated:-Risperidone Oral Tablet 0.25 mg, give 0.25 mg by mouth every evening shift related to irritability and anger, and violent behavior. Review of Resident #3's Clinical Nurse Note, dated 9/18/25, indicated: -The Physician recommended for the Resident to transfer to a psychiatric facility to address medications and the Resident's Depression. -The Resident's Legal Guardian declined the (continued on next page)

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	hospital transfer. -The Resident was to continue to have psychiatric services provided at the facility. Review of Resident #3's clinical record failed to indicate any evidence that Resident #3 had been referred to the PASRR office for a change in condition after the Resident expressed a wish to commit suicide, and antipsychotic medication was re-ordered for administration to manage the Resident's symptoms. During an interview on 12/9/25 at 10:56 A.M., the Social Worker (SW) said that Resident #3 would often make comments about killing him/herself when he/she was mad. The SW said the Resident's statements relative to killing him/herself were never specific until 9/16/25 when the Resident stated he/she would use a butter knife to stab him/herself in the neck. The SW said that the facility had never referred Resident #3 to the PASRR office for review relative to a significant change for SI.