STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225408	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maristhill Nursing & Rehabilitation Center	66 Newton Street Waltham, MA 02453

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for 5 Residents (#56, #82, #62, #73 and #2) out of sample of 30 residents. Specifically,1. For Resident #56, the facility failed to set oxygen as ordered by the physician.2.For Resident #82, the facility failed to clean the concentrator filter as ordered by the physician.3. For Resident #62, the facility failed to clean the concentrator filter.4. For Resident #73, the facility failed to clean the concentrator filter, keep the water bottle off the floor and keep an oxygen cannula clean.5. For Resident #2, the facility failed to clean the concentrator filter and keep an oxygen cannula clean.Findings include:A review of the facility policy titled 'Oxygen Administration' with a revision date of 5/9/25 indicated the following: -Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences Resident #56 was admitted to the facility in May 2025 with diagnoses including tachycardia. A review of the Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 indicating moderate impairment. On 9/30/25 at 8:34 A.M., the surveyor observed Resident # 56 sleeping, wearing a nasal cannula with Oxygen running at 3 Liters. On 10/1/25 at 7:38 A.M., the surveyor observed Resident #56 sitting in a chair next to his/her bed, wearing a nasal cannula. Oxygen was running at 4.5 Liters. A review of Resident #56's October 2025 physician's orders indicated the following: -PRN (as needed) at 1-2L to maintain O2 sat above 93% as needed for SOB (Shortness of Breath), start date 5/6/25. A review of a Comprehensive Metabolic Panel (CMP) dated 9/5/25, 7/7/25 and 6/14/25 respectively indicated the following Carbon Dioxide (CO2) levels, 35mmol/L (millimoles per liter) -High, 34mmoL/L (millimoles per liter) -High, and 37mmol/L (millimoles per liter) -High. (The normal reference range is 22-33mmoL/L (millimoles per liter). During an interview at 10/2/25 at 7:43 A.M., UM #2 said oxygen should be set as ordered. Unit Manager #2 said if the Resident changes the oxygen settings, the Nurses should make sure the Oxygen setting is correct at all times. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, observation and medical record review on 10/2/25 at 7:01 A.M., the Surveyor, Director of Nurses, Nurse #7 and Nurse #8 observed Resident #56 sleeping, wearing the nasal cannula. The Oxygen level was set at 5 Liters. The DON, Nurse #7 and Nurse #8 said oxygen should be set as ordered by the physician. Nurse #8 and the DON reviewed Resident #56's physician's orders and said the Oxygen should be set at 1-2 Liters. The DON said if the Resident changes the oxygen setting, Nurses should make sure the settings are set correctly. The DON reviewed Resident #56's most recent Comprehensive Metabolic Panel (CMP) dated 9/5/25, 7/7/25, and 6/14/25. She said the Carbon dioxide (CO2) levels were high. The DON said if the Oxygen is set that high, the Resident is at risk of retaining CO2, which would then cause shortness of breath. Review of facility policy titled Oxygen Administration, dated as revised 5/9/25, indicated the following: -Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. -1. Oxygen is administered under orders of a physician except in the case of an emergency. -7. Cleaning and care of equipment shall be in accordance with facility policies for such equipment. 2. Resident #82 was admitted to the facility in June 2025 with diagnoses that included shortness of breath and COPD (Chronic Obstructive Pulmonary Disease). Review of the most recent MDS Assessment, dated 7/1/25, indicated a brief interview for mental status exam score of 15 out of a possible 15, indicating that the Resident was cognitively intact. The MDS also indicated the use of oxygen therapy. On 9/30/25 at 12:20 P.M., The surveyor observed the Resident sitting up in his/her chair. The Resident was receiving oxygen at 2.5 lpm (liters per minute) via nasal cannula. The filter on the oxygen concentrator was covered in a thick layer of dust. On 10/01/25 at 7:11 A.M., The surveyor observed the Resident sleeping in his/her bed. The Resident was receiving oxygen at 2.5 lpm via nasal cannula. The filter on the oxygen concentrator was covered in a thick layer of dust. Review of Resident #82's active Physician orders indicated the following: -Oxygen: Change tubing and clean air filter weekly, dated 6/6/25. Review of the Resident's active care plan, dated as initiated 4/14/25, indicated the following: The Resident has oxygen therapy r/t CHF, COPD exacerbations. During an interview on 10/1/25 at 9:50 A.M., Nurse #5 said that the night nurses clean or change the oxygen filters on the concentrators once a week. During an interview and observation on 10/1/2025 9:54 A.M., Unit Manager #1 said that the night nurses clean the filters weekly. The surveyor and the Unit Manager observed the oxygen concentrator filter for Resident #82 and he said it was dusty and dirty. He said the Resident could breathe that in (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and it should not be that dusty after just a few days. During an interview on 10/1/25a at 1:15 P.M., the Director of Nurses said that she would expect that the nurses are cleaning the entire filter not just the inside. She said that the dust build up could trigger a reaction for a resident if not cleaned properly and regularly. 