STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225409	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nevins Nursing & Rehabilitation Center	Ten Ingalls Court Methuen, MA 01844

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 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 three Residents, (#2, #136 and #66) out of a sample of 34 Residents. Specifically,1.For Resident #2, the facility failed to provide oxygen to the Resident as indicated in the physician's orders.2.For Resident #136, the facility failed to ensure oxygen equipment and tubing was labeled, when changed/dated and that respiratory assessments were documented as indicated in the physician's orders. 3. For Resident #66, the facility failed to ensure nebulizer equipment and tubing was labeled, when changed/dated. Findings include: Review of the facility policy titled 'Policy and Procedure: Oxygen (O2) Management' with no revision date, indicated the following: -To ensure the safe and effective administration of oxygen therapy to residents, in compliance with Massachusetts Department of Public Health and CMS guidelines. -It is the policy of the facility to provide oxygen therapy to residents as prescribed by their physician or nurse practitioner (NP), ensuring proper administration, monitoring, and documentation to maintain resident safety and well-being. Resident #2 was admitted to the facility in September 2025 with diagnoses including heart failure. Review of the Minimum Data Set (MDS) Assessment, dated 12/26/25, indicated a Brief Interview for Mental Status score (BIMS) of 9 out of a possible 15, indicating moderate cognitive impairment. Review of Resident #2's January 2026 physician's orders indicated the following: -Oxygen at 2 Liters via nasal cannula care and comfort every shift. Start date 1/5/26. On 1/6/26 at 8:15 A.M., the surveyor observed Resident #2 sleeping with the nasal cannula on. Oxygen was set at 3 Liters. On 1/7/26 at 7:48 A.M., and 10:44 A.M., the surveyor observed Resident #2 sleeping with the nasal cannula on. Oxygen was set at 3 Liters. During an interview and observation on 1/7/26 at 10:45 A.M., the surveyor and Nurse #1 observed Resident #2 sleeping with the nasal cannula on. The oxygen was set at 3 Liters. Nurse #1 said the Resident is on oxygen for comfort and the physician's orders states the oxygen should be set at 2 Liters. (continued on next page)

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

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and medical record review on 1/7/26 at 11:04 A.M., Unit Manager #1 and the surveyor reviewed the Resident's medical record. The Unit Manager said that the Resident is currently on hospice and is on oxygen for comfort. The Unit Manager said the Resident's oxygen should be set at 2 Liters per the physician's orders. During an interview and medical record review on 1/7/26 at 11:38 A.M., the Director of Nurses reviewed the medical record and said the Resident is currently on hospice and on oxygen for comfort. The DON said the physician's orders should be followed and the oxygen should be set at 2 liters. 2. Resident #136 was admitted to the facility in March 2022 with diagnoses including, chronic diastolic congestive heart failure, moderate persistent asthma, essential primary hypertension, and morbid (severe) obesity. Review of the most recent Minimum Data Set assessment (MDS) assessment, dated 11/21/25, indicated the Resident scored a 14 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. On 1/6/26 at 8:35 A.M., the surveyor observed Resident #136 sitting up in bed with nasal canula tubing from an oxygen concentrator resting on his/her pillow. Resident #136 said he/she has been having shortness of breath at night and using oxygen. On 1/7/26 at 9:13 A.M., the surveyor observed Resident #136 receiving oxygen from a nasal canula from an oxygen concentrator. The oxygen tubing and one 540mL (milliliter) bottle of sterile water (used for humidification) was undated. The oxygen was set at 1.5 liters. Resident #136 said he/she was having shortness of breath overnight and said the overnight nurse placed him/her on oxygen. Resident #136 said he/she did not know his/her oxygenation saturation level because the nurse did not put that thing they use on my finger, referring to a pulse oximeter used to measure the level of oxygen in the blood. On 1/7/26 at 12:15 P.M., the surveyor observed Resident #136 receiving oxygen from a nasal canula from an oxygen concentrator. The oxygen tubing and one 540mL (milliliter) bottle of sterile water (used for humidification) was undated. The oxygen was set at 2 liters. Review of Resident #136's active physician orders indicated the following:-Oxygen at 2L (liters) via N.C (nasal cannula) to maintain oxygen saturation greater than 90% every 24 hours as needed for monitoring. Start Date 6/3/25.-Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally as needed for congestion BID. Start Date 3/4/24. Review of Resident #136's asthma care plan dated 9/21/24, indicated the Resident has asthma and is at risk for SOB (shortness of breath)/Respiratory distress, allergies, CHF (congestive heart failure) and is at risk for Respiratory distress. The following care plan interventions included: - Give medications as ordered. Monitor/document side effects and effectiveness. Initiated 10/1/24.-Monitor for s/sx (signs/symptoms) of impending asthma attack: coughing spells, decreased energy, rapid breathing, complaint of chest tightness or hurting, wheezing, shortness of breath, tightness of neck or chest muscles, malaise or fatigue. Initiated 10/1/24.- Monitor VITAL SIGNS as needed, skin color, pulse oximetry, airway functioning and degree of restlessness which may indicate hypoxia. Initiated 10/1/24.- Resident Avoids Lying Flat due to shortness of breath, see ETAR (electronic treatment administration record) if noted. Initiated (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/1/24.