

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

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Form Approved OMB
No. 0938-0391

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 05/08/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to notify the Provider as to whether treatment needed to be altered when a change in condition occurred for two Residents (#1 and # 53) out of total sample of 18 Residents. 1) Specifically for Resident #1, the facility failed to notify the Provider when the Resident experienced unanticipated weight loss, resulting in a significant weight loss (16.52% in 73 days) and malnutrition. 2) Specifically for Resident #53, the facility failed to notify the Provider and Occupational Therapist (OT) when the Resident was unable to tolerate the application of a left-hand palm guard as ordered by the Provider, and when therapy goals to tolerate the device were not being met. Findings include: Review of the Condition: Significant Change Policy and Procedure, dated April 2015, indicated: -professional staff will communicate with the physician. Regarding changes in condition to provide timely communication of resident/patient status change which is essential to quality care management. -The Physician, Resident/patient and or responsible party will be notified by the nurse in the event of a change in condition. -This notification shall be documented in the clinical record. 1) Resident #1 was admitted to the facility in October 2025 with diagnoses including Vascular Dementia with agitation and mood disturbance, history of Transient Ischemic Attack (TIA) and Cerebral Infarction (CI) without residual deficits, Dysphagia. Review of the Minimum Data Set (MDS) Assessment dated 4/24/26, indicated Resident #1: -was severely cognitively impaired with a score of 0 out of 15 on the Brief Interview of Mental Status (BIMS). -required setup from staff for eating. -had no weight loss or weight gain Review of Resident #1's Weights and Vitals Summary indicated the following weights: -2/1/26: 181.6 pounds (lbs.) -3/1/26: 161.4 lbs. (weight loss of 20.2 lbs. [11.12 % in 30 days]) -4/15/26: 151.6 lbs. (weight loss of 9.8 lbs. in 45 days; loss of 30 lbs. [16.52% in 73 days]) Review of Resident #1's March 2026 Progress Notes, failed to indicate that the Provider had been notified of the Resident's 20.2 lb. (11.12 %) weight loss that was identified by the facility on 3/1/26. Review of the Registered Dietician (RD) Progress Note dated 3/6/26 indicated: -Resident #1 had a significant weight loss in 30 days. -Resident #1 had a significant weight loss in 180 days. Review of the RD Progress note dated 3/27/26 indicated Resident #1: -Current weight on 3/1/26 was 161 lbs. [161.4] with significant gain [loss] in 30 days. -Weight 30 days ago was 181 [181.6]. During an interview on 5/6/26 at 11:10 A.M., the RD said she evaluated Resident #1 on 3/6/26 and identified a weight obtained on 3/1/26 (161.4), which was a 20 lbs. weight loss and felt it was significant. The RD said she was unsure if the Provider had been notified about the 20 lb. weight loss that occurred and said that the Nurses would be responsible for contacting the Provider. The RD said the nursing department did not notify the RD of Resident #1's weight loss, that the weight loss was identified when she reviewed the weekly weight report in the EMR (Electronic (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 225395	Facility ID: 225395 If continuation sheet Page 1 of 29

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical Record) on 3/6/26. ^^ During an interview on 5/6/26 at 2:17 P.M., Unit Manager (UM) #2 said it was the Nurse's responsibility to input the completed weights into the EMR and notify the Provider and RD of any weight loss or weight gain. UM #2 said the Provider and RD should have been notified right away on 3/1/26 when the weight loss was identified but they were not. UM #2 said that staff did not notify the Provider of the Resident's significant weight loss and did not implement interventions to address the Resident's weight loss until 4/17/26 (47 days after the facility identified the weight loss on 3/1/26). ^^ During an interview on 5/6/26 at 2:50 P.M., the Director of Nursing (DON) said Resident #1's weight loss was not reported to the Provider until 4/17/26 but should have been reported by the nursing department on 3/1/26. ^^ During an interview on 5/7/26 at 12:21 P.M., the Physician said if he or the NP had been updated regarding Resident #1's weight loss, they would have documented in their progress note and re-evaluated the Resident's food intake, need for supplements, and medical evaluation would have been completed at that time. 2) Review of the Splints/Orthotics/Prosthetics Policy and Procedure, dated April 2015, indicated: -Residents will receive splint/orthotics/ prosthetic devices as deemed appropriate by the physician and rehabilitation services. -Nursing staff should notify the rehabilitation department of any worn, ill-fitting and/or misplaced splint / orthotic/ prosthetic device. -If the resident refuses to wear the device, notify the rehab department, physician and responsible party. Resident #53 was admitted to the facility in January 2026 with diagnoses including Adult Failure to Thrive, altered mental status, and left-hand contractures. Review of the MDS assessment dated [DATE], indicated Resident #53: -was severely cognitively impaired with a score of 0 out of 15 on the Brief Interview of Mental Status (BIMS). ^ -had impairment of Range of Motion (ROM) on one side. -required maximum assistance from staff for completion of Activities of Daily Living (ADLs). Review of the Occupational Therapy Evaluation and Plan of Treatment dated 2/4/26, indicated a new goal that Resident #53 would be able to tolerate a left-hand orthotic (flat palm guard) for 8 hours without redness/irritation/discomfort to allow for skin integrity/ bathing/ nail care. Review of Resident #1's Alteration in Skin Integrity Care Plan, initiated 2/19/26, indicated: -Resident has potential alteration in skin integrity related to incontinence, left hand contracture. -Goal: Splint: apply left palm guard to left hand at A.M. care and off at P.M. care, as tolerated. Check skin integrity every shift. Review of Resident #1's April 2026 and May 2026 TAR (Treatment Administration Record) indicated: -Apply left palm guard to left hand at A.M. care and off at P.M. care as tolerated. Remove palm guard for skin hygiene. Check skin integrity every shift, initiated 2/18/26. On 5/5/26 at 10:22 A.M., the surveyor observed Resident #53 lying in bed with no left-hand palm guard visible in use and his/her left hand was closed in a fist. ^ During an interview on 5/5/26 at 3:51 P.M., Nurse #6 said Resident #53 did not like to have his/her hand opened and showed the surveyor that the Resident's fist was currently closed tightly. Nurse #6 attempted to slowly open Resident #53's left hand and he/she became agitated. When the surveyor asked about Resident #53's hand palm guard, Nurse #6 said he was unsure about the hand palm guard being applied and was unsure when it had last been used by the Resident. ^ During an interview on 5/5/26 at 4:01 P.M., Nurse #3 said that Resident #53's left hand palm guard was difficult to apply because he/she did not open the left hand easily. Nurse #3 said that the therapy department had issued Resident #53 a left-hand palm guard, but this morning Nurse #3 was unable to get the palm guard on because the Resident could not tolerate it. Nurse #3 said that it now required two staff members to apply the hand palm guard, so Nurse #3 preferred to apply a towel folded into the left hand because the Resident tolerated the towel better. Nurse #3 said she had not alerted physical therapy or the Physician that she was unable to apply the hand splint but should have. ^ On 5/6/26 at 7:47 A.M., the surveyor observed Resident #53 out of bed, fully dressed and sitting in a recliner chair and the (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	left-hand splint was sitting on Resident #53's lap and his/her left hand was closed in a fist. ^ ^ On 5/6/26 at 9:46 A.M., the surveyor observed Nurse #3 attempting to apply a hand splint to Resident #53's left hand. Nurse #3 was unable to apply the hand splint because Resident #53 became agitated. Nurse #3 said that the hand splint was a Physician order to be applied in the morning and removed at night and if they were unable apply the splint for any reason, then the therapy department and the Provider should be updated. Nurse #3 said that she had been unable to apply the hand splint for about two weeks and had taken care of Resident #53 several times in the past few weeks. ^ During an interview on 5/6/26 at 10:09 A.M., the Occupational Therapist (OT)/ Rehab Manager said Resident #53 was admitted to the facility with a left-hand contracture and had a history of being resistant. The OT said that Resident #53's left hand was tight upon admission and was he/she ordered a flat foam hand splint with a goal of keeping his/her hand open enough so that the hand and nail care could be performed. The OT said that the therapy department had not been notified that Resident #53 was unable to tolerate the application of the hand splint. The OT also said nursing should have alerted them right away to avoid worsening of the left-hand contracture. ^ During an interview on 5/6/26 at 12:07 P.M., the Regional Clinical Specialist said that when the Nurses were unable to apply the hand splint, they should have notified the Provider and therapy department right away instead of waiting two weeks. ^ During an interview on 5/6/26 at 1:00 P.M., Nurse #3 said that she had not applied Resident #53's left hand splint in a few weeks and should have alerted the Provider but did not. ^ During an interview on 5/6/26 at 2:38 P.M., UM #2 said the Provider and therapy department should have been updated right away when the Nurses noticed Resident #53 was not tolerating the hand-splint application. ^ During a follow-up interview on 5/6/26 at 4:55 P.M., the OT said that she was not aware staff were having difficulty with