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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225412	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medway Country Manor Skilled Nursing & Rehabilitat	115 Holliston Street Medway, MA 02053

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate pain management for one Resident (#7), out of a total sample of 24 residents, when the facility was unable to reach the Resident's primary care physician for a prescription to order Resident's Oxycodone (short-acting opioid medication used to treat moderate to severe pain), resulting in the Resident suffering with severe pain of 7 on a scale of 1-10 with 10 being the worst pain for 19 hours post-admission. Findings include:Review of the facility's policy titled Pain Assessment and Management, last revised 10/2022, included but was not limited to:-The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and address the underlying causes of pain. Monitoring and Modifying Approaches:-Re-assess the resident's pain and consequences of pain at least every shift for acute pain or significant changes in levels of chronic pain-Monitor the following factors to determine if the resident's pain is being adequately controlled: -The resident's response to interventions and level of comfort over time-Monitor the resident by performing basic assessment with enough detail and, as needed, with standardized assessment tools and relevant criteria for measuring pain management-If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. Reporting:Report the following information to the physician or practitioner:-Significant changes to the level of the resident's pain.-Prolonged, unrelieved pain despite care plan interventions. Review of the facility's policy titled Pain Assessment and Use of Standardized Scales, undated, included but was not limited to:-To ensure a systematic and consistent approach to identifying, assessing, and managing pain for all residents.-Quantify: Ask the resident to rate the pain using the Numeric Rating Scale-1-3: Mild pain-4-6: Moderate pain-7-10: Severe painResident #7 was admitted to the facility in February 2026 and had diagnoses including displaced supracondylar fracture without intracondylar extension of lower end of right femur (a fracture of the right thighbone just above the knee joint) and periprosthetic fracture around internal prosthetic right knee joint (a fracture occurring adjacent to an existing knee replacement implant), status post-surgical intervention requiring incisional sites to lateral right thigh and lateral right knee.Review of the Minimum Data Set (MDS) assessment, dated 2/15/26, indicated Resident #7 had intact cognition as evidenced by a score of 14 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS indicated the Resident's pain intensity had been severe.Review of the Hospital Discharge summary, dated [DATE], indicated Resident #7 was ordered to receive the following medication for pain management:-Oxycodone IR 5 mg (milligram) tablet- take 1-2 tablets (5-10 mg total) by mouth every 4 hours as needed for breakthrough pain for up to 7 days. Maximum daily amount: 60 mgReview of the Physician's Orders for pain management indicated:-Oxycodone HCL oral tablet 5 mg give one tablet by mouth every four hours as needed for breakthrough pain for 7 days maximum dose 60 mg-Acetaminophen Oral Tablet 325 mg- give 2 tablets by mouth every 6 hours as needed for pain/fever not to exceed 3 grams in 24 hours During an interview on 3/13/26 at 8:38 A.M., Resident #7 said when he/she had arrived, he/she did not get his/her pain medication for three days. Resident #7 said he/she was in severe pain; it was horrible.Review of the admission pain (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 0697 Level of Harm - Actual harm Residents Affected - Few	assessment, dated 2/11/26 at 5:59 P.M., indicated:Pain issue: #001 Location right posterior thigh. Pain score: 7. Aching, Sharp, StabbingPain issue: #002 Location right popliteal (knee) region. Pain score: 7, Aching, Sharp, StabbingPain Note: Resident complained of severe pain on his/her right leg that requires pain medicationReview of a Nurse's note, dated 2/12/26 at 12:52 A.M., indicated Resident reported severe pain and was restless.Review of a Nurse's note, dated 2/12/26 at 6:42 A.M., indicated Resident reported severe pain and was restless overnight. Resident was asking for his/her Oxycodone, but the medication did not come on the overnight run. Resident #7 had received acetaminophen at 10:00 P.M. and 4:00 A.M.Review of the narcotic log indicated Resident #7 did not receive his/her prescribed dose of Oxycodone until 2/12/26 at 12:00 P.M. (19 hours post-admission).During an interview on 3/13/26 at 2:21 P.M., the Physician said that the facility's medical video conferencing partner would reconcile admissions after hours. The medical video conferencing partner does not provide prescriptions for narcotics. The physician said he would provide the prescription if needed. The physician said staff should be calling the on-call phone number after hours.During a telephonic interview on 3/18/26 at 3:18 P.M., Pharmacist #4 said the facility's pharmacy provider received a prescription for Resident #7's Oxycodone on 2/12/26 at 10:30 A.M., seventeen and one half hours after admission. Pharmacist #4 said the prescription was given by Nurse Practitioner (NP) #1. Pharmacist #4 said the pull information (prescription verification and pharmacy entered code into the Pyxis MedBank authorizing the release of Oxycodone for Resident #7) was cleared by the pharmacy at 11:20 A.M. During an interview on 3/18/26 at 4:26 P.M., the Assistant Director of Nurses (ADON) said she had placed a text message to the physician to obtain a prescription for Residents #7's Oxycodone on 2/11/26 at 7:57 P.M. The ADON said she did not receive a return call. During an interview on 3/19/26 at 7:05 A.M., Nurse #6 said she was the nurse providing care for Resident #7 the day of admission overnight. Nurse #6 said Resident #7's Oxycodone had not arrived from the pharmacy. Nurse #6 said she only had an order for Tylenol to give him/her. Nurse #6 said Resident #7 was saying he/she was in severe pain despite having Tylenol at 10:00 P.M. Nurse #6 said she had given Resident #7 Tylenol at 6:00 A.M. with