- Monitor for any SOB (shortness of breath) and other related symptoms for any SOB while lying flat/upon exertion/at rest or if pt avoids lying flat d/t (due to) SOB. If any SOB is noted, elevate the head of bed or get pt (patient) OOB (out of bed), upright in chair, if able, to facilitate easier breathing. Take rest breaks if SOB is noted. Initiated 12/13/24. Review of Resident #136's medical record including Treatment Administration Record (TAR) and Medication Administration Record (MAR) for the month of January 2026 was left blank and contained no documentation of administration of Oxygen at 2L via N.C to maintain oxygen saturation greater than 90% every 24 hours as needed for monitoring per the physician order. Review of Resident #136's medical record failed to reflect an ongoing assessment of the Resident's respiratory status and response to oxygen therapy. The last documented oxygen saturation level was 90% on 12/26/25. Further review of the medical record failed to indicate physician orders were in place to change/date the oxygen tubing. During an interview on 1/7/26 at 9:23 A.M., Nurse #3 said Resident #136 uses oxygen as needed for shortness of breath and said respiratory assessments should be documented in the medical record. Nurse #3 said she was not aware that Resident #136 had shortness of breath overnight and said there is no respiratory assessment or documented oxygenation status. Nurse #3 reviewed the medical record and said Resident is currently receiving oxygen and it needs to be documented on the MAR, and a respiratory assessment must be completed. Nurse #3 said oxygen tubing and equipment must be dated weekly and stored appropriately when not in use. During an interview on 1/7/26 at 12:56 P.M., the Director of Nursing said physician's orders should be followed as ordered and said respiratory assessments must be documented. She further said that she would expect nurses to document the use of oxygen therapy in the medical record if administered. The DON said all oxygen equipment and nebulizer tubing should be changed weekly and should be dated, labelled and bagged. 3. Resident #66 was admitted to the facility in May 2025 with diagnoses including dysphagia, hypotension, and major depressive disorder. Review of Resident #66's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #66 had moderate cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible15. On 1/6/26 at 8:21 A.M., an uncovered nebulizer machine and mask were resting on top of a wheelchair, the tubing was undated. The Resident said he/she uses the nebulizer every day. On 1/6/26 at 11:30 A.M., an uncovered nebulizer machine and mask were resting on top of a wheelchair, the tubing was undated. On 1/7/26 at 8:06 A.M., an uncovered nebulizer machine and mask were resting on top of a wheelchair, the tubing was undated. Review of Resident #66's medical record indicated the following physician order:-Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium- Albuterol) 1 application via mask three times a day for congestion for 5 Days. Start Date 1/2/26. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #66's Medication Administration Record (MAR) indicated the Resident was receiving the oral inhalation medication via nebulizer three times daily. Review of Resident #66's medical record failed to indicate a physician's order or care plan for the care of the nebulizer machine, including tubing or mask, was developed or implemented. During an interview on 1/7/26 at 9:25 A.M., Nurse #3 said respiratory tubing and equipment must be changed and dated weekly and stored appropriately when not in use. During an interview on 1/7/26 at 12:58 P.M., the Director of Nursing said nebulizer equipment and tubing should be bagged, dated and changed weekly and documented in the medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments for three Residents (#16, #66, and #54) out of 34 total sampled residents. Specifically, the facility failed to:1.Ensure Resident #16's scheduled Tylenol was not left at the bedside while unsupervised by staff. 2. Ensure Resident #66's Augmentin Oral Tablet (antibiotic medication) was not left at the bedside while unsupervised by staff.3. Ensure Resident #54's Nasal Saline Solution was not left at the bedside while unsupervised by staff.Findings include: Review of the facility policy titled Storage of Medications, dated as revised in 2024, indicated but was not limited to the following:Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aids) are permitted to access medications, medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. 1.Resident #16 was admitted to the facility in March 2024 with diagnoses including spinal stenosis and bipolar disorder. Review of Resident #16's most recent Minimum Data Set (MDS) Assessment, dated 10/17/25, indicated Resident #16 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. On 1/6/26 at 8:00 A.M., the surveyor observed a medication cup on Resident #16's walker tray table with two white pills inside. Resident #16 stated that the medications inside the cup were Tylenol and he/she was waiting for breakfast to take them. Review of Resident #16's medical record failed to indicate that the Resident had met criteria to self-administer medications at his/her bedside. Review of Resident #16's physician order dated 9/29/24 indicated the following: -Acetaminophen Oral Tablet (Tylenol) Give 1000 mg (milligrams) by mouth three times a day for pain, scheduled at 8:00 A.M., 1:00 P.M., and 6:00 P.M. Review of the January 2026 Medication Administration Record indicated that Resident #16's scheduled 8:00 A.M. Tylenol was signed off as having received the medication on 1/6/26 at 7:39 A.M. During an interview on 1/7/26 at 11:13 A.M., Unit Manager #2 said medications are not supposed to be left at the bedside without a medication administration assessment completed and a physician's order. During an interview on 1/7/26 at 12:52 P.M., the Director of Nursing said medications should not be left at the bedside and signed off as administered when it was not. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #66 was admitted to the facility in May 2025 with diagnoses including dysphagia, hypotension, and major depressive disorder. Review of Resident #66's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #66 had moderate cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible score of 15. On 1/6/26 at 8:21 A.M., the surveyor observed a medication cup on Resident #66's overbed table with one white oval pill inside. Resident #66 stated he/she did not know what the medication was or how it got there. Review of Resident #66's physician orders and care plans failed to indicate that the Resident had met criteria to self-administer medications at his/her bedside. Review of Resident #66's physician order dated 1/5/26 indicated the following: -Augmentin Oral Tablet 500-125 MG (milligrams) (Amoxicillin & Pot Clavulanate) Give 1 tablet by mouth two times a day for pneumonia for 7 Days. Scheduled for 6:00 A.M., and 6:00 P.M. Review of Resident #66's January Medication Administration Record indicated that Resident #66's scheduled 6:00 A.M., Augmentin was as having received the medication on 1/6/26. During an interview on 1/6/26 at 12:46 P.M., Nurse #4 said a Certified Nursing Assistant notified her about the pill that was found on the bedside table and removed it because she did not know what it was and said medication should not be left at the bedside. Nurse #4 said when she investigated the medication it was noted this was Resident #66's scheduled 6:00 A.M. antibiotic that was left by the overnight nurse. Nurse #4 said Resident #66 cannot self-administer medication and should not have medications left at the bedside because he/she has a cognitive impairment During an interview on 1/7/26 at 12:52 P.M., the Director of Nursing (DON) said Resident #66's medications should not be left at the bedside and signed off as administered when it was not. The DON said Resident #66 did not have a self-administration assessment completed and said the Resident was not deemed to be appropriate to self-administer medications. 3. Resident #54 was admitted to the facility in January 2024 with diagnoses including type one diabetes mellitus, anemia in chronic kidney disease (low red blood cells) and epistaxis (nose bleeds). Review of Resident #54's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #54 had intact cognition as evidence by a Brief Interview for Mental Status (BIMS) score of 14 out of a possible score of 15. On 1/6/26 at 8:21 A.M., the surveyor observed one open and undated bottle of Saline Nasal Spray Nasal Solution on Resident #54's overbed table. The Resident said staff leave it in his/her room and administer it when it is due. On 1/6/26 at 12:34 P.M., the surveyor observed one bottle of Saline Nasal Spray Nasal Solution on Resident #54's overbed table. On 1/7/26 at 7:47 A.M., 9:16 A.M., and 12:34 P.M., the surveyor observed one bottle of Saline Nasal (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Spray Nasal Solution on Resident #54's overbed table. Review of Resident #54s physician orders and care plans failed to indicate that the Resident had met criteria to self-administer medications at his/her bedside. Review of Resident #54's physician order dated 3/20/25 indicated the following: -Saline Nasal Spray Nasal Solution (Saline) 1 spray in both nostrils two times a day for dry nostrils. Scheduled for 9:00 A.M., and 6:00 P.M. Review of Resident #54's January Medication Administration Record indicated that Resident #54's scheduled 6:00 A.M. and 6:00 P.M., Saline Nasal Spray Nasal Solution was signed off as Resident receiving medication on 1/6/26 and 1/7/26. During an interview on 1/7/26 at 12:46 P.M., Nurse #3 said Resident #54 should not have the nasal spray stored in his/her room and said the bottle must be dated when opened and stored in the medication cart until it is due to be administered. Nurse #3 said Resident #54 has not been cleared to self-administer medications. During an interview on 1/7/26 at 9:49 A.M., Unit Manager #1 said medication must be dated when opened and stored in the locked medication cart and not kept in the residents' room. Unit Manager #1 said Resident #54 has not been assessed for self-administration of medications and should not have the medication in his/her room. During an interview on 1/7/26 at 12:52 P.M., the Director of Nursing said Resident #54 should not have the bottle of Nasal Saline Solution accessible in his/her room and said the bottle must be dated when opened and stored in the nursing cart.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure resident meals were at an appropriate temperature and were palatable on 4 of 4 resident units. Findings include: During the initial screening process, multiple residents reported that meals are served cold and not palatable. During the Resident Group Interview held on 1/7/26 at 10:30 A.M., multiple participants reported that meals served to residents on the unit were cold, uncooked and not palatable. During an interview on 1/7/26 at 12:26 P.M., the Food Service Director (FSD) said that the food is brought up to the units on carts with closed cabinet doors and then plated on the units. On 1/7/26 at 12:47 P.M., the surveyor conducted a test tray on the B unit:Mashed Potato: 130 degrees Fahrenheit (F)Steamed Cauliflower: 119 degrees FPuree Meatloaf: 95 degrees F. The food items tasted cold and were not palatable. On 1/7/26 at 12:50 P.M., the surveyor conducted a test tray on the C unit:Meatloaf: 90 degrees F. Mashed Potato: 100 degrees F. Steamed Cauliflower: 90 degrees F. The food items tasted cold and were not palatable. On 1/7/26 at 12:55 P.M., the surveyor conducted a test tray on the A Unit:Clam Chowder: 120.6 degrees Fahrenheit (F)Mashed Potato: 146.8 degrees FMeatloaf: 136.6 degrees FSteamed Cauliflower: 112.2 degrees FThe food items tasted cold and were not palatable. On 1/7/26 at 12:55 P.M., the surveyor conducted a test tray on the TCU, (Transitional Care Unit):Mashed Potato: 122.9 degrees F.Steamed Cauliflower: 107 degrees F.Meatloaf: 147 degrees F.The mashed potato and cauliflower tasted cool and were not palatable. During an interview on 1/7/26 at 1:11 P.M., the FSD said that the expectation is for hot food items to be about 135 degrees when served to the resident.