3. Resident #62 was admitted to the facility in February 2025 with diagnoses including chronic obstructive pulmonary disease, heart failure and hemiplegia. Review of the Minimum Data Set assessment, dated 8/12/25, indicated Resident #62 was cognitively intact, scoring a 13 out of 15 on the Brief Interview for Mental Status exam. Further review indicated the use of oxygen therapy. On 9/30/25 at 8:05 A.M. the surveyor observed Resident #62 in bed receiving oxygen via nasal cannula. The surveyor also observed the oxygen filter to be covered in a thick covering of dust. On 10/1/25, at 9:00 A.M. the surveyor observed Resident #62 in bed receiving oxygen via nasal cannula. The surveyor also observed the oxygen filter to be covered in a thick covering of dust. 4. Resident #73 was admitted to the facility in December 2024 with diagnoses including chronic obstructive pulmonary disease and heart disease. Review of the minimum data Set assessment, dated 9/19/25, indicated Resident #73 was cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicted Resident #73 was receiving oxygen therapy. On 9/30/25 at 8:20 A.M. the surveyor observed Resident #73 in bed receiving oxygen (O2) therapy via nasal cannula. The surveyor also observed an O2 cannula on the wheelchair and an O2 bottle on the floor. The surveyor also observed the O2 filter to be covered in a thick covering of dust. 5. Resident #2 was admitted to the facility in May 2025 with diagnoses including chronic obstructive pulmonary disease, heart failure and diabetes. Review of the Minimum Data Set assessment indicated Resident #2 was cognitively intact, scoring 14 out of 15 on the Brief Interview for Mental Status exam. Further review indicated Resident #2 was receiving oxygen therapy. On 9/30/25 at 8:24 A.M. the surveyor observed Resident #2 in bed receiving oxygen (O2) therapy via nasal cannula. The surveyor also observed an O2 cannula on the wheelchair. The surveyor also observed the O2 filter to be covered in a thick covering of dust. During an interview on 10/01/25 at 10:15 A.M. Nurse #6 said that the O2 filters should be cleaned. During an interview and observation on 10/1/25 10:18 A.M., Unit Manager #1 said that the night nurses are supposed to clean the filters weekly.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review and interview, the facility failed to ensure medications were labeled and stored in accordance with acceptable professional standards on three of three units. Specifically,1.The facility failed to ensure medications were labeled in accordance with acceptable professional standards, to include open dates on medications with shortened expiration dates in three medication carts on three of three units.2. The facility failed to secure and lock an unattended medication cart on the first-floor unit.Findings include:Review of the facility policy titled medication Storage, dated revised 5/9/25, indicated that all medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each mediation room. 1a. On 9/30/25 at 2:50 P.M. the surveyor observed the following in the first-floor medication cart: One bottle of Latanoprost eye drops (used to treat glaucoma) open, without a label. One bottle of Latanoprost eye drops not opened, received at the facility on 9/17/25. Review of the manufacturer's directions indicated refrigerating the eye drops until opened. One bottle of Liquacel liquid protein open, without a date opened. Review of the manufacturer's directions indicated to discard the bottle three months after opening. During an interview on 9/30/25 at 2:50 P.M. Unit Manager #1 said that the eye drops should be labeled with an open date when opened because they are only good for 30 days. He then said that he didn't know the liquid protein was good for only three months after opening. 1b. On 9/30/25 at 3:05 P.M. the surveyor observed the following in the third-floor medication cart: One bottle of injectable Lidocaine (used to prevent pain). One Arnuity Ellipta inhaler (used to treat asthma) open without a date opened and received from the pharmacy 7/7/25. Review of the manufacturer's directions indicated that the inhaler is good for six weeks after opening. One Incruse inhaler (used to treat asthma) open without a date opened and received from the pharmacy 5/3/25. Review of the manufacturer's directions indicated that the inhaler is good for six weeks after opening. During an interview on 9/30/25 at 3:05 P.M., Nurse #3 said that all the unlabeled medications should have been labeled with a date of when opened. 