no relief. Nurse #6 said she did not reach out to the physician to update him on Resident #7's pain status.During an interview on 3/19/26 at 11:00 A.M., Nurse #7 said he was the admitting nurse for Resident #7. Nurse #7 said Resident #7 was stating he/she had severe pain. Nurse #7 said he had given Resident #7 his/her ordered acetaminophen at 10:00 P.M. with no relief. Nurse #7 said he was waiting for authorization to obtain Resident #7's Oxycodone from the Pyxis MedBank (an automated medication dispensing system). Nurse #7 said by the end of his shift he had not received authorization. Nurse #7 said he did not reach out to the physician to update him on Resident #7's pain status.During an interview on 3/19/26 at 11:20 A.M., NP #1 said she had arrived at the facility on 2/12/26 at approximately 10:15 A.M. NP #1 said Unit Manager #1 (UM) said she needed a prescription for Resident #7's Oxycodone. UM #1 said the pharmacy never received a prescription. NP #1 said she had not received a call requesting a prescription for Resident #7's Oxycodone day of admission. NP #1 said she had faxed a prescription and called the pharmacy at approximately 10:30 A.M. to get an authorization code (an authorized number that needs to be entered into the Pyxis MedBank to release a narcotic medication). NP #1 said staff should have used the after-hours phone number that would go directly to the personal cell phone for each provider. NP #1 said Resident #7 should not have gone 19 hours before receiving his/her dose of narcotic pain medication given Resident #7's recent acute pain from right leg fractures.During a telephonic interview on 3/19/26 at 2:31 P.M., the Physician said he did not receive a message on 2/11/26 for Resident #7's needed prescription. The physician said if he had received a message, he would have sent the prescription into the pharmacy and let the facility know.During an interview on 3/19/26 at 3:45 P.M., the Director of Nurses (DON) said she had learned that the facility did not receive a prescription for Resident #7's Oxycodone during the morning meeting on 2/12/26. The DON said staff should have utilized the on-call system to follow up on the status of the prescription and update on Resident #7's pain status. The DON said Resident #7 should not have gone 19 hours without appropriate pain medication.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interviews, and document review, the facility failed to ensure that residents were fully aware of the grievance process. Specifically, the facility failed to ensure their grievance policy included the right to file grievances anonymously and failed to ensure residents were aware of and had access to formulate grievances anonymously, should they choose not to alert a staff member of their concern(s).Findings include:Review of the facility's policy titled Grievances Policy and Procedures, revised 8/30/24, failed to indicate residents and/or their representatives had the right to file grievances anonymously.On 3/16/26 at 10:00 A.M., the surveyor held a resident group meeting with ten residents in attendance. All ten residents said that they were not aware of their right to file a grievance anonymously. They said if they have an issue, they must tell a staff member about it or write their name on the grievance form to include their room number, and hand the form into a staff member. The residents said there is nowhere to file them in a way to remain anonymous.On 3/18/26 at 10:56 A.M., the surveyor toured all three units in the facility and observed a document titled Resident Grievances/Complaints Procedures posted on a bulletin board on each unit. The document indicated but was not limited to:-Any person has the right to file a grievance anonymously.-Give the completed form to Charge Nurse, Social Services, Administrator, or Director of Nurses.-It is the policy of this facility to assist you in filing a grievance or complaint.The posting failed to indicate availability and location of grievance forms as well as instructions on where or how to submit the forms to file anonymously.During an interview on 3/18/26 at 12:12 P.M., the Administrator identified herself as the Grievance Officer with social services playing a role in handling the resolution and maintaining the grievance log binders. She said residents can complete a grievance form and turn the form in to the nurses, staff, or reception. She said there is no process to file anonymously. However, if a resident wants to file anonymously, they could slide it under a staff member's door on the ground level but if the resident is not mobile or unable to leave the unit they would have to hand the grievance to a staff member. She said there is no location on any unit or on the ground floor to place a grievance form to maintain anonymity.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide a safe, clean, comfortable and homelike environment on two out of three units. Specifically, the facility failed to ensure: 1. For the [NAME] unit, the residents' environment was free of a pervasive pungent odor of feces and urine; and 2. For one room on the second floor, the footboard was in place. Findings include:Review of the facility's policy titled Homelike Environment, undated, indicated residents are to be provided with a safe, clean, comfortable, and homelike environment and encouraged to use personal belongings to the extent possible. The policy stated staff and management are to maximize characteristics that reflect a personalized, homelike setting, including: -A clean, sanitary, and orderly environment -Clean bed and bath linens in good condition -Pleasant, neutral scents The policy also indicated staff and management are to minimize characteristics of an institutional setting, including institutional odors. 