applying Resident #53's palm guard until today when she spoke with the surveyor. The OT said she did not know that nursing staff had had not applied the palm guard for about two weeks. ^ During an interview on 5/8/26 at 11:22 A.M., Physician #1 said he did not recall having been notified that facility staff were unable to perform the left-hand treatment over the last two weeks until a couple of days ago when staff called him (during the survey period). Physician #1 said there was no evidence the on-call service had been contacted during off hours in relation to the left-hand treatment/ splint. During an interview on 5/8/26 at 12:35 P.M. the Nurse Practitioner (NP) said no one from the facility had called to alert her that Resident #53 had been unable to tolerate the left-hand splint being applied. The NP said she would have expected to be alerted so further instruction could have been given. See F688 and F692		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on observations, interviews, and record review, the facility failed to ensure that one Resident (#13) out of a total sample of 18 residents received foot care and treatment in accordance with professional standards of practice, increasing the Resident's risk for medical complications. Specifically, the facility failed to ensure that Resident #13 received podiatry toenail care when the Resident's invoked Health Care Proxy (HCP) consented for the Resident to receive podiatry care, and the Resident's toenails were growing out to the length where the toenails curled against the ends of the Resident's toes, placing the Resident at risk for pressure injury, and infection. Findings include: Review of the facility policy titled Consultant Services, dated April 2015, indicated: -The facility will identify and facilitate consultant services to meet the resident's needs, to ensure optimum care for each resident through consultant services. -For podiatry, ., all families will sign a release form upon admission indicating whether they do or do not want the facility to make these arrangements. -The facility routinely uses their own consultants in . podiatry. -Once the consultant is identified by the physician 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 #13 was admitted to the facility in February 2025 with diagnoses including Dementia, Right Foot Drop, and abnormalities of gait and mobility. Review of Resident #13's Nursing Progress Note dated 2/26/25, indicated the Resident's family came in to visit and signed the Resident's consents. Review of Resident #13's [Consultant Name] Request for Service form, undated, indicated the Resident's HCP consented for the Resident to receive podiatry services. Review of Resident #13's Skin Integrity Care Plan, initiated 2/26/25, indicated: -The Resident has potential alteration in skin integrity related to decreased mobility, . friction site to right lower lateral leg related to brace (resolved June 2025). -Assess skin under splint devices, orthotics, braces, . (2/26/25)-Follow physician orders for skin care and treatments. -Inspect feet daily with care . Review of Resident #13's Minimum Data Set (MDS) Assessment, dated 4/17/26, indicated: -has a diagnosis of Dementia. -has severely impaired cognitive skills for daily living. -was dependent upon staff for bathing, dressing, and personal hygiene. -was at risk for pressure injuries. Review of Resident #13's May 2026 Physician orders indicated: -Podiatry care as needed (9/3/25). -Skin protocol: Weekly skin checks on bath/shower day . (9/30/25). -Skin protocol: Remove right leg brace in the evening for skin check (10/28/25). -Right ankle-foot orthosis on when out of bed. Off when in bed. Check for skin irritation and breakdown after removal (11/3/25). -Apply ankle-foot orthosis to right foot when out of bed, off when in bed . Remove splint for skin hygiene. Check skin integrity Q (every) shift (1/20/26). On 5/6/26 at 8:55 A.M., the surveyor observed Resident #13 walking into the hallway from the Dining Room on the Elmwood Unit, wearing a brace on his/her right lower leg. The Resident stopped walking when he/she reached the surveyor who was in the hallway, stood in one place, bent his/her right knee and repetitively lifted his/her right foot off the floor. Resident #13 was observed to touch his/her right foot back on the floor and place most of his/her weight through the left leg briefly, then walked away from the surveyor. During an interview at the time, Certified Nurse Aide (CNA) #2 said Resident #13 always wore a brace on his/her right leg because he/she needs it to be able to walk safely. On 5/6/26 at 9:27 A.M., the surveyor observed Resident #13's right lower extremity (from mid-calf to the toes) with Nurse #4 and Unit Manager (UM) #2 as follows: -The Resident's great toenail was grown out approximately one inch beyond the tip of the toe. The toenail was yellowish in color and thick. -The Resident's other four toenails were grown out past the tips of the toes, yellowish in color and thick, and angled toward the great toe. One toenail was curled under toward the tip of the (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toe. During an interview on 5/6/26 at 10:00 A.M., UM #2 said Resident #13's toenails on the right foot were long and that she would provide Resident #13's podiatry visit notes for the surveyor's review. During an interview on 5/6/26 at 12:15 P.M., the Regional Clinical Specialist (RCS) said she could not locate any evidence Resident #13 had been seen by the Consultant Podiatry Provider since the Resident was admitted to the facility in February 2025. The RCS said she called the Consultant Podiatry Service Provider following the surveyor's observation of Resident #13's right foot with Nurse #4 and UM #2, and that the Consultant Podiatry Service Provider had no record of Resident #13 being enrolled for podiatry services. During a telephone interview on 5/6/26 at 1:02 P.M., the Podiatry Service Provider Representative said there was no record of Resident #13 ever being provided podiatry services and that there was no record the Resident was enrolled to receive podiatry services. On 5/6/26 at 2:06 P.M., the surveyor observed Resident #13's right and left feet with the Director of Nursing (DON) as follows:-The Resident had four toes on the left foot, and the left great toe was absent.-All four toes had thick, yellowish colored nails, grown out approximately three-quarters of an inch to one inch from the tips of the toes.-The toenail on the small toe was angled toward the adjacent toe (to the right of the small toe) on the Resident's left foot.-The surveyor's observation of the toenails on the Resident's right foot was unchanged from the previous observation on 5/6/26 at 9:27 A.M.During an interview immediately following this observation, the DON said the Resident's toenails were overgrown, growing toward the great toe sides of the feet and the nails were curling under. The DON said Resident #13 has a Physician ordered treatment to inspect the Resident's skin when applying and removing the Resident's leg brace and that there is also a Physician order for weekly skin checks. The DON said the Nurses are required to inspect the Resident's whole body during weekly skin checks. The DON said the Nurses assigned to care for Resident #13 should have observed that the Resident's toenails were not properly cared for and that the Resident should have been enrolled in the consultant podiatry service as indicated by the HCP's consent. The DON said the condition of Resident #13's toenails placed the Resident at increased risk for pressure injury and infection. Review of Resident #13's Nursing Progress Note, dated 5/7/26, indicated the Resident was seen by the Physician that morning and that the Physician trimmed the Resident's toenails. During an interview on 5/7/26 at 11:00 A.M., the Physician said he was alerted on 5/6/26 that Resident #13 needed his/her toenails trimmed and that he trimmed the Resident's toenails that morning (5/7/26). The Physician said the Resident's toenails were long, grown out, and ingrown toward the Resident's skin. The Physician said facility staff should have noticed that the Resident's toenails needed to be cared for and that facility staff should have either communicated with the Consultant Podiatry Service or with him (Physician) that the Resident required toenail care. The Physician said the condition of the Resident's toenails prior to being trimmed that morning placed the Resident at increased risk for infection.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that appropriate services to maintain or improve range of motion were implemented for one Resident (#53) out of a total sample of 18 residents. Specifically, for Resident #53, the facility failed to ensure the Physician's orders were followed relative to the use of the left-hand palm guard, resulting in a worsening contracture and increased pain when applying the left-hand palm guard. Findings include: Review of the facility policy titled Splints/Orthotics/Prosthetics Policy and Procedure, dated April 2015, indicated: -Residents will receive splint/orthotic/ prosthetic devices as deemed appropriate by the Physician and rehabilitation services. -Nursing staff will apply/remove the designated splint/ orthotic/ prosthetic device during scheduled wearing times. Review of the facility policy titled Activities of Daily Living (ADL) Policy and Procedure, dated April 2015, indicated: -A program of ADLs is provided to residents to maintain or restore maximum functional independence. -A program of assistance and instruction in ADL skills is developed and implemented based on the individual evaluation to encourage the highest level of functioning. Resident #53 was admitted to the Facility in January 2026 with diagnoses including~left-hand~contractures.^ ^ Review of the Minimum Data Set (MDS) assessment dated [DATE],~indicated~Resident #53:~ -was severely cognitively impaired as indicated by a score of 0 out of 15 on the Brief Interview of Mental Status (BIMS) exam.