1c. On 9/30/25 at 3:10 P.M. the surveyor observed the following in the second-floor medication cart: Two tubes of Visguard eye lubricant open without a date opened and received from the pharmacy 8/14/25. One bottle of Timolol eye drops, open without a date opened and received from the pharmacy 7/16/25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One tube of Erythromycin eye ointment, open, without a pharmacy label or date opened. One bottle Netarsudil ophthalmic solution (used to treat glaucoma) open without a date opened and received from the pharmacy 4/21/25. One Trelegy inhalers (used to treat asthma) open without a date opened and received from the pharmacy 5/4/25. Review of the manufacturer's directions indicated that the inhaler is good for six weeks after opening. One Breo inhaler (used to treat asthma) open without a date opened and received from the pharmacy 12/12/24. Review of the manufacturer's directions indicated that the inhaler is good for six weeks after opening. One Breo inhaler open, without a date opened and received from the pharmacy 6/16/25. Review of the manufacturer's directions indicated that the inhaler is good for six weeks after opening. During an interview on 9/30/25 at 3:20 P.M., Nurse #2 said that all the unlabeled medications should have been labeled with a date of when opened. During an interview on 10/1/25, at 12:45 P.M., the Director of Nursing said that all inhalers, eye drops and other medications with shortened expiration dates after opening should be labeled with the date of when opened. 2. On 9/30/25 at 8:09 A.M., the surveyor observed an unlocked and unattended medication cart First Floor Unit. Two residents were observed sitting in the hallway in wheelchairs in close vicinity to the unlocked medication cart. The surveyor was able to gain entry to medication cart which was storing over the counter and prescription medications. During an interview and observation on 9/30/25 at 8:11 AM Unit Manager #1 said the medication carts should be locked when they are unattended by nursing staff. During an interview on 10/1/25 at 1:24 P.M., the Director of Nurses said that she would expect that all medication carts are locked when unattended by staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the faciliy failed to 1. provide appropriate hand hygiene after glove changes and 2. appropriately label and date items in the unit kitchenettes on 2 of 3 units. Findings include: Review of the facility policy titled Hand Washing, dated 2021, indicated the following: When to wash hands:ˆi: Before donning disposable gloves for working with food and after gloves are removed. Review of the facility policy, undated, indicated the following: Any items for residents must be labeled with name, room number, and date. All refrigerated commercially prepared items must be discarded within 72 hours. All home/or restaurant prepared foods must be discarded within 24 hours. The following observations were made in the first floor dining room on 9/30/25: 8:27 A.M. the server removed gloves, did not wash or sanitize, and put on new gloves.8:32 A.M., the server served one meal, took off his gloves and put new gloves on without performing hand hygiene.The server removed gloves and changed them without hand hygiene at 8:34 A.M., 8:35 A.M., 8:36 A.M., and 8:40 A.M.On 9/30/25 at 12:58 P.M. and 1:00 P.M., the server on the first floor removed gloves, placed them on the counter and put on new gloves without performing hand hygiene. During an interview on 10/1/25 at 9:30 A.M., the Food Service Director said that staff should perform hand hygiene when changing gloves. During an interview on 10/1/25 at 11:39 A.M., the Infection Preventionist said that when staff are changing their gloves, they need to sanitize their hands between glove use. 2. During an observation on 9/30/25 at 8:10 A.M., the following was observed in the second floor kitchenette.a fast food milkshake that was unlabeled and undated. a container of peppermint stick ice cream in the freezer that was unlabeled and undated. a container of expired eggnog that was unlabeled and undated.a blender bottle filled with some liquid that was unlabeled and undated.During an observation on 9/20/25 at 9:20 A.M., the following was observed in the 3rd floor kitchenette.a frozen cup of red substance that was unlabeled and undated. a container of ice cream that was unlabeled and undated. During an interview on 10/1/25 at 9:35 A.M., the Food Service Director said that food that is in the kitchenette should be labeled and dated when opened and kept for 72 hours, according to their policy. He said it is everyone's responsibility to throw food out of the fridge.