1. On 03/12/26 at 08:20 A.M., the surveyor smelled a pervasive and unbearable odor of feces and urine upon entering the [NAME] Unit. On 03/17/26 at 08:10 A.M., the surveyor smelled a pervasive and unbearable smell of feces and urine upon entering the [NAME] Unit. On 03/18/26 at 8:05 A.M., the surveyor smelled a persistent odor of feces and urine upon entering the [NAME] Unit. The surveyor identified the following rooms as having the strongest, most noticeable odor: Rooms 178, 177, 176, 165, 159, 163, and 158. During an interview on 03/18/26 at 8:20 A.M., Certified Nursing Assistant (CNA) #6 said he always wears a mask because of the pervasive and overwhelming smell. During an interview on 03/18/26 at 10:48 A.M., CNA #5 said he usually wears a mask to avoid the unbearable smell. During an interview on 03/18/26 at 11:15 A.M., the Housekeeping Supervisor acknowledged the pervasive and overwhelming odor and stated it was present because many residents are incontinent with bowel and bladder. The Housekeeping Supervisor said if she was told that the smell was pervasive and overwhelming, she would have sent her staff to do a deeper cleaning. During an interview on 3/18/26 at 1:46 P.M., the Unit Manager stated the odor was pervasive and unbearable and attributed it to the number of incontinent residents on the [NAME] Unit. 2. On the following days and times, the surveyor observed the footboard of Resident #106's bed to be missing from the end of the bed and instead tucked under the Resident's mattress on top of the bedframe. The surveyor observed part of the metal bed frame to be extending off the end of the bed where the wood footboard should have been attached. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/12/26 at 11:15 A.M. -3/16/26 at 12:36 P.M. -3/17/26 at 3:40 P.M. -3/18/26 at 9:44 A.M. -3/18/26 at 10:30 A.M. During an interview on 3/18/26 at 10:30 A.M., Nurse #2 said the footboard has been off Resident #106's bed for a few weeks. Nurse #2 said the footboard should have been repaired by Maintenance. During an interview on 3/19/26 at 11:21 A.M., CNA #12 said he was aware the footboard was off the bed and that it was under the mattress. CNA #12 said he has been making the Resident's bed around the footboard under the mattress. During an interview on 3/18/26 at 2:38 P.M., the Maintenance Director said he goes in and out of every resident's room performing environmental rounds daily. The Maintenance Director said he should have seen the missing footboard and repaired it during daily rounds but missed it.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. Based on observations, record reviews, and interviews, the facility failed to ensure for three Residents (#105, #106, #29), out of a total sample of 24 residents, that services were provided to maintain their vision or hearing abilities. Specifically, the facility failed:1. For Residents #105 and #106, to ensure they were provided with audiology services after the Residents notified staff that their hearing aid devices were not working properly/broken, to support the Residents' hearing needs; and2. For Resident #29, to arrange for an optometry appointment to address the Resident's vision impairment. Findings include: Review of the facility's policy titled Sensory Impairments-Clinical Protocol, dated March 2018, indicated but was not limited to the following: -Treatment/Management: -For residents with impaired hearing, the staff should check for cerumen, and may (as indicated) help the individual obtain a hearing evaluation, hearing aid, or employ written or other means to communicate with the individual. -The physician will identify and order appropriate consultations to help manage causes, complications, and risks of sensory impairment. As part of the initial assessment, the staff and physician will help identify individuals with sensory impairments, including hearing, taste, vision, smell, and touch.The physician will order appropriate consultations (for example, ophthalmology or podiatry evaluations) to help define causes and complications of sensory impairments.The staff and physician will identify approaches to help the resident improve or compensate for sensory deficits. For example, they may refer visually impaired individuals for vision evaluation and/or corrective lenses.The physician and staff will adjust interventions based on the results of these interventions and on subsequent changes in the resident's condition, prognosis, and function. Review of the facility's policy titled Ancillary Mobile Health Services (Dental, Vision, Podiatry, Audiology), indicated but was not limited to the following: Establish a standardized process for the delivery of specialized clinical services by third-party mobile vendors, ensuring high-quality care, informed resident consent, and regulatory compliance.Residents must be informed that they have the right to choose these vendorsNo services shall be performed without a signed informed consent formThe vendor must provide a written or electronic Encounter Note for every resident seen before leaving the facility. This note must include assessment finding, treatments performed, and follow-up recommendations. 1. During an interview on 3/12/26 at 11:15 A.M., Resident #106 said he/she has been sharing hearing aids with his/her spouse. Resident #106 said they both wear hearing aids and are very hard of hearing. Resident #106 said the hearing aids broke so they have been sharing hearing aids because they have not been able to see the audiologist. Resident #106 said staff informed them both that they are on the list to be seen but it has been since July 2025 and they have not seen anyone. Resident #105 showed the surveyor a broken hearing aid. The hearing aid was observed to be in two pieces. Resident #105 said the hearing aid broke a while ago and said they have been trying to get with the audiologist and did not understand why it is taking so long. A. Resident #106 was admitted to the facility in June 2025 with diagnoses including but not limited to (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adjustment disorder with mixed anxiety and depressed mood. Review of Resident #106's Minimum Data Set (MDS) assessment indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. MDS indicated Resident wears hearing aids and received therapy services for speech-language pathology and audiology services. Review of Resident #106's care plan indicated but was not limited to the following: -Focus: Resident has a communication problem related to hearing deficit (8/26/25). -Goal: Resident will maintain current level of communication function through the review date (initiated 8/26/25, target date 5/3/26). -Interventions: Ensure hearing aid(s) are in place (8/26/25). Review of Resident #106's Physician's Orders failed to indicate orders for Audiology consult. Review