~~ -had impairment of Range of Motion (ROM) on one upper side. -required maximum~assistance~from staff for completion of ADLs. ^ Review of the Comprehensive Care Plan, initiated on 1/29/26, indicated Resident #53: -had impaired functional mobility related to Dementia, Arthritis, history of fracture, Osteoporosis and Pain. -Goal: functional mobility, positioning and transfers will be achieved daily with use of appropriate device. -was totally dependent on staff for completion of ADLs. Review of the Occupational Therapy Evaluation and Plan of Treatment dated 2/4/26,~indicated~a goal that Resident #53 would be able to tolerate a~left-hand~orthotic (flat palm guard) for eight hours without redness/irritation/discomfort to allow for skin integrity/bathing/nail care.^ Review of Resident #53's Alteration in Skin Integrity~Care plan,~initiated~2/19/26, indicated:~ -The Resident has potential alteration in skin integrity related to incontinence and left-hand contracture. -Goal: Splint: apply left palm guard to left hand at A.M.^Care and off at P.M.^Care, as tolerated. Check skin integrity every shift.^ -Follow Provider orders for skin care and treatments. ^ Review of Resident #53's Order Summary Report, dated 5/6/26, indicated:~ -Splint: Apply Left palm guard to left hand at A.M. care and off at P.M. care, as tolerated. Remove palm guard for skin hygiene. Check skin integrity every shift. start date 2/18/26.^ ^ On 5/5/26 at 10:22 A.M., the surveyor observed Resident #53 lying in a recliner chair with the left hand closed in a fist without a left-hand palm guard in his/her left hand. During an interview and observation on 5/5/26 at 3:51 P.M., Nurse #6 said Resident #53 did not like to have his/her hand opened and showed the surveyor that the Resident's fist was currently closed tightly. Nurse #6 attempted to slowly open Resident #53's left hand and he/she shouted and stopped shouting immediately when Nurse #6 released his/her hand. When asked about Resident #53's palm guard, Nurse #6 said he was unsure why the palm guard was not on the Resident's left hand because it gets applied with morning care. During an interview on 5/5/26 at 4:01 P.M., Nurse #3 said Resident #53's left hand palm guard was difficult to apply because he/she did not open the left hand very easily. Nurse #3 said that the therapy department had issued Resident #53 a left-hand splint, but this morning Nurse #3 was unable to get the palm guard on because the Resident could not tolerate it. Nurse #3 said that two staff members (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were now required to apply the palm guard because the Resident becomes agitated and aggressive. Nurse #3 said she preferred to apply a folded facecloth into the Resident's left hand because it was better tolerated by the Resident. On 5/6/26 at 7:47 A.M., the surveyor observed Resident #53 out of bed, fully dressed and sitting in a recliner chair. The left-hand palm guard was observed on Resident #53's lap and the Resident's left hand was closed in a fist. ^ On 5/6/26 at 9:46 A.M., the surveyor observed Resident #53 sitting in a recliner chair with his/her left hand in a fist. Nurse #3 gently opened Resident #53's left hand by lifting the fingers away from his/her palm. Resident #53 said Ow that hurts, that's awful and then started hitting Nurse #3 with his/her right hand. Nurse #3 was unable to apply the palm guard to the Resident's left hand at that time. Nurse #3 said she had been unable to apply the Resident's palm guard for about two weeks and had taken care of Resident #53 several times during that time period. During an interview on 5/6/26 at 10:09 A.M., the Occupational Therapist (OT)/ Rehabilitation Services Manager said Resident #53 was admitted to the facility with a left-hand contracture. The OT said that Resident #53's left hand was very tight upon admission, and the Resident was ordered a flat foam palm guard with a goal of keeping his/her hand open enough so that hand and nail care could be performed. The OT said when the palm guard was ordered in February 2026, staff was able to open the Resident's left-hand half to three-quarters of an inch but now was unable to open the Resident's left hand as much. The OT said Resident #53's left hand was tighter. The OT said that if staff had applied the left-hand palm guard as ordered during the last few weeks, the left-hand contracture would not have worsened.^The OT said that the therapy department had not been notified that Resident #53 was unable to tolerate the application of the palm guard and nursing should have alerted them right away to avoid worsening of the contracture. During an interview on 5/6/26 at 1:00 P.M., Nurse #3 said she had not applied the left-hand palm guard to Resident #53's left hand for a few weeks and should have. Nurse #3 said Resident #53 showed symptoms of increased pain during the attempt to apply the left-hand palm guard today. During an interview on 5/6/26 at 4:55 P.M., the surveyor and the OT reviewed the updated evaluation dated 5/6/36. The OT said she was not aware staff were having difficulty with applying the palm guard to Resident #53's left hand until today when she spoke with the surveyor. The OT said she did not know that nursing staff had not applied the palm guard for about two weeks and further said that the contracture was a little bit worse today than it was when the OT did her initial evaluation. The OT said that it is just enough worse that the palm guard would not fit like it did when it was ordered in February 2026 and the Resident now expressed pain.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on interviews, and record reviews, the facility failed to adequately provide nutritional services for one Resident (#1) out of total sample of 18 residents. Specifically, the facility failed to implement timely interventions to maintain nutritional needs when the Resident had a severe weight loss of 16.52% (30 pounds) (lbs.) between 2/1/26 and 4/15/26, resulting in Protein Calorie Malnutrition. Findings include: Review of the facility policy titled "Food First Nutrition Policy and Procedure, dated August 2015, indicated: "It is the policy of this facility to assess all residents/ patients and identify those residents/patients at risk for weight loss and provide appropriate interventions according to the physical and mental abilities of his/her wishes." "The following residents/patients are weighed weekly x4: "Residents/patients with an unanticipated, unplanned weight loss of > five percent (%) in one month. "All residents with a significant weight loss are reviewed by the Interdisciplinary team and the resident/responsible party, and interventions are implemented as appropriate and are monitored weekly." "Review of the facility policy titled "Weights Policy and Procedure, dated August 2015, indicated: "The following residents/patients are weighed weekly x4: "Residents/ patients with an unanticipated, unplanned weight loss >five % in one month. "All residents with a significant weight loss are reviewed by the Interdisciplinary team and the resident/responsible party, and interventions are implemented as appropriate and are monitored weekly." "Residents will be weighed monthly, unless clinically indicated." "Resident #1 was admitted to the facility in October 2025 with diagnoses including Vascular Dementia with agitation and mood disturbance, history of Transient Ischemic Attack (TIA) and Cerebral Infarction (stroke) without residual deficits, and Dysphagia (difficulty swallowing). "Review of the Minimum Data Set (MDS) Assessment dated 4/24/26, indicated Resident #1: "was severely cognitively impaired with a score of 0 out of 15 on the Brief Interview of Mental Status (BIMS) exam. "required setup from staff for eating. "had a significant weight loss. Review of the Nutritional Care plan, initiated 10/27/25, indicated: "Resident #1 is at risk for nutritional issues related to dementia and past medical history. "Goals of care include food intake of 75-100% and weight maintenance, target date 6/22/26. "Provide regular diet as ordered and encourage intake of at least 75% Review of Resident #1's "Weights and Vitals Summary included the following weights: "2/1/26: 181.6 lbs. "3/1/26: 161.4 lbs. (loss of 20.2 lbs. in 30 days) "4/15/26: 151.6 lbs. (loss of 30 lbs. in 73 days from 2/1/26) Review of the Registered Dietician (RD) "Progress Note dated 3/6/26 indicated: "Resident #1 had a significant weight loss in 30 days. "Resident #1 had a significant weight loss in 180 days. "Resident #1 had variable by mouth (PO) intake. "The Dietician had recommended Ensure (nutritional supplement) and indicated that Resident #1 refused a cup of Ensure that she had offered. "RD to monitor. "Review of the RD Progress note dated 3/27/26 indicated Resident #1: "Current weight on 3/1/26 was 161 lbs. [161.4] with significant gain [sic] in 30 days. "Weight 30 days ago was 181 lbs. [181.6]. "Review of Resident #1's clinical record failed to indicate: "new interventions for identified weight loss on 3/1/26. "weekly weights were not ordered for identified weight loss on 3/1/26 per the facility policy Review of the MAR for April 2026 indicated: "Ensure Plus 237 ml. (milliliters) container two times a day, initiated 4/17/26 (46 days later). "Prosource 30 ml. three times a day, initiated 4/17/26 (46 days later) "Evening snack related to weight loss [sic] at bedtime for weight loss, initiated 4/17/26 (46 days later). Review of Resident #1's Weight loss Care Plan, initiated 4/17/26 indicated: "The Resident had a weight loss. "Goal: to maintain his/her body weight (avoid significant changes) through next review. "Interventions: Offer the Resident bedtime snacks nightly and provide the Resident with double (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Lanessa Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 751 School Street Webster, MA 01570	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	portions each meal. Review of Resident #1's Malnutrition Care Plan, initiated 4/24/26, indicated: -The Resident has protein calorie malnutrition related to inadequate calorie/protein intake as evidenced by the Nutrition Focused Physical Exam (NFPE) with findings of Protein Calorie malnutrition (PCM). -Goal