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and interview the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, 1. The facility failed to maintain Enhanced Barrier Precautions (EBP) while caring for a resident with a gastrostomy tube.Findings include:Review of the Centers for Disease Control (CDC) website indicated the following, dated June 28, 2024:-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).Resident #53 was readmitted to the facility in September 2025 with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy status. Review of the Minimum Data Set (MDS) Assessment, dated 8/11/25, indicated that the Resident was independent with cognitive skills for daily decision making. On 9/30/25 at 7:53 A.M. the surveyor observed Resident #53 in bed and receiving tube feeding. On the doorway of Resident #53's room was a sign indicating for staff to maintain Enhanced Barrier Precautions. On 09/30/25 at 7:57 A.M., the surveyor observed Nurse #4 with Resident #53. Nurse #4 entered the Resident's room with only gloves on and then elevated the head of the bed then assessed and touched the Resident's gastrostomy tube. On 9/30/25 at 8:06 A.M., the surveyor observed Nurse #4, while wearing only gloves, disconnect the Resident's tube feeding and check the Resident's vital signs. During an interview on 10/1/25 at 11:36 A.M., the Infection Preventionist said that Enhanced Barrier Precautions (EBP) are utilized during direct high contact care of a resident. Residents with foley catheters, feeding tubes, or open wounds would be on EBP. If a nurse is touching a feeding tube or disconnecting a tube feed, a gown should have been worn in addition to gloves. During an interview on 10/1/25 at 1:22 P.M., the Director of Nurses said that staff should be wearing a gown and gloves when managing the Resident's feeding tube feeding.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to assess two Residents (#10 and #18), out of a total sample of 30 residents, for the ability to self-administer medications and determine if it was clinically appropriate.Findings include:Review of the facility policy titled Resident Self Administration of Medication, dated revised 5/9/25, indicated that when determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following:a. the medications are appropriate and safe for administration.b. the resident's physical capacity to swallow without difficulty, open medication bottles .c. the resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for.d. the resident's capability to follow directions and tell time to know when to take the medications.e. the resident's comprehension of instructions . including the dose, timing and signs of side effects and when to report to staff. 1. Resident #10 was admitted to the facility in April 2025 with diagnoses including Alzheimer's disease, heart disease and diabetes. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #10 scored a 6 out of 15 on the Brief Interview for Mental status exam indicating severe cognitive impairment. On 10/1/25 at 7:35 A.M. the surveyor observed Resident #10 to have a bottle of tums, Nystop powder (a medicated antifungal powder) and artificial tears at the bedside on top of the over the bed table. Review of the physician's orders failed to indicate an order for the self-administration of medications. Review of the medical record failed to indicate Resident #10 was assessed for the ability to self-administer medications.2. Resident #18 was admitted to the facility in June 2024 with diagnoses including psychotic disorder and high blood pressure. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #18 was cognitively intact, scoring 15 out of 15 on the Brief Interview for Mental Status exam. On 10/1/25 at 8:28 A.M. the surveyor observed Resident #18 to have a bottle of Nystop powder (a medicated antifungal powder) at the bedside on top of the over the bed table. During an interview on 10/1/25 at 8:28 A.M. Resident #18 said the antifungal powder was for red arms. Review of the physician's orders failed to indicate an order for the self-administration of medications. Review of the medical record failed to indicate Resident #18 was assessed for the ability to self-administer medications. During an interview on 10/01/25 at 10:15 A.M. Nurse #6 said that Residents #10 and #18 had not been assessed to have medications at bedside and they should not be there.