of Resident #106's medical record indicated a consent was signed on 6/27/25 for ancillary mobile health services, requesting services for audiology, dental, eye care, and podiatry. Review of Resident #106's medical record progress notes indicated but was not limited to the following: -7/19/25- Nurses note: indicated decreased hearing. -8/20/25-Nurses note: indicated hearing impairment. B. Resident #105 was admitted to the facility in June 2025, with diagnoses including but not limited to adjustment disorder with mixed anxiety and depressed mood. Review of Resident #105's MDS assessment indicated he/she was cognitively intact as evidenced by a BIMS score of 14 out of 15. The MDS failed to indicate Resident #105's hearing deficit or use of hearing aid(s) (12/19/25). Review of Resident #105's Physician's Orders failed to indicate orders for an Audiology consult. Review of Resident #105's care plan indicated but was not limited to the following: -Focus: Resident has potential for communication problem related to hearing deficit (7/27/25). -Goal: Resident will maintain current level of communication function with use of hearing aids through the review date (initiated 7/27/25, target date 6/7/26). -Interventions: Communication- -Resident requires bilateral hearing aids to communicate. Ensure availability and functioning of adaptive communication equipment (7/27/25). (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ensure bilateral hearing aids are in place and volume is at the highest setting (7/27/25). -Refer to Audiology for hearing consult as ordered (7/27/25). Review of Resident #105's medical record indicated a consent was signed on 7/6/25 for ancillary mobile health services, requesting services for audiology, dental, eye care, and podiatry. Review of Resident #105's medical record progress notes indicated but was not limited to the following: -12/5/25 Nurse Practitioner (NP) progress note: indicated Resident not hearing well. -12/10/25 NP progress note: indicated Resident not hearing well. -1/5/26 NP progress note: indicated Resident not hearing well. During an interview on 3/17/26 at 9:11 A.M., Ancillary Services Consultant (ASC) #3 said Residents #106 and #105 do not have audiology appointments scheduled. ASC #3 said both Residents' enrollment forms were received from the facility on 12/19/25 and would be able to be seen on the next scheduled visit sometime in May 2026. ASC #3 said the audiologist visited the facility on 7/9/25 and 7/17/25. ASC #3 said if a resident needs to be sooner for a concern or device issue they will have a provider working in the area go to the facility and see the resident sooner. During an interview on 3/18/26 at 4:17 P.M., Social Worker (SW) #1 said she was aware both Resident's had concerns with the function of their hearing aid(s), specifically that Resident #106's hearing aid was broken. SW #1 said she sent an email to Ancillary services providers which provided signed consents requesting services, however there was no further follow-up to the ancillary services providers since 12/2025. SW#1 said and they should have done this knowing there was a concern. SW#1 said she does not have a system in place to track residents' ancillary service needs and should have. During an interview on 3/19/26 at 11:47 A.M., Nurse Practitioner (NP) #1 said she would have expected both Residents to have been seen by audiology services for hearing aid concerns and if the nursing staff needed orders for this service, she would have expected them to contact her. During an interview on 3/19/26 at 12:01 P.M., the Director of Nursing (DON) said both Residents should have been seen by the ancillary service providers for audiology services and were not. The DON said her expectations are as residents admit to the facility, they complete a consent for requesting services for the ancillary service needs of choice, then that form is faxed to the ancillary service consulting provider, and the resident is placed on the next visit date for care needs. 2. Resident #29 was admitted to the facility in April 2025 with diagnoses which included diabetes mellitus and optic neuritis. Review of the MDS assessment, dated 12/18/25, indicated Resident #29 scored 15 out of 15 on the BIMS indicating the Resident was cognitively intact. Review of Physician's Orders, dated 3/19/2026, include Optometry consult 4/3/25. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated Resident #29 signed a Request for Service, including eye care, on 4/16/25. Review of physician and nurse practitioner progress notes indicated Resident #29 would be referred to optometry on 7/7/25, 7/15/25, 8/20/25 and 10/8/2025. Review of the facility's consultant eye care group schedules failed to indicate Resident #29 was scheduled to be seen between April 2025 and February 2026. Review of the Care Plan failed to indicate vision as a focus area. On the following dates and times, the surveyor observed Resident #29 not wearing glasses: 3/12/26 at 9:27 A.M.3/16/26 at 8:14 A.M.3/17/26 at 4:30 P.M.3/18/26 at 9:11 A.M. During an interview on 3/12/26 at 9:27 A.M., Resident #29 said his/her glasses are no good and would like to get that resolved. During an interview on 3/16/26 at 12:57 P.M., Unit Manager #3 said Resident #29 occasionally wears glasses and his/her preference is not to wear them. Unit Manager #3 did not know when Resident #29 was seen by Optometry. During an interview on 3/17/26 at 9:20 A.M., consultant eye care group Regional Account Manager #3 said Resident #29 was not enrolled with the facility's consultant eye care group. During an interview on 3/18/26 at 9:11 A.M., Resident #29 said if he/she got a new pair of glasses, he/she might be able to see more clearly. Resident #29 also said he/she wears glasses for distance. During an interview on 3/18/26 at 11:15 A.M., Social Worker #1 said that consultant eye care group consents are reviewed during quarterly care plan meetings and if any new services are requested, the consent is updated and sent to the consultant eye care group to initiate service.