of care includes food intake 75-100% and weight maintenance. -Interventions: Provide diet as ordered and Prosourse and Ensure as ordered. ^ ^ Review of the Nursing Progress Note dated 4/17/26, indicated the Nurse Practitioner (NP) was updated on Resident #1's weight loss and a new order was implemented for double portions every meal. ^ ^ Review of the NP Progress Note dated 4/17/26, indicated Resident #1: ^ -weighed 151.6 lbs. ^ on 4/15/26. ^ -Staff reported the Resident had a 30 lb. weight loss. ^ -Staff reported the Resident's appetite had been appropriate. ^ ^ Review of the RD Progress Note dated 4/17/26, indicated Resident #1: ^ -was being seen for weight loss. ^ -had a weight of 161.4 lbs. ^ on 3/1/26. ^ -had a weight of 151.6 lbs. ^ on 4/15/26. ^ -had a physical exam and was found to have mild to moderate malnutrition. ^ -was started on Ensure Plus twice a day. ^ -was started on Prosourse 30 ml three times a day. ^ ^ During an interview on 5/6/26 at 11:10 A.M., the RD said she evaluated Resident #1 on 3/6/26 and identified a 20 lbs. weight loss in 30 days and felt it was significant. The RD assessed Resident #1 on 3/6/26 and tried to give him/her a cup of Ensure but he/she refused to drink it at that time. The RD said she did not implement Ensure or any other new intervention but should have implemented Prosourse and Ensure (even though Resident #1 had refused a cup), in the hopes that staff could get him/her to start taking it, but these interventions did not get implemented until 4/17/26. ^ The RD said Resident #1 should have had weekly weights implemented when she identified the weight loss on 3/6/26 but he/she remained a monthly weight and then staff did not obtain Resident #1's monthly weight on 4/1/26 and did not obtain another weight until 4/15/26. The RD said Resident #1 did not have a weight obtained for 45 days resulting in an additional 10 lbs. weight loss from 3/1/26 to 4/15/26. ^ The RD said Resident #1's weight had stabilized from the Ensure and Prosourse that was started on 4/17/26 but was unsure if the weight loss could have been avoided if started earlier because Resident #1 had a period of sickness and medical leave at the end of March (3/19/26 - 3/23/26). ^ ^ ^ During an interview on 5/6/26 at 2:17 P.M., Unit Manager (UM) #2 said nursing staff was responsible for completing monthly weights on every patient on the 1st of the month, and weekly weights on Residents that had a Physician order. UM #2 said Nurses should input the weights into the Electronic Medical Record (EMR) and notify the Provider and RD of any weight loss or gain. UM #2 said the Provider and RD should have been notified right away on 3/1/26 when the weight loss was identified and weekly weights and other interventions such as Ensure should have been implemented but were not. UM #2 said she had not been notified that the RD had attempted to try a cup of Ensure on 3/6/26 but had she been made aware, she would have suggested nursing try again or something else. UM #2 said that the Provider was notified on 4/17/26 that Resident #1 had a significant weight loss and new interventions were implemented at that time. UM #2 said she was not aware of Resident #1 having a weight loss prior to 4/17/26. UM #2 said she was unsure why staff had not obtained Resident #1's monthly weight on 4/1/26 but it was completed on 4/15/26 (2 weeks later). ^ ^ ^ During an interview on 5/6/26 at 2:50 P.M., the Director of Nursing (DON) said nursing staff should have been completing weights for Resident #1 according to the Physician orders. The DON said she did not know why Resident #1's identified weight loss was not reported to the Provider and said the RD should have implemented interventions such as weekly weights and supplements right away when she saw the Resident on 3/6/26. ^ The DON said Resident #1's weight loss was not reported to the Provider until 4/17/26. ^ ^ During an interview on 5/7/26 at 12:21 P.M., the Physician said if Resident #1 was (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	losing weight and the~intake of food was~not adequate, then supplements~should~have been attempted.~The Physician said if the supplements did~not help,~then the~Resident should be evaluated medically~to rule out malignancy or something else~that may be going on medically.~The Physician said~all~those factors would prompt~a conversation with~the family to~determine~course of treatment,~but he was unsure if this had occurred.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, and interviews, the facility failed to maintain proper sanitation, food handling, and food storage practices to prevent the outbreak of foodborne illness in the main facility kitchen. Specifically, the facility failed to: 1) ensure that the minimum wash temperature necessary was maintained per manufacturer's guidelines for the dish machine utilized for cleaning and sanitizing dishware for resident use in the main facility kitchen, when the high temperature dish machine was operating at registered temperatures below acceptable ranges of 150 degrees Fahrenheit (F) for the wash cycle. 2) properly label and date prepared food items before storing them in the refrigerator and also failed to discard expired bread products that were being stored in the dry storage area. Findings include: Review of the Dishwashing Instructions Guide provided by the facility, dated October 2000, indicated: -Minimum water temperatures is: >Hot Water Wash 150 degrees Fahrenheit. Review of The Food Safe Pal, Dishwashing Temperature Guidelines, dated 10/29/24, retrieved from https://foodsafepal.com/dishwashing-temperature-guidelines/ indicated the following: Review of the Dietary Department Guidelines, dated May 2015, indicated: -The Dietary Department will be maintained in a clean and sanitary manner to prevent food borne illness. -All items stored in the refrigerator will be covered, labeled with the contents and the date. All potentially hazardous food must be discarded within 3 calendar days after the date prepared. -All food items should be labeled and dated to allow for rotation of supplies. -Dishwashing must reach certain temperatures to effectively kill bacteria and other disease-causing organisms called pathogens that can lead to foodborne illnesses. -Ensuring that the wash and rinse water of your dishwasher reaches a certain minimum temperature is just as important as cooking food to the proper minimum internal temperature. -Just as bacteria and other pathogens can survive on food that's not cooked to its minimum internal temperature, they can also survive on dishes and utensils that aren't washed and rinsed at the proper temperatures. -The minimum wash and rinse temperature depends on the type and whether it uses heat or chemicals to sanitize. -High-temperature dishwashers should operate at a minimum temperature of 150°F to (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	165°F (66°C to 74°C) during the wash cycle and at 165°F to 180°F (74°C to 82°C) during the rinse cycle. 1) On 5/7/26 from 10:05 A.M. through 10:30 A.M., the surveyor observed the following during a walkthrough of the main facility kitchen: ^ -Dish machine was in operation and running. -Dietary Aide (DA) #1 was pre-rinsing and loading dirty dish ware and meal trays into the dish racks to be washed. -Dish machine wash temperatures fluctuated and did not reach above 150 degrees F. -Dish machine wash temperatures were observed at 130 to 132 degrees F. During an interview at the time, DA #1 said she was not able to get the dish machine temperature to rise above 140 degrees F. DA #1 said she only worked in the facility one day every week. DA #1 said when the dish machine temperature does not rise above 150 degrees, she would finish washing the dishes and then notify the Administrator. DA #1 said the facility would usually reach out to a vendor when this happened. On 5/7/26 at 11:31 A.M., the surveyor and the Food Service Director (FSD) observed the lunch tray line in the main kitchen. During an interview at the time, the FSD said that washing and rinsing dishes at 132 degrees F was an acceptable temperature because the dish machine rinse cycle was not affected by the low temperature of the dish wash and that because the rinse temperature was normal, there was no concern about the low dish wash temperature. The FSD further said washing dishes at temperatures below 150 degrees F, the dishes may not be as clean as they should be. During an interview on 5/7/26 at 11:41 A.M., the Administrator said the plates should not be used to serve Resident meals as the dish machine did not reach the manufacturer recommended temperature. The Administrator said there was a risk for foodborne illness if the residents are served food on a plate that had not been adequately cleaned. The Administrator said the residents needed to receive their meals in a Styrofoam/disposable plate until the dish machine was either repaired or the plates had been re-washed by hand. 2) During the initial kitchen walk through on 5/5/26 at 7:08 A.M., the surveyor observed: -the following items that were undated and unlabeled in the refrigerator: sliced ham, two seafood sandwiches, tortilla wraps, lettuce, container of scrambled eggs. -container of hard-boiled eggs, dated 4/28/26. -A cooked ham in the walk-in refrigerator dated 4/30/26. -the following items were on the bread shelf: 1 Package of Tortillas (use by date 12/30/25), 1 Package of tortillas (use by date 2/1/26), 1 Package of tortillas (use by date 4/13/26), three packages of rolls - undated. -bag of green split peas on the shelf in the dry storage area, open and undated. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-bag of pasta on the shelf in the dry storage area, open and undated. During an interview at the time, the Regional Food Service Director (RFSD) said he was unsure of how long the undated food items (sliced ham, seafood sandwiches, tortilla wraps, lettuce and scrambled eggs) had been in the refrigerator and that all food items in the refrigerator should be dated when put into the refrigerator and discarded within three days if not used. The RFSD said he was unsure if the tortillas had been previously frozen but said that they should have been labeled and dated if defrosted but were not. The RFSD was unsure when the split peas and pasta had been opened but said they should have been labeled accordingly.