

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Lanessa Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 751 School Street Webster, MA 01570	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose physician's orders included parameters for blood pressure readings related to the administration of Lisinopril (antihypertensive, reduces blood pressure) medication, and who sustained two unwitnessed falls which resulted in head injuries, the facility failed to ensure professional standards of practice were provided and maintained when the nursing staff 1) administered the Lisinopril despite his/her blood pressure readings being outside of the physician ordered parameters, and 2) failed to monitor him/her for neurological changes following two unwitnessed falls, in accordance with nursing best practice and facility policy. Findings include: 1) Review of the facility's policy titled, Specific Medication Administration Procedures, dated 2017, indicated the following: -Review the five rights [patient, medication, dose, route, time] (3) times. -Prior to removing the medication from the container, check the label against the order on the Medication Administration Record (MAR). -Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. -Document administration in the MAR. Resident #1 was admitted to the facility in January 2025 diagnoses included Hypertension (elevated blood pressure) and dementia with agitation. Review of Resident #1's Medication Administration Record (MAR) for the month of May 2026 indicated he/she had an order for Lisinopril (for hypertension) 10 milligram (mg) - give one tablet by mouth once a day, hold for systolic blood pressure (top number, maximum pressure in the arteries when the heart contracts and pumps blood to the circulatory system) less than 110 and diastolic blood pressure (bottom number, minimum pressure in the arteries when the heart is at rest between beats) less than 70. Further review of the MAR indicated nursing signed off as having administered Resident #1's Lisinopril on the following dates with the following blood pressure readings (which were below the acceptable parameters set by the provider): -05/13/26- Blood pressure (BP) 104/62-05/14/26- BP 101/62-05/15/26- BP 108/64-05/26/26- BP 104/65-05/27/26- BP 106/62-05/29/26- BP 105/65. During an interview on 07/07/26 at 2:06 P.M., Nurse #1 said she administered the Lisinopril 10 mg to Resident #1 on 05/13/26, 05/14/26, 05/15/26, 05/26/26, 05/27/26, and 05/29/26. Nurse #1 said she didn't know how it happened that she administered Resident #1's medication when she should have held it based on the physician ordered blood pressure parameters. During an interview on 07/07/26 at 3:51 P.M., the Director of Nurses (DON) said that nursing should not have administered Resident #1's Lisinopril when his/her blood pressure readings were outside of the physician's ordered parameters. The DON said it was her expectation that nursing followed the physician's orders. 2) Review of the facility's policy, titled Neurological Signs, undated, indicated the following: -Any resident who sustains a head injury or when a head injury is questioned or suspected will have neurological signs monitored as follows: *Every 15 minutes for one hour *Every 30 minutes for one hour *Every hour for four hours *Every four hours for 16 hours *Every eight hours for 48 hours. -Neurological signs to be evaluated and inclusive of: *Pupils reaction to light *Level of (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consciousness*Change in mental status*Change in speech*Change in strength in extremities*Vital signs- blood pressure, pulse, respirations*Head pain*Nausea/vomitingThe findings of each evaluation are compared, analyzed and documented in the medical record. The physician is promptly notified of any abnormal findings.Review of Resident #1's Fall Incident Report, dated 05/16/26 at 5:20 A.M., indicated he/she sustained an unwitnessed fall and was found by nursing on his/her bathroom floor.Further review of the Report indicated Resident #1 had a bruise and swelling on the back of his/her head and he/she was transferred to the Hospital Emergency Department (ED) for evaluation and treatment.Review of Resident #1's After [Hospital] Visit Summary, dated 05/16/26, indicated he/she was evaluated and CT scan (provides detailed images of the inside of the body) of his/her head and cervical spine showed no intracranial bleeding or fractures.Review of Resident #1's Fall Incident Report, dated 05/16/26 at 12:45 P.M., indicated Resident #1 sustained an unwitnessed fall in his/her room.Further review of the Report indicated Resident #1 was bleeding from the back of his/her head and he/she was transferred to the Hospital ED for evaluation and treatment.Review of Resident #1's After [Hospital] Visit Summary, dated 05/16/26, indicated he/she was evaluated for the second time that day, and there were no acute fracture or post traumatic malalignment of the cervical spine, and head CT scan was negative for bleeding.Review of Resident #1's medical record indicated there was no documentation to support that Resident #1's neurological checks were initiated or completed by nursing after either of his/her falls, per facility policy. During an interview on 07/07/26 at 2:06 P.M., Nurse #1 said neurological checks should have been initiated for Resident #1 after his/her falls. During an interview on 07/07/26 at 3:51 P.M., the Director of Nurses (DON) said that neurological checks were to be initiated by nursing following every unwitnessed fall or a fall with a head injury. The DON said neurological checks should have been completed for Resident #1 following his/her falls.		