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interviews, and record review, the facility failed to assess the use of an abdominal binder as a potential restraint for one Resident (#40) out of a total sample of 30 residents.Findings include:Review of the facility policy titled Restraint Free Environment, dated 5/9/25, indicated Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Resident #40 was admitted to the facility in March 2025 with diagnoses that included cerebral infarction, epilepsy, aphasia, and dysphagia. Review of the Minimum Data Set (MDS) assessment, dated 8/12/25, indicated he/she was assessed by nursing staff to have severe cognitive impairment. Further review of the MDS indicated no restraints used. Further review of the MDS indicated the Resident was dependent on staff for activities of daily living. Review of Resident #40's physician order dated 6/13/25, indicated Apply Abdominal binder every shift May remove for care/skin assessment/prn (as needed) for comfort. Review of Resident #40's care plans failed to indicate a restraint care plan or potential restraint. Review of Resident #40's medical record failed to indicate a restraint assessment was completed. During an interview on 10/1/25 at 9:15 A.M., Certified Nurse Aide (CNA) #1 said the Resident does try to pull out his/her g-tube (gastrostomy tube- a tube inserted through the abdomen that brings nutrition directly to the stomach) all the time and wears an abdominal binder to stop him/her from getting at it. During an interview and observation on 10/1/25 at 9:18 A.M., Nurse #1 said she is not sure if the Resident is able to remove the abdominal binder and wears it all the time to prevent him/her from removing his/her g-tube. Nurse #1 said she is not sure if a restraint assessment and care plan needs to be completed for the use of an abdominal binder. During an interview on 10/1/25 at 9:26 A.M., the Nursing Supervisor said an abdominal binder is not considered a restraint and would not need to be assessed. The Nursing Supervisor said it does restrict the resident from pulling out his/her g-tube. During an interview on 10/2/25 at 8:16 A.M., the Director of Nurses (DON) said a restraint assessment and care plan should be completed on a Resident who wears an abdominal binder.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, the facility failed to ensure one Resident (#27) was free from unnecessary psychotropic medications by ensuring a reassessment of an as needed (PRN) dose of Haldol (an antipsychotic medication) after 14 days, out of a total sample of 30 residents. Findings include: Review of facility policy titled Use of Psychotropic Medication(s), dated as reviewed 5/9/25, indicated the following:-PRN (as needed) orders for antipsychotic medications only, shall be limited to 14 days with no exceptions, If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. Resident #27 was admitted to the facility in September 2025 with diagnoses that included dementia and parkinsonism. Review of Resident #27's most recent Minimum Data Set (MDS) Assessment, dated 9/15/25, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating that the Resident had moderate cognitive impairment. The MDS further indicated the use of antipsychotic medications on an as needed basis only. Resident #27 was unable to participate in an interview about his/her medications. Review of active physician orders, as of 10/1/25, indicated the following:-Haloperidol Lactate Oral Concentrate (an antipsychotic medication) 2 mg/ml, give 0.5 ml by mouth every 4 hours as needed for agitation only if combative, dated 9/9/25. Review of the medical record indicates that the as needed Haldol order remained an active order after 22 days. Review of the September 2025 Medication Administration Record (MAR) indicated that the Resident received as needed doses of Haldol on 10 occasions. Review of Nurse Practitioner (NP) progress notes dated 9/9/25, 9/16/25, 9/23/25 and 9/30/25 failed to address the use of Haldol. Review of Resident #27's care plan indicated the following:-The Resident uses psychotropic medication, Haldol, related to agitation/ anxiety as needed per hospice orders, initiated 9/11/25. During an interview on 10/1/25 at 12:52 P.M., Unit Manager #1 said that all psychotropic medications ordered on an as needed basis require a 14 day stop date and reevaluation by a provider. Unit Manager #1 said that hospice recommended continuing the order on 9/23/25 but there was not a Physician or Nurse Practitioner visit to assess the Resident and determine the need to continue, and there should have been. During an interview on 10/1/25 at 1:17 P.M., the Director of Nurses said that psychotropic medications, especially antipsychotic medications, require a 14 day stop date and reevaluation by the Physician or Nurse Practitioner for continued use. She said that continued use requires a face-to-face visit and the orders require a 14 day stop date.

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Maristhill Nursing & Rehabilitation Center	66 Newton Street Waltham, MA 02453