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to afford the opportunity to formulate an advance directive relative to orders for life sustaining treatment, for one Resident (#5) out of a total sample of 18 residents, increasing the Resident's risk for undesired care in the event of a medical emergency. Specifically, the facility failed to review life sustaining treatment options with Resident #5's healthcare proxy (HCP) when:-the Resident was incapacitated at the time of admission.-the Resident's HCP was invoked.-the Resident's Medical Orders for Life Sustaining Treatment (MOLST), indicating Do Not Resuscitate (DNR) and Do Not Intubate (DNI), was not signed by the Resident's invoked HCP. Findings include: Review of the facility's MOLST policy, dated [DATE], indicated:-Purposes of the policy were to: -provide an outline for the process to follow when a resident is admitted with a MOLST form. -outline procedures regarding the completion of a MOLST form by a resident and the steps necessary when reviewing or revising a MOLST form.-The MOLST form should be executed as part of the health care planning process and preliminary advance care planning conversations.-The MOLST is designed to be a portable, valid and immediately actionable medical order consistent with the individual's wishes and current medical condition, which shall be honored across treatment settings.-Once the MOLST is completed, it must be signed by the resident, or if the resident lacks decision-making capacity the resident's legally recognized health care agent, AND the attending health care provider.-The MOLST will be reviewed by the facility interdisciplinary team (IDT) during the quarterly care planning conference, . Resident #5 was admitted to the facility in [DATE] with diagnoses including Atrial Fibrillation (A-fib) and Dementia. Review of Resident #5's Social Service Summary, dated [DATE], indicated:-The Resident's HCP was invoked.-The Resident was full code (resuscitation and intubation in event of cardiac or respiratory arrest) status. Review of Resident #5's Minimum Data Set (MDS) Assessment, dated [DATE], indicated:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of 15 total possible points.-HCP was invoked. -advanced directives included DNR and DNI. Review of Resident #5's IDT Care Plan Meeting Notes, dated [DATE] and [DATE], indicated:-advance directives were reviewed at the meeting.-The Resident or Representative were invited and declined to attend the meeting. Review of Resident #5's clinical record indicated:-The Resident was determined permanently incapacitated by his/her Nurse Practitioner (NP) on [DATE] (prior to admission to the facility).-A MOLST, dated and signed by NP #1 on [DATE] (prior to admission to the facility) for DNR and DNI.-The MOLST Form was not signed and was not dated by the Resident's HCP.-The signature line for the Resident's Representative indicated: verbal consent via telephone.Further review of Resident #5's clinical record failed to include evidence that the Resident's wishes relative to life sustaining treatment had been reviewed with the Resident's HCP between the Resident's admission to the facility and the survey period. During an interview on [DATE] at 9:30 A.M., the surveyor and Nurse #3 reviewed Resident #5's MOLST Form and Nurse #3 said Resident #5's MOLST Form was not valid because the MOLST Form was not signed by the Resident's HCP. Nurse #3 said in the event Resident #5 experienced cardiac or respiratory arrest, because the MOLST Form indicating DNR and DNI was not valid, the facility would be required to treat the Resident as full code status and provide cardiopulmonary resuscitation (CPR). Nurse #3 said the invalid MOLST Form would result in the Resident receiving CPR and that receiving CPR may not be upholding the wishes of the Resident/Representative. During an interview on [DATE] at 10:00 A.M., the Director of Nursing (DON) (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she spoke to Resident #5's HCP following the surveyor's inquiry and that the Resident's HCP said he/she elected DNR and DNI for the Resident. The DON said she emailed a new MOLST Form to Resident #5's HCP so that the HCP could complete, including sign and date, the MOLST Form and return it to the facility. During an interview on [DATE] at 10:39 A.M., the Regional Clinical Specialist (RCS) said Resident #5's MOLST form required Resident #5's representative's signature to be considered valid. The RCS said that the facility should have provided Resident #5's HCP with information relative for MOLST. The RCS said the Resident's HCP could either sign the [DATE] MOLST form, or a new MOLST form could have been completed relative to life sustaining treatment with the required HCP signature.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to resolve grievances timely for two Residents (#57 and #68) out of a total sample of 18 residents. Specifically, a) for Resident #57, the facility failed to ensure that the Resident's grievance for missing money was reviewed and followed through the grievance process when nursing staff filed the grievance on the Resident's behalf. b) for Resident #68, the facility failed to appropriately investigate the Resident's grievance related to missing clothing before documenting that the grievance was resolved. Findings include: Review of the facility's policy titled Grievance, undated, indicated: -The facility will make prompt efforts to resolve any grievances in accordance with the policy. -Upon receiving the grievance, the staff person receiving the grievance shall immediately notify the grievance officer. -The grievance officer shall begin the grievance process by logging a summary of the grievance (if oral), the date the grievance was received and by initiating an investigation. -Review of any grievance filed should be completed within seven days. If the review cannot be completed within this timeframe, the grievance officer should communicate the status of the review and an updated time in which it is expected the review will be completed. -Upon completion of the review, the grievance officer should document the following: a) The date the grievance was received. b) A summary of the residents' grievance. c) Steps taken to investigate grievance. d) A summary of the pertinent findings or conclusions regarding the grievance. e) A statement as to whether the grievances were confirmed or not; and f) Any corrective action taken or to be taken in response. 1. Resident #57 was admitted to the facility in February 2025 with diagnoses including Heart Failure, Hypertension and Dysphagia oropharyngeal phase. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #57 was cognitively intact as evidenced by a BIMS score of 13 out of 15 total possible points. During an interview on 5/5/26 at 8:04 A.M., Resident #57 said he/she reported his/her missing money to one of the evening Nurses over a week prior but had not received any feedback from his/her report. Review of Resident #57's Nursing Progress Note dated 4/26/26 at 10:56 P.M., indicated the Resident had reported his/her missing money to Nurse #5. During an interview on 5/6/26 at 4:04 P.M., Nurse #5 said Resident #57 reported the missing money to her and she had filed a grievance on his/her behalf. Nurse #5 said the facility's policy indicates when a Resident reports any concern, the staff would file a grievance on the Residents behalf, leave it in the Social Worker's (SW) mailbox and write a progress note. 2. Resident #68 was admitted to the facility in March 2026 with diagnoses including Dementia with Mild Behavioral Disturbance and Psychoactive Substance Dependence. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #68 was cognitively intact as evidenced by a BIMS score of 14 out of 15 total possible points. During an interview on 5/5/26 at 7:52 A.M., Resident #68 said he/she had reported and filed grievances about his/her missing clothes that were sent to the laundry a few weeks back but never received responses. Resident #68 said the clothes were brought to him by his/her sibling after he/she was admitted to the facility. Review of the Grievance Binder provided by the facility indicated that on 4/30/26, Resident #68 filed a grievance with a statement they have repeated [sic] failed to return any of the clothes I turned in to them. Further review of the grievance indicated that the SW had attached Resident #68's clothing inventory sheet and signed off that the grievance was complete. During an interview on 5/6/26 at 4:17 P.M., the Social Worker (SW) said she was the grievance officer for the facility. The SW said when she receives grievance she would follow through with investigation and notify the resident of the findings and conclusion. The SW (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she found Resident #57's grievance in a pile of paperwork on her desk but has not had the time to review, investigate, or follow through with findings. The SW said she should have reviewed, investigated and communicated the investigative findings with the Resident, but she had not. The SW also said she received Resident #68's grievance but after she reviewed the Resident's inventory sheet on admission, she thought the Resident was not admitted with any clothing, so she never followed through with the investigation and filed the grievance as complete. The SW said she should have performed an investigation to find out when Resident #68 received his/her clothing, who brought them in for him/her and followed through with resolution, but she did not. During an interview on 5/6/26 at 4:54 P.M., the Administrator said she was not aware of Resident #57's missing money. The Administrator said the SW should have followed through the grievance process for Resident #57, but she had not. The Administrator further said there was no evidence that Resident #68's grievance was investigated before it was resolved.		