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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 facility failed to store and prepare food in accordance with professional food safety standards. Specifically, the facility failed to1. Ensure food items were stored appropriately in the main kitchen reach in and walk in refrigerator and2. Failed to ensure staff maintained proper hand hygiene while serving food on two of four units.Findings include:Review of the facility's policy titled Food Labeling Policy and Procedures for [The Facility], undated, indicated: Policy: All food items must be labeled accurately and clearly to ensure proper identification, traceability, and safe consumptions. Procedures: 1. Labeling Requirements: All food items must be labeled with the following information: Name of the item, date item was brought into facility, use-by or expiration date. Labels must be legible and securely attached to the container or packaging. 1. On 1/6/26 at 7:11 A.M., the surveyor observed the following in the reach-in refrigerator and walk-in refrigerators: -A shopping bag with containers of food. A staff person said that the bag contained a staff persons' lunch and should not be stored in the refrigerator. -A sandwich dated labeled use for 1/2/26 -A plastic cup filled with pasta salad, undated and unlabeled. -A bowl of breakfast sausages, undated and unlabeled. -Ten bowls of fruit, undated and unlabeled. -A container of a brown gravy- like substance, undated and unlabeled. During an interview on 1/7/26 at 10:58 A.M., the Food Service Director said all items in the refrigerator should be dated and labeled and the sandwich should have been disposed of. 2a. During an observation on 1/6/26 at 8:20 A.M., the surveyor observed a food service employee on the A unit pull a steam cart down the hallway with gloved hands. The employee proceeded to plug in the steam table with her same gloved hands. Without changing her gloves, pressed buttons on the upper part of the steam table, turning lights on. She then proceeded to grab a plate and serve residents meals without changing her gloves. During an interview on 1/7/26 at 1:09 P.M., the Food Service Director said that the staff should not be wearing gloves when serving the food, and that the employee should not have been touching the table and plug and then serving food without changing or removing her gloves and performing hand hygiene. 2b. During an observation on the Transitional Care Unit (TCU) on 1/7/26 at 12:30 P.M, the surveyor observed Diet Staff #1, without gloves on and without previously sanitizing her hands, obtain serving utensils from a metal bin by taking the utensils out of the bin by the bowl end (potentially contaminating the utensils) and then placing the bowl end of the utensil directly into the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/26 at 12:55 P.M., Diet Staff #1 said that she should not have touched the bowl end of the serving utensils. During an interview on 1/7/26 at 1:09 P.M., The Food Service Director said that the staff member should not have grabbed the utensils by the serving end with her bare hand and then use it to serve food.