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to develop a person- centered comprehensive care plan for one Resident (#53) out of a total sample of 30 residents. Specifically, for Resident #53, the facility failed to develop a person-centered comprehensive care plan for a pacemaker.Findings include:Review of facility policy titled Use of Pacemaker, dated as revised 5/9/25, indicated the following:-All residents with a pacemaker will be monitored according to standard protocol and plan of care.-All documentation about the pacemaker will be placed in the residents' chart and part of their permanent record.-All immediate care staff will be aware that the resident has a pacemaker. Resident #53 was readmitted to the facility in September 2025 with diagnoses that included sick sinus syndrome. Review of the Minimum Data Set (MDS) Assessment, dated 8/11/25, indicated that the Resident was independent with cognitive skills for daily decision making. Review of the Physician Discharge Summary from the acute care hospital, dated 9/23/25, indicated the following:-history of SSS (sick sinus syndrome) s/p PPM (permanent pacemaker) 2014. Review of Resident #53's physician orders failed to indicate orders for monitoring to include the Resident's paced rate. Review of Resident #53's active care plan failed to indicate a plan of care around the management of a pacemaker, to include cardiologists name, the paced rate and next pacemaker check. Review of the Nurse Practitioner Progress note, dated 7/24/25, indicated the following:-5. Sick sinus syndrome Clinical Notes: S/p (status post) pacemaker previously, had replacement 5/30/25 Followed [by cardiology]. Review of Nursing progress notes dated 5/30/25 indicated the following:Resident returned from his/her cardio appointment, Pacemaker Generator Changed. Has dressing on his/her left side of the chest. Discharge instructions relayed to NP (Nurse Practitioner) and is in agreement. Instructions are Remove dressing on Wednesday, 6/4/25 and then apply dry and clean dressing for 4 more days, May shower after four days, do not remove steri strips they will fall off, report any bleeding or infection, Tylenol for pain, Limit arm motion and lifting for a week, Follow up in 2-3 Weeks. Patient is stable at this time. Plan of care ongoing. During an interview on 10/1/25 at 1:02 P.M., Unit Manager #1 said that residents who have a pacemaker should have a care plan indicating the cardiologist and paced rate of the pacemaker. Unit Manager reviewed the active medical record for Resident #53 and said that there was no active care plan present. Unit Manager #1 said that he is not sure if Resident #53 still has a pacemaker. During an interview and observation on 10/01/25 at 1:11 P.M., Resident #53 was observed sitting up in his/her wheelchair in the dining room. Resident #53 said that he/she has a pacemaker that was just replaced four months ago and pointed to his/her chest indicating the location of the pacemaker.During an interview on 10/1/25 at 1:20 P.M., the Director of Nurses said that when residents have a pacemaker, there should be an active person-centered care plan indicating the resident's cardiologist, manufacturer and paced rate.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review and interview, the facility failed to ensure one Resident (#40) received care in accordance with professional standards of practice, out of a total sample of 30 residents. Specifically, for Resident #40, the facility failed to ensure nursing completed a weekly skin assessment per the physician order. Findings include:Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following:- Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Resident #40 was admitted to the facility in March 2025 with diagnoses that included cerebral infarction, epilepsy, aphasia, and dysphagia. Review of the Minimum Data Set (MDS) assessment, dated 8/12/25, indicted he/she was assessed by nursing staff to have severe cognitive impairments. Review of Resident #40's Braden Scale (Scale for Predicting Pressure Ulcer Risk Evaluation) 9/30/25, indicated he/she scored a 12 indicating high risk. Review of Resident #40's physician order dated 5/2/25, indicated Weekly Skin Assessment every day shift Friday. Review of Resident #40's September 2025 's Treatment Administration Record (TAR), indicated on 9/19/25 and 9/26/25 that the weekly skin check was completed. Review of Resident #40's medical record indicated the last completed skin check was on 9/12/25. The skin check from 9/12/25 indicated foot evaluation was completed and there was an open lesion noted to the left heel and the skin issue was not evaluated. During an interview and observation on 10/1/25 at 9:18 A.M., Nurse #1 said Resident #40 is at risk for skin breakdown and skin checks should be completed weekly and if the resident refuses a nursing progress should be written and not signed off on the treatment as administered. During an interview on 10/1/25 at 9:26 A.M., the Nursing Supervisor said if a skin check is completed it would be under the assessment tab in the electronic medical record and if the resident ever refused a weekly skin check, then a nursing note should have been written. During an interview on 10/2/25 at 10:02 A.M., the Director of Nurses (DON) said weekly skin checks should be completed weekly as ordered. Review of Resident #40's medical record failed to indicate the Resident refused the skin checks on 9/19/25 and 9/26/25.