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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 the safe and secure storage of medications as required to meet the needs of the facility residents and for one medication storage room (Windsor Unit) out of a total of two medication storage rooms. Specifically, the facility failed to: 1. ensure medications kits are replaced by the pharmacy after being opened with medications removed and not accounted for. 2. ensure the refrigerator that stored medications in the medication room was within the required temperature range of 36 to 46 degrees. 3. ensure medications were securely stored and only accessible by authorized staff on the Windsor Unit medication storage room. Findings include: Review of the facility policy titled Medication Storage Room, revised April 2015, indicated: -All licensed personnel are responsible for always ensuring the cleanliness of the medication room and at the end of the shift. -Drugs requiring refrigeration are stored separately in a refrigerator that is used exclusively for medication and medication adjuncts. -If anything needs to be repaired, please notify maintenance immediately. Review of the facility policy titled Storage of Medications, dated 2017, indicated: -Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity. -Medications and biologicals are stored at their appropriate temperatures and humidity according to the United States Pharmacopeia guidelines for temperature ranges. -Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit). -Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. -The facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day per CDC Guidelines. 1. On 5/6/26 at 10:02 A.M., the surveyor and Unit Manager (UM) #1 observed the following in Windsor Unit Medication Storage Room: a. Intravenous (IV) kit was opened with no paper documentation indicating what was removed from the kit and for which resident. b. An emergency kit Super Kit (a kit that had most of the facility's used medications for the residents) was laying on the floor in the Medication Storage Room. The Super Kit contained a paper that itemized all the medications that should have been available in the kit. The surveyor further observed: >No documentation of which resident a medication had been removed for. >No documentation of the date the medication was removed. >No documentation of which Nurse opened the kit. >No evidence that the Super Kit had been re-ordered from the Pharmacy. c. An antibiotic had been opened, and there was no evidence that the kit had been re-ordered from the Pharmacy. 2. The surveyor and UM#1 reviewed of the refrigerator temperature log in the Windsor unit medication room indicated: >Temperature checks must be done twice per day. >Temperatures should be 36 to 46 degrees Fahrenheit. Review of the refrigerator temperature log documentation in the Windsor Unit medication room indicated the following: a) 2/1/26 &ndash; 2/28/26: the refrigerator temps were out of range 16 times (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Lanessa Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 751 School Street Webster, MA 01570	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the month of February 2026. -47 degrees was documented one time -48 degrees was documented seven times -49 degrees was documented five times -50 degrees was documented three timesb) 3/1/26 - 3/31/26: the refrigerator temps were out of range 31 times for March 2026. -47 degrees was documented four times -48 degrees was documented nine times -49 degrees was documented 13 times -50 degrees was documented five timesc) 4/1/26 - 4/30/26, the refrigerator temps were out of range 30 times for April 2026. -48 degrees was documented one time -49 degrees was documented 20 times -50 degrees was documented nine timesd) 5/1/26 - 5/7/26, the refrigerator temps were out of range seven times. -49 degrees was documented five times -50 degrees was documented one time -51 degrees was documented one timeAt the time, UM #1 opened the refrigerator, and the surveyor and UM #1 observed the thermometer gauge at 50 degrees F. During an interview at the time, UM #1 said the refrigerator felt warm. The surveyor and UM #1 observed the following medications in the refrigerator with the temperature at 50 degrees F:a) One bottle of Acidophilus (probiotic medication used to maintain digestive health) required to be refrigerated for freshness and potency within a temperature range of 36 to 46 degrees F for long-term viability. b) One bottle of Omeprazole liquid (works by reducing the production of stomach acid, relieving the symptoms associated with acid-related gastrointestinal conditions) - Refrigerated storage: 2˚ - 8˚ degrees C (36˚ - 46˚ degrees F). c) Five vials of unopened Humalog (insulin lispro for Diabetes) should be stored between 36 degrees F and 46 degrees F (2 degrees C and 8 degrees C) to maintain stability and effectiveness. d) Three Trulicity (for Diabetes) pens. e) One Tresiba (insulin degludec pen) should be stored between 36˚ degrees F and 46˚ degrees F (2˚ degrees C to 8˚ degrees C) until it is ready to be used. f) Seven vials of Lantus (for Diabetes). g) Three vials of Munjaro (for weight loss and diabetes management). h) One vial of Insulin Lispro (for Diabetes). i) One Xalatan (eye drop for Glaucoma). During an interview at the time, UM #1 said the refrigerator appeared to have been broken for a while and that the medications observed in the refrigerator needed to be discarded and re-ordered and that the medications were not good to be administered to the Residents. Review of the refrigerator medications listed above and retrieved from: https://www.drugs.com/medical-answers, indicated that medications requiring refrigeration should be kept in the refrigerator at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C) until ready to use. This ensures the medications remain stable and effective. During an interview on 5/6/26 at 12:05 P.M., the Assistant Director of Nursing (ADON) said he was not aware the emergency kits had been opened and not re-ordered. The ADON said he was not aware that the facility staff had documented the refrigerator temperatures above the required temperature. The ADON further said that the medications in the refrigerator needed to be discarded and new medications re-ordered for the residents. During an interview on 5/6/26 at 12:25 P.M., the Director of Nursing (DON) said she was not aware the Windsor Unit medication room refrigerator had not been working at the required temperature range. The DON said the medications would be discarded and re-ordered. The DON further said anytime an emergency kit is opened, facility staff are required to document the date the medication was removed, the resident's name, and the staff removing the medication. The DON further said the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency medication kits should have been re-ordered but they were not. 3. Review of the facility policy titled Medication Storage Room/Medication Cart Policy, reviewed in January 2025 indicated: -Storage for other medications will be limited to a locked medication room. On 5/6/26 at 8:09 A.M., the surveyor observed the door of the Windsor Unit medication storage room (located behind the nurse's station and accessible to anyone) was slightly ajar and able to be opened by the surveyor. The surveyor also observed several residents ambulating in the hallway in the vicinity of the medication storage room. During an interview immediately following the observation, the ADON said the medication storage room door was supposed to be closed and always locked. The ADON said only the Nurses had a key to open the medication storage room. On 5/6/26 at 4:15 P.M., the Windsor Unit medication storage room door was slightly ajar and able to be opened by the surveyor. The surveyor observed several residents ambulating in the hallway in the vicinity of the medication storage room. During an interview immediately following the observation, the ADON said the door to the medicating storage room was supposed to be closed and locked. On 5/7/26 at 8:05 A.M., the Windsor Unit medication storage room door was slightly ajar and able to be opened by the surveyor. The surveyor further observed several residents ambulating in the hallway in the vicinity of the medication storage room. During an interview immediately following the observation, Nurse #5 said the medication storage room should always be locked and only the Nurses on the unit had access. The surveyor opened the door that was slightly ajar and Nurse #5 said the door should not be open and that the surveyor should not have been able to open the door. Nurse #5 said the medications in the medication storage room could be accessed by anyone when the door was not closed completely and locked, and that it was not safe. Nurse #5 said the door should be closed and always locked and not accessible to anyone else other than the Nurses on the unit. During an interview on 5/7/26 at 11:27 A.M., the DON said the medication storage rooms should always be locked and only accessible to the nursing staff on that unit. The DON said if the door was not completely closed, anyone, including unauthorized staff, residents or visitors would be able to walk into the medication storage rooms. The DON said she was not aware that the medication storage room door was not completely closing all the way.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to serve food that was palatable, attractive, and appetizing on one resident Unit (Elmwood) and the facility Main Dining Room, placing residents at risk for reduced meal consumption. Specifically, the facility failed to: -For the Elmwood Unit: >serve chicken that was attractive and easy to chew.