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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 record review and interview, the facility failed to ensure Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were consistently documented in the medical record for one Resident (#66), out of a total sample of 34 residents.Findings include: Review of the facility policy titled Advanced Directives, dated as revised September 2022, indicated but was not limited to the following:The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy.-Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section that is retrievable by any staff.-If the Resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents' medical record and are readily retrievable by any facility staff member. -The Director of Nursing Services (DNS) or designee notified the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the residents' medical record and plan of care.-The residents' wishes are communicated to the residents' direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meetings. -The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive.-Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may require new documents if changes are extensive. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan.Resident #66 was admitted to the facility in May 2025 with diagnoses including dysphagia, hypotension, and major depressive disorder. Review of Resident #66's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #66 had moderate cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible score of 15.Review of Resident #66's plan of care related to advanced directives, dated 5/16/25, indicated:- Provide education to resident/family regarding care options.- Review existing advance directives and whether the resident wishes to change or continue these instructions as part of the comprehensive care planning process and PRN (as needed).On 1/6/26, the surveyor observed in the electronic health record, in the clinical dashboard, that Resident #66's Code Status Advance Directive section was left blank.Review of Resident #66's active physician's orders, failed to indicate an order for advance directives was in place. Review of Resident #66's Medical Orders for Life Sustaining Treatment (MOLST) form dated 7/21/25, indicated:-Do Not Resuscitate.-Transfer to Hospital.Review of Resident #66's medical record included a MOLST indicating the following: Page 1 Section D of the MOLST indicated: -Do Not Resuscitate-Transfer to HospitalPage 2 Section G of the MOLST, was signed but did not indicate who was signing the form. The form did not include a legible printed name of the signer and was left blank, the form was not dated and was left blank, and the telephone number of the signer section was left blank. The MOLST was dated and signed 7/21/25 by the Nurse Practitioner.During an interview on 1/7/26 at 9:21 A.M., Nurse #3 reviewed Resident #66's clinical dashboard and she said that she was not sure what Resident #66's code status was due to the missing information and said there is no active physician order in place. Nurse #3 said she would need to review the medical record because she does not know the residents' code status.During an interview on 1/7/26 at 9:23A.M., the surveyor along with Unit Manager #1 and Nurse #3 reviewed Resident #66's clinical dashboard including physician orders and Unit Manager #1 said Advance Directive status should be documented in the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic medical record with a physician order in place and said the care plan should indicate the code status but does not. Unit Manager #1 said he would need to check as he does not know the Resident's code status. During an interview on 1/7/26 at 10:50 A.M., Unit Manager #1 said he found the MOLST form and gave the surveyor a printed copy of a MOLST form dated 9/4/24. The MOLST form did not match the MOLST form that was located in Resident #66's physical medical chart. The MOLST form dated 9/4/24 indicated: -Do Not Resuscitate -Do Not Transfer to Hospital. The surveyor and Unit Manager #1 obtained the MOLST form dated 7/21/25 located in front of Resident #66's physical medial chart. During an interview on 1/7/26 at 10:55 A.M., Unit Manager #1 said the Resident #66's medical record has missing and conflicting code status information and said the MOLST form dated 7/21/25 should have been filled out completely because the Residents wishes had changed to be transported to the hospital. Unit Manager #1 said MOLST needs to be signed, dated and updated in the medical record. Review of Resident #66's medical record on 1/7/26 at 12:00 P.M., indicated the clinical dashboard Advance Directive code status section now indicated: Do Not Resuscitate, Do not intubate/ventilate/Do not use Non-invasive ventilation/ Do not transfer to Hospital.During an interview 1/7/26 at 12:49 P.M., the Director of Nursing (DON) said Resident #66's code status should consistently be documented in the medical record and include a physician order and said the plan of care should include the Advance Directive status. The DON said any updates to the Residents MOLST form should be complete and accessible in the medical record.

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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 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 implement the plan of care for one Resident (#4) out of a total sample of 34 residents. Specifically, for Resident #4 the facility failed to obtain and document vital signs as indicated in the plan of care. Findings include:Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated as revised March 2022, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Resident #4 was admitted to the facility in February 2025 with diagnoses including presence of a pacemaker, congestive heart failure and atrial fibrillation.Review of the Minimum Data Set (MDS) assessment, dated 11/14/25, indicated that Resident #4 had moderate cognitive impairment as evidenced by a score of 9 out of 15 on the Brief Interview for Mental Status exam. Further review indicated Resident #4 was dependent on staff for activities of daily living.Review of the care plan dated 3/3/25 indicated a focus of the resident has a pacemaker r/t (related to) atrial fibrillation with interventions including monitor vital signs (blood pressure, heart rate and respiratory rate) daily. Notify MD (medical doctor) of significant abnormalities. Review of the progress notes failed to indicate nursing obtained vital signs daily.Review of the treatment administration record, dated January 2026, failed to indicate vital signs were obtained daily.Review of the medication