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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 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 observation, interview, and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment, and help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to ensure a nebulizer machine (used to treat airway obstruction and bronchospasm by nebulizing aerosol medications) mouthpiece and reservoir (chamber that hold the liquid medication) were maintained in a sanitary manner for one Resident (#106), of 24 sampled residents. Findings include:Review of the facility's policy titled Respiratory Treatment Administration Policy, undated, indicated but was not limited to the following:-Respiratory treatments (including nebulizer treatments, oxygen therapy, and inhalation therapies) will be administered as ordered by the provider, following proper technique and infection control practices.-Equipment Care:-equipment must be changed weekly and as needed if soiled, contaminated, or malfunctioning-equipment must be stored in a clean, single-use designated bag at bedside-storage bags must be changed weekly and as needed if soiled or damaged Resident #106 was admitted to the facility in June 2025 with diagnoses including acute respiratory failure (sudden onset when lungs cannot adequately supply oxygen to the blood or remove carbon dioxide) with hypoxia (body tissues are deprived of adequate oxygen).Review of Resident #106's Minimum Data Set (MDS) assessment indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Furthermore, the MDS assessment indicated he/she was moderately to completely dependent on staff for activities of daily living.Review of Resident #106's Physician's Orders indicated but were not limited to the following:-Change tubing, mouthpiece and bag weekly - on Sundays Note: Date and Initial tubing and bag (3/15/26).-DuoNeb Inhalation Solution (use to open lung airways) 0.5-2.5 (3) milligrams (mg)/3milliliters (mL), give 3mg inhale orally three times a day, 6:00 A.M., 12:00 P.M., and 8:00 P.M. (3/12/26).-DuoNeb Inhalation Solution 0.5-2.5 (3) MG/3ML, give 3mL inhale orally every 6 hours as needed (PRN) (8/21/25). On the following dates/times, the surveyor observed Resident #106's Nebulizer mouthpiece and the chamber holding clear liquid residual medication resting directly on his/her bedside nightstand and open to air, with a undated clear plastic bag folded up on the bedside nightstand behind the nebulizer machine:-3/17/26 at 3:50 P.M.,-3/18/26 9:44 A.M.During an interview on 3/18/26 at 10:30 A.M., the surveyor, with Nurse #2 present, observed Resident #106's nebulizer equipment resting directly on the Resident's bedside table. Nurse #2 said the equipment should have been cleaned out to remove residual medication and stored in a dated plastic bag when it is not in use.During an interview on 3/18/26 at 11:17 A.M., Unit Manager (UM) #1 said the nebulizer equipment should have been cleaned after each treatment, then stored in a clean bag and the bag should be dated.During an interview on 3/19/26 at 12:01 P.M., the Director of Nursing (DON) said the nebulizer equipment should have been cleaned and stored properly.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to accurately complete an assessment with the Preadmission Screening and Resident Review Level I (PASARR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) program for one Resident (#6), out of a total sample of 24 residents. Specifically, the facility failed to document the resident's diagnosis of Post-traumatic stress disorder (PTSD) in Question 4A, history of substance use disorder (SUD) in Question 4B and Department of Mental Health (DMH) Involvement/case management in Question 5A resulting in an incorrect negative serious mental illness (SMI) screen.Findings include:Review of the facility's policy titled PASARR, established and revised 8/2025, indicated but was not limited to: The facility coordinates assessments with the PASARR program under Medicaid to ensure that individuals with mental disorders (MD), intellectual disability (ID), or a related condition receive care and services in the most integrated setting appropriate to their needs.1. Applicants to the facility will be screened for serious MD or ID and related conditions in accordance with the State's Medicaid rules for screening.a. PASARR Level I - initial pre-screening that is completed prior to admissioni. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious MD or ID or intellectual disability arises later.ii. Positive Level I Screen - necessitates and PASARR Level II evaluation prior to admission.a. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services that the individual needs.1. The facility will only admit individuals with a MD or ID who the State mental health or ID authority has determined as appropriate for admission2. Recommendations such as any specialized services, from a PASARR Level II determination and/or PASSAR evaluation report will be incorporated into the resident's assessment, care planning and transitions of care. Resident #6 was admitted to the facility in July 2025 with diagnoses that included but were not limited to schizoaffective disorder, PTSD, bipolar disorder, anxiety disorder, and major depressive disorder.Review of the Minimum Data Set (MDS) Assessment, completed on 1/27/26, indicated Resident #6 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 3/17/26 at 3:33 P.M., Resident #6 said that he/she has lived in the facility for a few months. The Resident said he/she has had some mental health issues and hard times in life. The Resident said he/she lived in a group home prior to coming to the facility and does not want to be in the facility for long-term. The Resident said he/she is looking for an apartment or place to live as he/she doesn't want to live in a nursing home for the rest of his/her life.Review of Social Service Assessment 1, dated 7/22/25, indicated but was not limited to:G1. Substance Use Disorder - Yes, Hx (History) of drug/alcohol abuse. Currently clean and soberReview of Hospital History and Physical Reports, dated 7/18/25, indicated but was not limited to:Department of Mental Health (DMH)Review of PASRR Level I Screening, dated 7/22/25, failed to indicate the following in Section B: Screening for SMI: diagnosis of PTSD; history of SUD; and DMH involvement/case management. Further review of the PASRR Level I Screening, dated 7/22/25, indicated in the section titled SMI: Screening Results: Negative SMI screen (Level II PASRR Evaluation is not indicated)During an interview on 3/17/26 at 3:53 P.M., the Administrator said she reviewed the PASARR Level I form she completed when the Resident was admitted in July of 2025. She said she missed checking off the diagnosis of PTSD and history of SUD and the fact that the Resident was being followed by DMH. She said at the time of the admission, she thinks she talked with the resident's stepfather, but she should have talked with his/her DMH case worker or the Resident at the time, but she did not. She said that if she had filled out the PASARR Level I correctly on admission, Resident #6 would have had a positive SMI screen.