>serve banana slices that could be identified as banana by taste. -For the facility's Main Dining Room: -serve chicken that was easy to cut and chew. Findings include:Review of the facility's Food Committee Minutes indicated: -3/11/26: Residents said food was served cold. -4/15/26: Residents stated that the food is cold mostly on weekends and nights and the portions are too small. During a screening interview on 5/5/26 at 7:52 A.M., Resident #68 said his/her main concern at the facility was the food. Resident #68 said the food was [expletive]. During the Resident Council Meeting on 5/6/26 at 10:26 A.M., residents in attendance reported the following relative to food:-Four of six residents said they do not receive food items they request.-one of six residents said the meatloaf is like a hockey puck.-A second resident said the food was not good and that he/she attended monthly Food Committee meetings, and that there is never any change. -A third resident said the food is not edible, that it's terrible and most meals are cold. On 5/7/26, from 12:29 P.M. through 12:58 P.M., lunch meal test trays were conducted as follows on the Elmwood Unit and in the facility's Main Dining Room: >The surveyor completed the test tray observation on the Elmwood Unit after the last resident meal tray was passed at 12:29 P.M. -The test tray included but was not limited to boneless chicken breast and fruit cocktail containing banana slices. -The boneless chicken breast was discolored on one side with grey and pink patches on the outside of the chicken breast. -The boneless chicken breast was difficult to cut and chew and had a rubbery texture. -The banana slices in the fruit cocktail did not taste like bananas, were stringy and tasted like fruit cocktail syrup. >The surveyor completed the test tray observation in the facility's Main Dining Room after the last resident meal was delivered at 12:58 P.M. -The test tray included but was not limited to boneless chicken breast. -The boneless chicken breast was difficult to cut and hard to chew. During an interview at the time, the Minimum Data Set (MDS) Nurse, who also tasted the food, said the chicken was hard to cut and chew. During an interview on 5/8/26 at 10:02 A.M., the Administrator said that she had been made aware of the Resident complaints about food. The Administrator said food being served to residents should look appetizing and should not be difficult to cut and chew.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure staff served food that accommodated resident allergies, intolerances, and/or food preferences for three Residents (#49, #57 and #70) out of a total sample of 18 residents. Specifically, the facility failed to ensure that the meal preferences requested were provided for Resident's #49, #57 and #70 as requested. Findings include: Review of the facility policy, dated August 2015, indicated the following in part: Residents/patients will receive nourishing, attractive meals to meet individual nutritional and special needs.-this will be done while providing a positive dining experience to enhance the residents/patient's quality of life and respect his/her rights. Review of the resident council meeting minutes dated 2/20/26, the following was stated in part: The biggest issue in the facility is the kitchen. The kitchen was short help for dietary aides and cooks. Review of food committee minutes dated 4/15/26 the following was stated in part: Multiple issues with the kitchen. the kitchen department was short staffed. Review of the 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 15 out of a possible 15. Review of the MDS assessment dated [DATE] indicated Resident #57 was cognitively intact as evidenced by a BIMS score of 13 out of a possible 15. Review of the MDS assessment dated [DATE] indicated Resident #70 was cognitively intact as evidenced by a BIMS score of 14 out of a possible 15. During an interview 5/5/26 at 10:55 A.M., Resident #70 said the food was not edible. Resident #70 further said he/she would eat whatever they brought in because he/she did not want to deal with having to wait. During an interview on 5/5/26 at 11:09 A.M., Resident #49 said he/she often did not receive the requested meals during mealtime. Resident #49 said that dinnertime seemed to be the most challenging for the kitchen staff and that dinner time was the meal he/she most often did not receive the items he/she requested. During a resident council meeting held on 5/6/26, the following was stated relative to food concerns:-At 10:26 A.M., one resident said they did not receive what they ordered often.-By a show of hands, four out of six residents in attendance indicated they often did not receive what they ordered for a meal.-Resident #57 said he/she believed that the staff in the kitchen simply did not read what was on the ticket because he/she rarely received the food he/she requested, on their meal tray. On 5/7/26 at 12:46 P.M., the surveyor was observing the lunch meal tray pass near the meal cart located at the nurse's station and Resident #57 could be heard yelling from his/her room. Resident #57 was yelling profanities and asking what is wrong with these people? How stupid can they be? During an interview on 5/7/26 at 12:48 P.M., Resident #57 said the kitchen staff put pork on his/her tray even though he/she requested chicken. Resident #57 said he/she did not like pork and would never choose pork over chicken and that was not what he/she ordered. Resident #57 was upset as he/she was slamming the silverware onto the tray and pushed the tray table away from him/her. The surveyor observed pork on the Resident's tray. During an interview on 5/7/26 at 1:04 P.M., with the Administrator, the Regional Clinical Specialist, and Resident #57, the Resident said he/she was happy that the staff brought him/her chicken. Resident #57 said he/she was initially supposed to get soup and crackers with the chicken, however only received the crackers with no soup. Resident #57 said he/she was satisfied with the meal that was brought to him/her, that it was good, he/she wished that his/her meal would come as ordered. Resident #57 said he/she understood the staff were trying to do their jobs but felt discouraged, and that it appeared like things were never going to get better. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When the surveyor requested to see the meal ticket that was on the tray, Resident #57 said when the staff brought him/her a new tray, there was no new ticket, and the staff removed the old tray with the original meal ticket on it. During an interview on 5/7/26 at 1:36 P.M., the Food Service Director (FSD) said there were two soup options available for lunch today that the residents could have. The FSD said he did not know why Resident #57 did not receive soup if he/she requested it. The FSD could not provide additional information as to the Resident's food requests for lunch on 5/7/26. The FSD said chicken was the main meal and pork was the alternate meal for lunch service. The FSD reviewed the alternate meal list for residents dated 5/7/26 and said Resident #57's name was not on the list, so he/she should have initially received the main meal of chicken.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and interviews, the facility failed to adhere to infection control standards of practice to prevent contamination and the spread of infections for one Resident (#61) out of a total sample of 18 residents. Specifically for Resident #61, the facility failed to ensure that appropriate Personal Protective Equipment (PPE: items such as gowns and gloves worn to prevent the spread of infection) was worn as required for the Resident on Enhanced Barrier Precautions (EBP) placing the Resident at increased risk of contamination and the spread of infections. Findings include: Review of Centers for Disease Control and Prevention (CDC) Guideline for Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revised 6/28/24, retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html indicated: -Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. -Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -Enhanced Barrier Precautions expand the use of gowns and gloves beyond anticipated blood and body fluid exposures. They focus on use of gowns and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. -Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. Review of facility policy titled, Enhanced Barrier Precaution Policy, undated, indicated: -The policy is to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms. Novel or targeted MDROs (Multidrug Resistant Organisms) are organisms that are resistant to all or most antibiotics tested, are uncommon in a geographic area, or have special genes that allow them to spread their resistance to other germs. -Enhanced barrier precautions (EBP) require the use of gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk for transmission of multidrug-resistant organisms. High-contact resident care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care. Resident #61 was admitted to the facility in July 2024 with diagnoses including Extended-Spectrum Beta-Lactamases (ESBL) in urine, Basal Cell Carcinoma of Overlapping Sites of Skin, Adult Failure to Thrive and Dementia. Review of Resident #61's May 2026 Physician's orders indicated: -Enhanced Barrier Precaution related to history of ESBL, start 10/27/25. On 5/5/26 at 3:34 P.M., the surveyor observed the following: -Signage at Resident #61's door indicated that the Resident #61 was on EBP. -EBP signage indicated that anyone entering the room should wash their hands when entering or exiting the room and staff must wear gloves and a gown for high-contact care activities. -CNA #1 was observed providing incontinent care to the Resident, the Resident's door was wide open, and the curtain was partially pulled. -CNA #1 was not observed donning a gown prior to providing personal care to the Resident. -CNA #1 changed and dressed Resident #61. -CNA #1 exited Resident #61's room with used linen in her gloved hands and placed them in a hamper in the hallway and sanitized her hands. During an interview on 5/5/26 at 3:40 P.M., CNA #1 said Resident #61 was not on any form of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precaution and that the EBP sign at the door should not be there. CNA #1 walked to the nurse's station and was observed talking to Nurse #1. CNA #1 returned to Resident #61's door and removed the EBP sign and told the surveyor that the sign was a mistake and was not supposed to be there. During an interview on 5/5/26 at 3:42 P.M., Nurse #1 said the Resident was not on precautions and the EBP sign was not supposed to be posted at Resident #61's door. During an interview on 5/5/26 at 3:44 P.M., Nurse #2 said Resident #61 had a history of ESBL in the urine and required to be on EBP. Nurse #2 obtained an EBP sign and replaced the sign at the Resident's door. Nurse #2 said Nurse #1 and CNA #1 should have checked before removing the sign at the Resident's door. During an interview on 5/5/26 at 3:59 P.M., the Infection Prevention Nurse (IP) said Resident #61 was on EBP for ESBL in his/her urine. The IP said CNA #1 should have worn a gown while changing the Resident and should not have removed the sign from the Resident's door. The IP said Nurse #1 should have checked before informing CNA #1 to remove the EBP sign from the Resident's door.