administration record, dated January 2026, failed to indicate vital signs were obtained daily.During an interview on 1/7/26 at 10:20 A.M., Unit Manager #1 said that nurses should follow the care plan. He then said that vital signs should be taken and documented on the treatment record per the care plan.During an interview on 1/7/26 at 11:25 A.M., the Director of Nursing said that care plans are to be followed by facility staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review and interview the facility failed to ensure assistance with Activities of Daily Living were provided for two Residents (#62 and #129) out of a total sample of 34 Residents. Specifically,For Resident #62 the facility failed to provide supervision or touching assistance with meals as indicated in the Resident's plan of care.For Resident #129 the facility failed to provide continuous supervision with meals as indicated in the Resident's plan of care.Findings include:Review of the untitled policy provided to the surveyor when the Activities of Daily Living (ADL) policy was requested, undated, indicated the following: -Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's abilities in activities of daily living do not diminish unless circumstances of the individuals clinical condition demonstrate that such diminution was unavoidable. -The center must ensure that: a patient who is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. Resident #62 was admitted to the facility in November 2025 with diagnoses that included protein-calorie malnutrition and adult failure to thrive. Review of Resident #62's most recent Minimum Data Set (MDS) assessment, dated 11/12/25, indicated a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. The MDS further indicated that the Resident required supervision/ touching assistance for eating. During an observation on 1/6/26 at 8:26 A.M., the surveyor observed a Certified Nurse Aide (CNA) deliver the breakfast meal to the Resident in his/her room and then exit the room. The Resident was observed eating alone in his/her room in bed with the head of the bed elevated. During a continuous observation on 1/7/26 from 8:29 A.M. to 8:41 A.M., the surveyor observed a CNA deliver the breakfast meal to the Resident in his/her room. The CNA set up the meal and exited the room. The Resident was observed eating alone in his/her room in bed with the head of the bed elevated. Review of a Speech Therapy (ST) encounter note, dated 1/6/26, indicated the following: -Precautions: aspiration risk. -Skilled interventions addressing swallow dysfunction included liquid swallows to increase safe oral intake. Review of the Activities of Daily Living (ADL) care plan, dated as revised 11/11/25, indicated the following intervention: Eating: The resident requires one assist/supervision with meals, no straws at the bedside. Review of Resident #62's Kardex (a form that instructs staff on the level of assistance required to care for the resident) indicated the following: Eating: The resident requires one assist/supervision with meals, no straws at the bedside. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Initial or Annual Nutrition Assessment, dated 11/6/25 indicated the following: -Pt (patient) reports occasional cough since admission on puree/NTL (nectar thickened liquids). Per nurse fully dependent. -Summary: intake variable- requires assist. Review of CNA documentation from 12/25/25 through 1/6/26 indicated that set up or clean up assistance was provided for meals and failed to indicate that supervision or touching assistance was provided as indicated in the Resident's plan of care. During an interview on 1/7/26 at 10:43 A.M., CNA #1 said that they use the Kardex on the computer that comes from the care plan for instructions on patient care. She said that if a Resident's Kardex says supervision or touching assistance, then the staff should remain with the resident while they are eating. During an interview on 1/7/26 at 11:13 A.M., the Director of Nurses said that if the resident's care plan indicates supervision or touching assistance is required, then someone should remain with the resident for the duration of the meal, or the resident should eat the meal in the dining room. She said the plan of care should be followed. 2. Resident #129 was admitted to the facility in October 2017 with diagnoses including dementia and chronic obstructive pulmonary disease (COPD). Review of Resident #129's most recent Minimum Data Set (MDS) assessment, dated 11/14/25, indicated Resident #129 had severe cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 3 out of a possible score of 15. During an observation on 1/6/26 at 8:30 A.M., the surveyor observed Resident #129 sitting up alone in bed with the head of the bed elevated. Resident #129 had a plate of eggs and oatmeal on his/her bedside table that was directly in front of him/her. The eggs and oatmeal appeared untouched, and Resident #129 was observed pushing the plate away. During an observation on 1/6/26 at 8:36 A.M., the surveyor observed Certified Nurse Aide (CNA) #5 come into Resident #129's room. CNA #5 stated would you like a muffin because I know you don't like eggs. CNA #5 then exited the room. During an observation on 1/6/26 at 8:38 A.M., the surveyor observed CNA #/5 come back into Resident #129's room. CNA #5 removed the plate with eggs and oatmeal from in front of the Resident and placed down a plate with a cut-up muffin on it. CNA #5 then exited the room. During a continuous observation on 1/7/26 from 8:30 A.M. to 9:05 A.M., the surveyor observed CNA #5 deliver the breakfast meal to the Resident in his/her room. The CNA set up the meal and exited the room. The Resident was observed sitting up in his/her room in bed with the head of the bed elevated with a breakfast meal in front of him/her. The surveyor observed Resident #129 push his/her breakfast meal away multiple times and when asked by the surveyor if he/she was going to finish eating his/her breakfast, the Resident would reply where is my breakfast. The surveyor observed CNA #5 come into Resident #129's room multiple times to remind the Resident to eat and she would push the breakfast tray back in front of the Resident and exit the room. Resident #129 was observed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leaving the breakfast meal untouched unless the Resident was reminded that the food was directly in front of him/her. Review of Resident #129's Activities of Daily Living care plan, revised on 9/30/25, indicated the following intervention: Require setup/clean up and continuous supervision with eating D/T (due to) decreased attention span, and nutrition concerns. Review of CNA documentation from 12/1/25 through 1/6/26 