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for one Resident (#40) who was assessed to be at high risk for developing pressure ulcers, out of a total sample of 30 residents. Specifically, for Resident #40, the facility failed to notify the provider of an open skin lesion of his/her left heel.Findings include: Resident #40 was admitted to the facility in March 2025 with diagnoses that included cerebral infarction, epilepsy, aphasia, and dysphagia. Review of the Minimum Data Set (MDS) assessment, dated 8/12/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Review of Resident #40's Braden Scale (Scale for Predicting Pressure Ulcer Risk Evaluation) 9/30/25, indicated he/she scored a 12 indicating high risk. Review of Resident #40's medical record indicated the last completed skin check was on 9/12/25. The skin check from 9/12/25 indicated foot evaluation was completed and there was an open lesion noted to the left heel and the skin issue was not evaluated. During an interview and observation on 10/1/25 at 9:18 A.M., Nurse #1 said he/she has a yellow scab about the size of a dime and is not sure how long the area has been there, but it needs a treatment, and his/her heels are red. During an interview on 10/1/25 at 9:26 A.M., the Nursing Supervisor said he does not remember completing the skin check on 9/12/25 that says there is an open area on the left heel. The Nursing Supervisor said if an area is identified on a skin check, then the doctor or Nurse Practitioner should have been notified, and a treatment should have been ordered if the area was open. Review of Resident #40's medical record failed to indicate an order was put in place for the open lesion on the left heel from 9/12/25 to 10/1/25. The medical record also failed to indicate that the doctor or nurse practitioner was notified or aware of the area on the left heel.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews and record review, the facility failed to ensure staff provided appropriate care and services for one Resident (#53) with a gastrostomy tube (a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication), out of 30 sampled residents. Specifically, the facility failed to ensure that the head of the bed was elevated to prevent potential aspiration while receiving enteral feedings. Findings include: Review of facility policy titled Care and Treatment of Feeding Tubes, revised 5/9/25, indicated the following:-It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.-The resident's plan of care will direct staff regarding proper positioning of the resident consistent with the resident's individual needs. Resident #53 was readmitted to the facility in September 2025 with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy status. Review of the Minimum Data Set (MDS) Assessment, dated 8/11/25, indicated that the Resident was independent with cognitive skills for daily decision making. On 9/30/25 at 7:53 A.M. the surveyor observed the Resident lying flat in bed, awake. A tube feeding was running at 120 ml (milliliters) per hour. The Resident was restless and exhibiting a congested cough. A hard neck collar was in place on the Resident. The surveyor immediately notified the nurse. Review of Resident #53's active Physician orders indicated the following:-Jevity 1.2 cal at 120 ml/hr (milliliters per hour) x 14 hours from 6:00 P.M. to 8:00 A.M., dated 9/23/25.-Elevate HOB (head of bed) 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped, dated 9/23/25. Review of the Nutrition Assessment, dated 9/24/25, indicated the use of tube feeding. During an interview and observation on 9/30/25 at 7:57 A.M. the surveyor reported to Nurse #4 that the Resident was lying flat, coughing and receiving his/her tube feeding. The nurse and the Unit Manager observed the Resident in bed. The nurse raised the head of the bed and said the Resident should not be lying flat in bed and should be at least 45 degrees elevation, but he/she was not. During an interview on 9/30/25 at 8:12 A.M., Unit Manager #1 said that the Resident was lying flat and should not have been. He said that the Resident should have been elevated at least 45 degrees. During a follow up interview on 10/1/25 at 1:01 P.M., Unit Manager #1 said that he interviewed a Certified Nurses Aide who had assisted the Resident around 7:00 A.M. the previous day and put the head of the bed down to perform care and forgot to put the head of the bed back up. He said this placed the Resident at risk of aspiration. During an interview on 10/1/25 at 1:22 P.M., the Director of Nurses said that the head of the bed should be elevated at least 30-45 degrees when a Resident is receiving a tube feeding to prevent the risk of aspiration.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record and interviews, the facility failed to provide behavioral health care services in a person-centered environment for one Resident # 88 out of a sample of 30 Residents. Specifically, the facility failed to implement psychiatric recommendations provided after the Resident expressed suicidal ideations. Findings include: A review of the facility policy titled ?Behavioral Health Services' revised 5/9/25 indicated the following:-It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychological functioning and well-being.