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to administer the pneumococcal immunization to one Resident (#11) out of five applicable residents for immunizations, out of a total sample of 18 residents, placing the Resident at increased risk for pneumococcal infection. Specifically, the facility failed to administer the pneumococcal immunization to Resident #11 when the Resident:-was eligible to receive the pneumococcal immunization.-Consented for the pneumococcal immunization to be administered. Findings include:Review of the facility's policy titled Immunization of Residents, dated April 2017 and revised January 2026 indicated the following:-All eligible residents will be offered the . pneumococcal vaccine unless medically contraindicated.-Adults 50 years and older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive a pneumococcal conjugate vaccine (either PCV15, PCV20, or PCV21). Resident #11 was admitted to the facility in March 2026 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Malignant Neoplasm of Unspecified Part of Right Bronchus or Lung, and Dementia. Review of Resident #11's clinical record indicated the Resident was aged 50 years or older. Review of Resident #11's admission Vaccination Education Form, signed by the Resident's health care proxy and dated 3/25/26, indicated:-The PCV20 or PCV21 vaccine is recommended for persons greater than or equal to [AGE] years of age .-The Resident/Representative had been given a copy of the Vaccine Information Statement (VIS) and had the opportunity to ask questions.-The Resident/Representative agreed to receive the pneumococcal conjugate vaccine. Review of Resident #11's Immunization Record on 5/7/26 failed to indicate any evidence the pneumococcal conjugate vaccine had been administered to the Resident. Review of the facility's Resident Immunization Log, undated, indicated Resident #11 was not up to date with his/her pneumococcal conjugate vaccine. During an interview on 5/7/26 at 11:19 A.M., the Infection Preventionist (IP) said the facility did not have a record of Resident #11 ever having a pneumococcal vaccine. The IP said the facility obtained consent to administer the pneumococcal conjugate vaccine to Resident #11 on 3/25/26, and he was unsure whether the pneumococcal vaccine had already been administered to the Resident. During an interview on 5/7/26 at 2:45 P.M., the Director of Nursing (DON) said when a resident consents to receive a pneumococcal conjugate vaccine, the facility will order the vaccine from the pharmacy, and the vaccine will be delivered to the facility on the overnight after the vaccine is ordered. The DON said the facility should have ordered the pneumococcal conjugate vaccine for Resident #11 to be administered when the Resident's Representative consented to the vaccine so that the vaccine could have been administered to the Resident. The DON said the pneumococcal conjugate vaccine was not ordered to be administered to the Resident until after the surveyor's inquiry relative to the Resident's pneumococcal vaccination status.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to offer and administer the 2025/2026 COVID-19 vaccine to one Resident (#11) out of five applicable residents for vaccinations, out of a total sample of 18 residents, in accordance with Centers for Disease Control and Prevention (CDC) recommendations, placing the Resident at increased risk for COVID-19 infection and COVID-19 infection complications. Specifically, the facility failed to offer and administer the 2025/2026 COVID-19 vaccine to Resident #11 in a timely manner when Resident #11 was eligible to receive the vaccine. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled 2025/2026 COVID-19 Vaccine Guidance, dated 11/4/25 and located at 2025-2026 COVID-19 Vaccination Guidance Covid CDC indicated the following:- . some people may be at increased risk for SARS-CoV-2 infection including . residents . in long-term care facilities.-vaccination is recommended based on individual-based decision-making with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk, according to the CDC list of COVID-19 risk factors (including COPD and Diabetes).-For individuals aged 12-64 years previously vaccinated before the 2025/2026 vaccine, administer one dose of 2025/2026 vaccine. Review of the facility's COVID-19 Vaccination Policy, undated, indicated:-It is the facility's policy to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 by offering residents immunization to COVID-19.-COVID-19 vaccines will be offered as per Centers for Disease Control and Prevention (CDC) and/or Food and Drug Administration (FDA) guidelines unless such immunization is medically contraindicated, the resident has already been immunized during this time period, or resident/responsible party refuses to receive the vaccine. -COVID-19 vaccines may be administered in the facility by the Infection Preventionist (IP) or licensed staff member. -Resident's receiving the COVID-19 vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine . The completed, signed, and dated record will be filed in the resident's medical record. -Documentation will . include if the resident received or did not receive the immunization due to medical contraindication or refusal, . Resident #11 was admitted to the facility in March 2026 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Malignant Neoplasm of Unspecified Part of Right Bronchus or Lung, and Dementia. Review of Resident #11's clinical record indicated:-The Resident was between the ages of 12- [AGE] years of age.-The Resident had diagnoses including COPD and Diabetes.-The Resident's most recent COVID-19 vaccine was administered on 4/12/21.-The facility offered, and the Resident's Representative agreed to receive the 2024/2025 COVID-19 vaccine on 3/25/26.Further review of Resident #11's clinical record did not indicate any evidence the facility offered the 2025/2026 COVID-19 vaccine to Resident #11 and/or his/her Representative and whether the Resident received or did not receive the COVID-19 immunization due to medical contraindication or refusal. Review of the facility's Resident Immunization Log, undated, indicated Resident #11's most recent COVID-19 vaccine was administered on 4/21/21. During an interview on 5/7/26 at 11:19 A.M., the IP said Resident #11's most recent COVID-19 vaccine was administered on 4/21/21. The IP said Resident #11's Representative consented for a COVID-19 immunization to be administered to the Resident on 3/25/26 and he was unsure whether an updated COVID-19 vaccine had been administered to the Resident after his/her (continued on next page)		

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 05/08/2026
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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Representative gave consent. During an interview on 5/7/26 at 2:45 P.M., the Director of Nursing (DON) said the facility offers updated COVID-19 vaccines when residents are admitted to the facility. The DON said if a resident is not up to date with the COVID-19 vaccine and consent is obtained to administer the vaccine, facility staff will order the vaccine from the pharmacy, and the pharmacy will deliver the vaccine on the overnight after it is ordered. The DON said the 2025/2026 COVID-19 vaccine was not offered and administered to Resident #11 until 5/7/26, after the surveyor's inquiry about the Resident's COVID-19 vaccination status.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily required nurse staffing information was posted as required. Specifically, the facility failed to:-ensure the total hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift (Registered Nurses (RN), Licensed Practical Nurses (LPN) or Licensed Vocational Nurses (LVN), and Certified Nurses' Aides (CNA) were posted as required.-maintain a copy of the staffing records for 18 months. Findings include:On 5/5/26 at 7:18 A.M., the surveyor observed that the nurse staffing information was handwritten with an erasable marker on a wipe off board posted at the entrance of the reception area. The handwritten information on the wipe off board did not include the following required information:-the total hours worked by staff directly responsible for resident care per shift (RN's, LPN's, LVN's and CNA's). During an interview on 5/5/26 at 9:26 A.M., the Scheduler said she would leave the information for the Receptionist the day before and the Receptionist would write the information on the wipe off board with an erasable marker daily. The Scheduler said she did not have a record of the daily staff posting for 18 months as required.During an interview on 5/5/26 at 10:28 A.M., the Receptionist said she was responsible for updating the daily staff posting. The Receptionist said she would write the staffing information provided to her by the Scheduler on a wipe off board with an erasable marker.During an interview on 5/6/26 at 7:51 A.M., the Administrator said she was unaware that total number of hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift needed to be on the nursing staff posting. The Administrator also said the facility has not maintained the posted daily staffing for 18 months as required.		