indicated that set up or clean up assistance was provided for meals and failed to indicate that continuous supervision was provided as indicated in the Resident's care plan. During an interview on 1/7/26 at 12:55 P.M., CNA #5 said a resident's level of assistance is reported during shift report and the residents electronic medical record would indicate if the resident needs assistance such as extensive or total assistance. CNA #5 said if a resident required continuous supervision, you would not leave the resident until the meal is over. CNA #5 said Resident #129 is continuous supervision because he/she needs help bringing food to his/her mouth. CNA #5 said she should not have left Resident #129 until the meal was completed. During an interview on 1/7/26 at 1:00 P.M., Unit Manager #2 said continuous supervision is a one-to-one sit down with the resident, and she would expect the CNAs to sit down with the residents until the entire meal is completed. During an interview on 1/7/26 at 11:13 A.M., the Director of Nurses said that if the resident's care plan indicates supervision or touching assistance is required, then someone should remain with the resident for the duration of the meal, or the resident should eat the meal in the dining room. She said the plan of care should be followed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and records reviewed, the facility failed to ensure standards of quality of care for one Resident (#36) out of a total sample of 34 residents. Specifically, the facility failed to follow up on a biopsy to Resident #36's nose, failed to identify a change in a skin condition on his/her nose, and failed to document the skin area on a skin assessment. Findings include:Review of the facility policy titled Skin Management Program Assessment and Prevention of Skin Breakdown, undated, indicated but was not limited to the following:The following measures will be employed as warranted for all residents noted to be at a moderate to high risk for the development of a skin breakdown via the Norton Plus Scale.7.Check the residents skin condition daily and whenever giving care for any signs or symptoms of skin irritation or breakdown.9. Perform and document weekly in the electronic health record the weekly skin check. 10. If a wound is identified the area will be assessed, measured, and documented weekly in the electronic health record.Review of the facility policy titled Change in a Residents Condition or Status, dated as revised February 2021, indicated but was not limited to the following:The nurse will notify the resident's attending physician or physician on call when there has been a (an); b. discovery of injuries of an unknown source; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly.5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.Resident #36 was admitted to the facility in March 2025 with diagnoses including dysarthria following cerebral infarction, hemiplegia, and hemiparesis affecting left non-dominant side, hypertension and vascular dementia.Review of Resident #36's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score 14 out of a possible 15, indicating intact cognition. The MDS also indicated Resident #36 requires substantial/maximal assistance and is dependent on staff for functional daily tasks. On 1/6/26 at 7:14 A.M., Resident #36 was observed lying in bed. The Resident had a dark pink and red scabbed area in the crease of his/her left nostril. The Resident said he/she has an abscess on his/her nose that was biopsied last spring but needs to be rechecked. On 1/6/26 at 10:24 A.M., Resident #36 was observed sitting up in a wheelchair. The Resident had a dark pink and red scabbed area in the crease of his/her left nostril.On 1/7/26 at 7:24 A.M., Resident #36 was observed lying in bed. The Resident had a dark pink and red scabbed area in the crease of his/her left nostril.On 1/7/26 at 10:49 A.M., and at 11:08 A.M., Resident #36 observed sitting up in a wheelchair The Resident had a dark pink and red scabbed area in the crease of his/her left nostril.Review of Resident #36's physician orders indicated the following: Weekly skin check by licensed staff. Document findings in Skin Assessment one time a day every Thursday for Skin Check 7:00 A.M.-3:00 P.M. Start Date 5/29/25.Review of the skin check completed on 12/25/25 and 1/3/26 indicated the nurse documented the following: skin intact. Review of Resident #36's skin integrity care plan, date Initiated 2/12/25, indicated the following interventions:-Follow facility protocols for treatment of injury. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.Review of the Nursing Progress notes for the month of December 2025 and January 2026 failed to mention the area observed on Resident #36's nose. During an interview on 1/7/26 at 9:21 A.M., Nurse #3 said the Resident has had an open area on his/her nose for a while now and said she noticed the area to Resident #36's nose had gotten worse and looked different with open areas that had dried blood and said the area should be documented on a skin check or in the medical record. The surveyor along with Nurse #3 reviewed the medical record and Nurse #3 said the area should have been documented on a skin check when it was noticed last week but was not documented. Nurse #3 said the area looks worse than when she saw it last week.Review of Resident #36's medical record indicated the following nursing progress note dated 4/30/25:Resident LOA (leave of absence) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with staff from Element Care to go to his/her Dermatologist Appointment at 9:00AM. Returned back to (facility) 1:00PM Biopsy done to nose/right hand. will call back with the results, in 1-2 weeks. No new orders were given.Review of Resident #36's medical record indicated the following Physician consultation report dated 4/30/25: Biopsy done to nose/right hand. Will call for results in 1-2 weeks. see attached. No supporting documentation was attached to the report or located in the medical record.Review of Resident #36's medical record indicated a Skin Observation Tool dated 5/29/25, indicated scabbed area noted to left nostril.Further review of the medical record indicated the following Physician Progress note dated 5/13/25: Resident reports he/she went to the dermatologist last week and they did something to his/her area around the nose, but he/she is sure they did not take a biopsy. Physical Exam: Crusted plaque on the left nose with band-aid in place, looking covered with drainage.Assessment and Plan: 1 skin lesion-left nose was seen by the dermatologist and biopsy done results pending. Clean area and leave it open to air. Review of the medical record failed to indicate any follow up recommendations or results of the biopsy taken in April 2025. During an interview on 1/7/26 at 10:56 A.M., Unit Manager #1 said he was aware of the area on Resident #36's nose and said he would expect it to be documented on skin check and said he knew the Resident had a biopsy but was unable to obtain results. Unit Manager #1 said he would expect the nurses to document the area on a skin check and report to the physician if the open area is getting worse and bleeding. During an interview on 1/7/26 at 12:55 P.M., the Director of Nursing (DON) said all skin impairments, including skin tears, open areas, should be documented on skin checks, in progress notes and reported. The DON said she would expect the provider to be notified, to obtain new treatment orders, and interventions needed to update the plan of care for the area identified.