-The facility will ensure that necessary behavioral health services are person centered and reflect the resident's goals of care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety.Resident #88 was admitted to the facility in September 2021 with diagnoses including suicidal ideations and multiple sclerosis.A review of the Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15 indicating moderate impairment.A review of Resident #88's psychiatric note dated 6/6/25 indicated the following:-Psych progress notes-HPI (History of Present Illness): Asked to see the pt (patient) in order to evaluate the safety of giving him/her back colored pencils and sharpener, in light of his/her recently trying to cut himself/herself with a plastic knife, I believe. At 4 pm, pt (patient) in gown in bed. Alert, responsive, O x 3 (Oriented to person, place and time. Affect [NAME] (cooperative), polite, able to smile and laugh at times. Pt (patient) describes continuing thoughts of desire to cut himself/herself. He/she says he/she has cut his/her wrists off and on over the decades, never required suturing but may have led to his/her stay at a psychiatric hospital in his/her 40s. [sic]Recommendations:-Given his/her persistent thoughts of hurting him/herself, I would not return his/her pencils and sharpener. [sic]A review of Resident #88's care plan initiated 8/20/25 indicated the following intervention:-Resident is allowed to have colored pencils for coloring but no pencil sharpeners, staff will sharpen his/her pencils for him/her when it is needed.On 9/30/25 at 1:22 P.M., the surveyor observed sharp coloring pencils on the Resident's windowsill.During an interview on 9/30/25 at 1:22 P.M., Resident #88 said he/she loves to use coloring pencils to color. He/she said coloring is his/her favorite activity. He/she said staff are always available to give him/her the coloring pencils on the windowsill whenever he/she wants to color. The Resident said he/she last used the coloring pencils about 2-3 weeks ago.On 10/1/25 at 7:48 A.M., the surveyor observed Resident #88 getting prepared for Activities of Daily Living Care, (ADL) by a Certified Nurse's Assistant (CNA#2). Sharp coloring pencils in a carton, and sharp coloring pencils in a pencil holder were observed on the Resident's windowsill.During an interview on 10/1/25 at 7:49 A.M., CNA #2 said she takes care of the Resident most mornings. She said if the Resident requests his/her coloring pencils, she gives them to him/her because he/she likes to color. On 10/2/25 at 7:09 A.M., the surveyor observed Resident #88 sleeping, a box of sharp coloring pencils, and sharp coloring pencils in a pencil holder were observed on the Resident's windowsill.During an interview on 10/1/25 at 12:11 P.M., the Activities Director said Resident #88's favorite activity is coloring. The Activities Director said he/she loves to use coloring pencils instead of crayons because he/she loves how they color. The Activities Director said the Resident does not participate in most public activities; he/she loves to color in his/her room. The Activities Director said staff are always available to give him/her coloring pencils as he/she is not able to transfer on his/her own.During an observation, interview and medical record review on 10/2/25 at 7:26 A.M., Unit Manager #2 observed the sharp coloring pencils on the Resident's windowsill with the surveyor. The Unit Manager reviewed the 6/6/25 psychiatric recommendation and said Resident #88's psychiatric recommendations should be followed at all times since the Resident has a history of suicidal ideations.During an observation, interview and medical record review on 10/2/25 at 8:08 A.M., the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker and the surveyor observed sharp coloring pencils on the Resident's windowsill. The Social Worker reviewed the 6/6/25 psychiatric recommendation and said if the psychiatric recommendations do not recommend sharp coloring pencils, the sharp coloring pencils should not be in the Resident's room.During an interview and medical record review on 10/2/25 at 8:10 A.M., the Director of Nurses reviewed the 6/6/25 psychiatric recommendation and said psychiatric recommendations should be followed and implemented in the Resident's plan of care.During an interview on 10/2/25 at 9:30 A.M., the Psychiatrist said all the recommendations he makes should be implemented in the plan of care. The Psychiatrist said he has no concerns with Resident #88 having sharp coloring pencils in his/her room but could not provide documentation that stated so. The Psychiatrist said the facility asked him to write a late entry progress note today indicating he did not have any concerns with the Resident having sharp coloring pencils in his/her room.