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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 interviews, the facility failed to develop and implement a person-centered plan of care which included care and management for one Resident (#15) who had been determined by the staff to be at risk of elopement (an incident when a resident leaves the premises or a safe area without authorization or the necessary supervision to do so safely), out of a total sample of 24 residents. Findings include:Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised 3/2022, included but was not limited to:-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.-care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.-assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.Review of the facility's policy titled Wandering and Elopements, last revised 3/2019, included but was not limited to: -The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.-If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.Review of the facility's policy titled Wander Guard Policy, undated, included but was not limited to:-The facility will use the Wander Guard system (or equivalent) as part of its elopement prevention program.-The system will be implemented only after a comprehensive assessment determines that a resident is at risk for unsafe wandering.-Nursing staff will complete an Elopement Risk assessment upon admission and as needed thereafter.-The decision to use a Wander Guard device must be documented in the resident's care plan and approved by the interdisciplinary team.Resident #15 was admitted to the facility in October 2023 with diagnoses including: bipolar disorder, alcohol abuse, alcoholic cirrhosis of the liver with ascites (advanced liver disease where scarring causes high pressure in the liver's blood vessels leading to abdominal fluid accumulation), and cancer of the liver. Review of the Minimum Data Set (MDS) assessment, dated 1/23/26, indicated Resident #15 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. During an interview on 3/12/26 at 4:48 P.M., Family Member (FM) #2 said they were called by the facility and were told Resident #15 was found in the parking lot early in the morning. FM #2 said Resident #15's health care proxy had been invoked. FM #2 said the date they had received the call was around 1/22/26. During an interview on 3/13/26 at 9:11 A.M., Resident #15 said he/she had this thing on their left leg (referring to the wander guard). Resident #15 said he/she wanted it removed. Resident #15 said, They told me I was sleepwalking and slapped this thing on. Resident #15 could not recall who had placed the wander guard on him/her. Review of the medical record indicated but was not limited to the following: - The Healthcare proxy was activated on 1/22/26 secondary to cognitive decline.- Nursing admission assessment indicated the Resident was not at risk for wandering.- Social Service Progress Notes failed to indicate the Resident demonstrated a behavior of wandering or was a risk for elopement.- Nurse Practitioner and Physician Notes failed to indicate the Resident demonstrated a behavior of wandering or was at risk for elopement.- Nursing Progress Notes from January 2026 to March 13, 2026, failed to indicate the Resident demonstrated a behavior of wandering or was a risk for elopement. - Current March 2026 Physician's Orders did not indicate use of a wander guard.- On 3/13/26, current care plans for Resident #15 failed to indicate the Resident was at risk for elopement and required a wander guard device. During an interview on 3/13/26 at 10:14 A.M., Certified Nursing Assistant (CNA) #1 said she was not sure why Resident #15 had a wander guard placed. CNA #1 said she believed he/she was trying to go out unsupervised.During an interview on 3/13/26 at 10:41 A.M., CNA #2 said Resident #15 had a wander (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guard place because he/she was going outside to smoke unsupervised. CNA #2 said she did not know when the wander guard was placed. CNA #2 said Resident #15 needed to be supervised for his/her cigarette scheduled times. During an interview on 3/18/26 at 12:14 P.M., Unit Manager (UM) #1 said she was not sure who placed a wander guard on Resident #15. UM #1 said she heard Resident #15 was found outside by staff around 5:00 A.M. but she could not recall the date. UM #1 reviewed the medical record and could not locate a progress note indicating Resident #15 had exited the facility. In addition, UM #1 did not locate an elopement risk assessment or updated care plan for risk of elopement and wander guard use. UM #1 said whoever put the wander guard on Resident #15 should have completed the elopement assessment and updated the care plan.During an interview on 3/19/26 at 11:05 A.M., Nurse Practitioner (NP) #1 said she was asked to look at invoking Resident #15's health care proxy on 1/22/26. NP #1 said the decision was made to invoke the HCP secondary to Resident #15's cognitive decline and poor decision making. NP #1 said she was made aware that Resident #15 was found outside around 5:00 A.M. on 1/21/26.During an interview on 3/18/26 at 4:08 P.M., the Director of Nurses (DON) said she was made aware during morning meeting on 1/21/26 that Resident #15 was found outside at approximately 5:30 A.M. just outside the main lobby door. The DON said she did not know who had found the resident outside. The DON reviewed the medical record and said there were no progress notes indicating Resident #15 was outside unsupervised. The DON said whoever put the wander guard on Resident #15 should have written a progress note, completed the elopement assessment, and updated the care plan.