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to consistently provide range of motion (ROM) care and treatment in accordance with professional standards of practice for one Resident (#36) out of a total sample of 34 residents. Specifically, the facility failed to ensure staff implemented physician's orders for his/her left-hand splint (a device to properly position and protect hand joints) use based on the Occupational Therapist's recommendation and failed to develop a comprehensive resident-centered care plan with individualized interventions for Resident #36 assessed left-hand contracture.Findings include:Resident #36 was admitted to the facility in March 2025 with diagnoses including dysarthria following cerebral infarction, hemiplegia, and hemiparesis affecting left non-dominant side, hypertension and vascular dementia.Review of Resident #36's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score 14 out of a possible 15, indicating intact cognition. The MDS also indicated Resident #36 requires substantial/maximal assistance and is dependent on staff for functional daily tasks. The surveyor made the following observations:-On 1/6/26 at 7:14 A.M., Resident #36 was observed lying in his/her bed. Resident #36 was not wearing a left-hand splint and there was no hand splint observed in the vicinity of the Resident's bed or in the room. The Resident had not received morning activities of daily living (ADL) care yet.-On 1/6/26 at 10:24 A.M., Resident #36 was observed sitting up in a wheelchair. Resident #36 was not wearing a left-hand splint and there was no hand splint observed in the vicinity of the Resident's bed or in the room.-On 1/7/26 at 7:15 A.M., Resident #36 was observed lying in his/her bed. Resident #36 was not wearing a left-hand splint and there was no hand splint observed in the vicinity of the Resident's bed or in the room. The Resident had not received morning ADL care yet.-On 1/7/26 at 10:49 A.M., Resident #36 was observed sitting up in a wheelchair. Resident #36 was not wearing a left-hand splint and there was no hand splint observed in the vicinity of the Resident's bed or room.Next to Resident #36's bed, hanging on the wall, were two photos of Resident #36 wearing a left-hand splint with the following directions:-Caregivers: Splint on left hand at night.-Night only thank you.Review of Resident #36's Occupational Therapy (OT) Discharge summary, dated [DATE], indicated: Patient tolerating splint for 2 hours during day to assess for redness/irritation. Caregivers trained and pictured proper orthotic donning provided in patients room to promote carryover amongst shifts. -Discharge Recommendations: Recommend resting hand spline (splint) applied to L (left) wrist/hand after dinner, overnight and removed in AM. -Functional Maintenance: Splint and Brace Program Established/Trained. Resting hand splint applied to LUE (left upper extremity) overnight only. Review of Resident #36's physician's orders on 1/6/26 indicated the following:-OT (occupational therapy): Other Rehabilitation Orders: (x) Splint to L HAND/WRIST per splint wearing schedule: OVERNIGHT ONLY- OFF DURING DAY. Verbal Active 3/28/25. The physician's order failed to include documentation to support a splint wearing schedule as the physician order was not completed. Review of Resident #36's Medication Administration Records and Treatment Administration Records failed to indicate the use of a left-hand splint due to the physician's order having incomplete directions for use.Review of Resident #36's plan of care on 1/6/26, failed to indicate Resident #36 had a left-hand contracture and failed include documentation to support a splint wearing schedule.During an interview on 1/7/26 at 10:40 A.M., Nurse #3 said Resident #36 has never worn a left-hand splint and said she has never seen one in his/her room and said the Resident does not have orders to apply a left-hand splint. During an interview on 1/7/26 at 10:59 A.M., Certified Nursing Assistant (CNA) #3 said Resident #36 does not wear a left-hand splint and she does not remember ever putting one on or taking one off him/her.During an interview on 1/7/26 at 11:08 A.M., Occupational Therapist (OT) #1 said Resident #36 should be wearing the left-hand splint and said staff education was provided and signs are posted in his/her room to remind (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225409	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nevins Nursing & Rehabilitation Center	Ten Ingalls Court Methuen, MA 01844

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to apply the hand splint. OT #1 said Resident #36 was evaluated in March 2025 and has a left-hand contracture and needs to wear the left-hand splint. During an observation and interview on 1/7/26 at 11:45 A.M., OT #2 said Resident #36 has a left-hand contracture and was evaluated in March 2025 and said orders were in place for the use of a left-hand splint at bedtime and said staff had completed education on applying and removing the splint and said she was not aware that the Resident was not wearing it. OT #1 asked Resident #36 if staff have been putting the splint on and Resident #36 said no that he/she has not seen the left-hand splint in a long time. Upon inspection in the Resident's room, OT #2 found a left-handed splint on top of a bureau located under wheelchair footrests and padding equipment. During an interview on 1/17/26 at 12:40 P.M., the Director of Nursing (DON) said recommendations and physician orders for Resident #36 should be followed. The DON said the physician order for applying the left-hand splint should be located on the MAR and TAR and said staff should be signing off on the physician order. The DON said the care plan should indicate that Resident #36 has a left-hand contracture and should be updated with interventions to include the use of the left-hand splint.