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review and interview, the facility failed to ensure nutritional status was maintained for two Residents (#83 and #3), out of a total sample of 24 residents. Specifically, the facility failed:1. For Resident #83, to ensure a strict fluid restriction was provided and accurately documented.2. For Resident #3, to ensure a strict fluid restriction was provided and accurately documented. Findings include:Review of the facility's policy titled Encouraging and Restricting Fluids, dated as revised October 2010, indicated but was not limited to:The purpose of this policy is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids.General Guidelines1. Follow specific instructions concerning fluid intake or restrictions.2. Be accurate when recording fluid intake3. Record fluid intake in mLs. (milliliters)1. Resident #83 was admitted to the facility in January 2024 with diagnoses that included Type 2 diabetes mellitus with diabetic chronic kidney disease, end stage renal disease and dependence on renal dialysis (a medical procedure that filters products, toxins, and excess water from the blood when the kidneys fail). Review of the Minimum Data Set (MDS) Assessment, completed on 2/17/26, indicated Resident #83 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of March 2026 Physician's Orders indicated but was not limited to:1000 cubic centimeter (cc) fluid restriction: 840 cc dietary (360 cc-B (Breakfast), 240 cc-L (Lunch), 240cc-D (Dinner)) 160 cc Nursing (60 cc 7-3, 60 cc 3 - 11, 60 cc 11 - 7) every day for fluid restriction. On 3/16/26 at 12:50 P.M., the surveyor observed Resident #83 eating lunch in the main dining room. He/She received 480 cc cranberry juice and drank the entire glass. Review of Resident #83's Lunch meal ticket, dated 3/16/26, indicated 8 oz (240 cc) diet ginger ale with each meal. Further review of the meal ticket failed to indicate the Resident was on a fluid restriction. During an interview on 3/16/26 at 12:50 P.M., Certified Nursing Assistant (CNA) #11 said he did not know that the Resident had restricted fluids because there was nothing on the ticket. He said he checks the meal ticket for any instructions. During an interview on 3/16/26 at 2:01 P.M., Nurse #5 said Resident #83 is on a fluid restriction and the fluid intake is recorded in the Treatment Administration Record (TAR). She said she documents only the fluid that she administers and does not document what is given by CNAs or with meals in the dining room. She said she does not know where that gets documented. Review of the TAR for the day shift on 3/16/26 with Nurse #5 indicated Resident #83's fluid intake for the day shift was 160 (cc). Nurse #5 said that was the amount of fluid she gave Resident #83 on the day shift. She said the physician's order for fluid was 60 cc for nursing to give on days and she gave too much. She said she did not know how much fluid Resident #83 drank with lunch. On 3/17/26 at 8:30 A.M., the surveyor observed Resident #83 in the main dining room eating breakfast. Resident #83 was observed drinking 480 cc cranberry juice, 240 cc coffee and water in a large styrofoam glass. He/She finished all of the drinks. Review of Resident #83's meal ticket, dated 3/17/26, indicated 12 oz (360 cc) fluid restriction for breakfast. During an interview on 3/17/26 at 8:40 A.M., CNA #10 said he did not know that Resident #83 was on a fluid restriction, no one told him. During an interview on 3/17/26 at 1:00 P.M., Resident #83 said he/she knows that his/her fluid intake is restricted because of kidney failure. He/she said his/her biggest hope is to get a kidney transplant someday. He/she said that the staff provide reminders about the fluid restriction, but sometimes it's hard to follow because he/she likes to drink. 2. Resident #3 was admitted to the facility in December 2025 with diagnoses that included end stage renal disease and dependence on renal dialysis and stage five chronic kidney disease. Review of the MDS Assessment, completed on 1/27/26, indicated Resident #3 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Review of Resident #3's Physician's Orders for March 2026 indicated but was not limited to: Fluid restriction. (1000mL) Dietary: 120ml per meal Nursing 7-3 130mL, 3-11 150mL, 11-7 120mL, and 240ml Nepro QD Further review of the Physician's Order indicated Miralax oral powder 17GM (gram)/scoop. Give one scoop by mouth two times a day for constipation. Mix 17 g in 4 - 6 oz of fluids. On 3/16/26 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 8:49 A.M., the surveyor observed Resident #3's breakfast tray that was delivered to his/her room and left on the overbed table. Drinks on the tray included 240 cc of tea and 120 cc of milk. Review of Resident #3's breakfast meal ticket, dated 3/16/26, indicated 8 oz (240cc) tea at every meal. Further review of the ticket failed to indicate any fluid restriction. During an interview on 3/16/26 at 8:49 A.M., Unit Manager #3 said the Resident was at dialysis and the tray was for Resident #3 and they would get another tray from the kitchen when he/she returned. On 3/16/26 at 12:45 P.M., the surveyor observed Resident #3 sitting in his/her room with a lunch tray on the overbed table. On the tray from the kitchen was 240 cc of tea and a 120 cc carton of milk, which the Resident had finished. On the table there was a one-liter bottle of ginger ale approximately half full and four unopened juice containers (120cc). The Resident also had a personal pink water bottle in a holder on his/her wheelchair containing approximately 240 cc of water. During an interview on 3/16/26 at 12:45 P.M., Resident #3 said he/she drank the tea and milk with lunch. The Resident said he/she knows that fluids are restricted, but he/she likes to drink. The Resident said the staff bring drinks to him/her when he/she asks. Review of the TAR for day shift on 3/16/26 with Nurse #5 indicated Resident #3's fluid intake for the day shift was 120 (cc). During an interview on 03/16/26 at 2:01 P.M., Nurse #3 said that Resident #3 is on a fluid restriction. She said she gives the Resident two cups of water with meds, one for meds (150cc) and another (150cc) for Miralax. She said she was supposed to give 130cc on her shift, but she was giving the Resident more every day, approximately 300 cc with the morning med pass. She said she documents only the fluid that she administers on the TAR and does not document what is given by CNAs or with meals. She said that she documented an intake of 120 cc on the TAR and that was incorrect. On 3/17/26 at 12:45 P.M., the surveyor observed Resident #3 sitting in his/her room eating breakfast. There was an empty mug. The Resident said that it had tea in it and he/she finished it. Review of Resident #3's breakfast meal ticket, dated 3/17/26, indicated 8 oz (240cc) tea at every meal. Further review of the ticket failed to indicate any fluid restriction. During an interview on 03/16/26 at 3:09 P.M., the Registered Dietitian (RD) said that when a resident requires a fluid restriction, she divides the liquid amounts between nursing and dietary and notifies them. She said for Resident #3, she was unaware of the addition of the 240cc of tea to each tray (three times per day day) along with 120 cc that she allotted. She also said she was unaware that nursing is administering MiraLAX twice a day in 4 - 6 oz of water that she did not include in her calculation. She said that amount is more than the 1,000 cc fluid restriction and she didn't think that he/she should be getting that much extra. The RD further said that both Resident #3 and Resident #83 are on strict fluid restrictions because the nephrologist at dialysis ordered it. She said she meets with the dialysis team once a month about both residents and the nephrologist is firm about the restrictions. She said both residents have been educated by her and the dialysis staff about the restriction and importance of compliance. During an interview on 03/17/26 at 10:13 A.M., the Food Service Director said fluid restrictions for residents are not on meal tickets. He said dietary staff use the tickets to see what fluids to put on the meal trays. He said he updates the tickets but he's not always aware of what the restrictions are and what the dietary portion of the fluid is allowed. He said that if a resident requests extra fluids they will add that to tickets because it's the resident's right, but they don't have a process to let the RD know it has been added. During an interview on 03/18/26 2:57 P.M., Nurse Practitioner (NP) #3 said that when a resident goes to dialysis and the nephrologist orders a fluid restriction, the provider at the facility will review the recommendation and put the order in place at the facility if in agreement. She said she expects that the RD will determine how the fluid amounts are divided up between nursing and dietary. She said the kitchen should know how much fluid to provide with meals and nursing should be documenting the total intake. She said it's important to make sure residents adhere to the restriction because there is a risk of fluid overload or other complications. They need to avoid getting more than ordered. During an interview on 03/18/26 at 4:23 P.M., the Director of Nursing (DON) said when a fluid restriction is ordered for a resident, the RD divides the ordered volume of fluid between nursing and dietary. She said her expectation is that the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing staff will offer those amounts to the residents. If they ask for more, the staff should educate the residents about the restrictions but if the residents persist, the staff should give the residents what they want because it's their right, then the physician and RD should be notified. She said the volume should be documented in the TAR and totaled by the night shift. Nursing should document all fluids given on the shift including during meals and with medications. During the interview, the surveyor and DON reviewed the fluid intake documentation on the March TAR. The DON said that the nurses were not consistently documenting the intakes and it would need to be corrected.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with professional standards of practice. Specifically, the facility failed to ensure the medications were administered under direct supervision of a licensed nurse and not left at the bedside for one Resident (#126), out of a total sample of 24 residents.Findings include:Review of the facility's policy titled Self-Administration of Medications, dated February 2021, indicated but was not limited to the following:-Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them.-Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.Resident #126 was admitted to the facility in March 2026 with diagnoses which includes chronic obstructive pulmonary disease (COPD) (restriction of airflow causing chronic breathing difficulties, cough, and fatigue) and panlobular emphysema (severe form of COPD where there is destruction of alveoli throughout the lung).Review of the medical record indicated Resident #126 was advised of their right to self-administer medications on 3/4/26 and indicated he/she wished to have the medication nurse administer their medications.During an interview with observation on 3/12/26 at 4:12 P.M., the surveyor observed Resident #126 sitting on his/her rollator walker seat and on the seat next to the Resident's bed was an Albuterol inhaler. Resident #126 said nurses are always late, especially at night providing medications and he/she kept the inhaler provided by the nurses to use when he/she feels the medication is needed. On 03/19/26 at 10:29 A.M., the surveyor observed Resident #126's Albuterol inhaler on the Resident's bedside table which was at the foot of the bed close to the window. Resident #126 was sitting in a chair next to his/her bed and said he/she has been using the inhaler frequently and needs a replacement because the inhaler is almost empty.During an interview on 3/19/26 at 10:40 A.M., Nurse #7 said the Resident should not have this medication at the bedside.During an interview on 3/19/26 at 11:29 A.M., Unit Manager (UM) #1 said the medication should have been locked up.During an interview on 3/19/26 at 11:47 A.M., Nurse Practitioner (NP) #1 said Resident #126 should not have medications at the bedside.During an interview on 3/19/26 at 12:01 P.M., the Director of Nursing (DON) said Resident #126 should not have had an Albuterol inhaler at the bedside and the medication should have been locked up in the nurse's medication cart.