| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to: 1. ensure respiratory care was provided consistently with professional standards of care for one Resident (#148) out of a sample of 31 residents and 2. failed to maintain respiratory equipment to ensure it was clean and prepared for use.Findings include: Review of the facility policy titled Oxygen Administration, undated, indicated the following: The purpose of this procedure is to provide guidelines for oxygen administration. -Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2-3 Liters per minute. -Adjust the delivery device so that it is comfortable to the resident and the proper flow of oxygen is being administered.-Observe the resident to be sure oxygen is being tolerated. -Check the mask, tank, etc., to be sure they are in good working order and are securely fastened.<br><br>Resident #148 was admitted to the facility in [DATE] with diagnoses including anemia (low level of red blood cells) urinary tract infection and dementia.<br><br>Review of Resident #148's medical record indicated the Minimum Data Set assessment, was not completed as Resident #148 was newly admitted .<br><br>On [DATE] at 8:38 A.M., Charge Nurse #3 told the surveyor that Resident #148 was unresponsive and said 911 emergency services were on the way.<br><br>On [DATE] at 8:39 A.M., Resident #148 was observed lying in bed wearing an oxygen nasal canula. The oxygen concentrator was set to .5 liters per minute. The concentrator psi gauge (meter used to measure amount of oxygen in the tank), black arrow indicator was pointed to the red section 0 (zero) REFILL. There were no staff members in the room with Resident #148.<br><br>During an interview and observation on [DATE] at 8:40 A.M., Nurse #6 entered Resident #148's room and placed a pulse oximeter (device used to measure oxygen saturation in blood) on Resident # 148's right index finger. The oxygen saturation level was 88 %. Nurse #6 looked at the oxygen tank gauge and liter flow, (which still indicated the psi gauge black arrow indicator was pointed to the red section 0 (zero) REFILL) and said Resident #148 was having difficulty breathing and not responding so he/she was placed on oxygen. Nurse #6 then walked out of the Resident's room.<br><br>On [DATE] at 8:42 A.M., Unit Manager #1 entered Resident #148's room and said he/she is having difficulty breathing and does not use oxygen regularly but was in respiratory distress this morning and is being sent to the hospital. The Unit Manager then turned up oxygen to 2 Liters and said his/her oxygen saturation is low and he/she is requiring more oxygen until 911 arrives. The oxygen saturation level was 86 %. The Unit Manager then walked out of the Resident's room.<br><br>On 12:30/25 at 8:44 A.M., Nurse #6 was observed obtaining Resident #148's blood pressure and<br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | adjusted the pulse oximeter to Resident #148's right index finger. The oxygen saturation was 86%. Nurse #6 then walked out of Resident #148's room. The oxygen concentrator was set to 2 Liters per minute. The concentrator psi gauge black arrow indicator was still pointed to the red section 0 (zero) REFILL.<br><br>During an interview and observation on [DATE] at 8:45 A.M., the surveyor observed Resident #148's oxygen saturation level drop to 83%. The oxygen concentrator was still set to 2 Liters per minute and the psi gauge black arrow indicator was pointed to the red section 0 (zero) REFILL. The surveyor walked to the doorway and asked Unit Manager #1 to visualize Resident #148's oxygen settings and tank gauge. Unit Manager #1 then increased the oxygen to 5 Liters and observed the arrow on the pressure gauge in the red zone and said the oxygen tank is empty. Unit Manager #1 said Resident #148 needs a new tank because this one is not delivering any oxygen, then exited the Residents room to obtain a new oxygen concentrator.<br><br>On [DATE] at 8:48 A.M., a new oxygen tank was obtained, and Resident #148 was placed on 5 Liters of oxygen via nasal cannula. Resident #148's oxygen saturation fluctuated between 86% to 88%.<br><br>During an interview on [DATE] at 8:54 A.M., Nurse #6 said she was unaware that the tank was empty and thought he/she was receiving the oxygen through the nasal cannula, but he/she was not as the tank was empty. Nurse #6 said the black arrow on the gauge was pointed to zero and needed to be changed.<br><br>During an interview on [DATE] at 8:57 A.M., Unit Manager #1 said she obtained the oxygen tank off the emergency code cart this morning around 8:30 A.M., after the Resident was found to be unresponsive by a staff member and placed Resident #148 on oxygen because his/her oxygen saturation was 86% on room air.<br><br>During an interview on [DATE] at 9:11 A.M., Occupational Therapist (OT) #1 said she observed Resident #148 lying in bed unresponsive, diaphoretic, eyes were shut and his/her color did not look good. OT #1 said Resident #148's oxygen saturation was 86-87% and said this was not the Resident's baseline and said she immediately notified the charge nurse who assessed Resident #148 and said he/she did not respond to a sternal rub done by the charge nurse and a call to 911 was placed.<br><br>During an interview on [DATE] at 11:13 A.M., Charge Nurse #3 said Resident #148 was unresponsive and having trouble breathing this morning and was placed on oxygen until 911 arrived. Charge Nurse #3 said Resident #148 does not have breathing issues and said this was a change in respiratory status. Charge Nurse #3 said staff need to check the oxygen tank to make sure it is not empty and check to see if the Resident is responding to the oxygen therapy.<br><br>During an interview on [DATE] at 12:01 P.M., the Director of Nurses (DON) said Resident #148 should have been placed on appropriate oxygen therapy when he/she was first identified as having breathing difficulty. The DON said staff must check the oxygen tank settings prior to administering oxygen and after administration to make sure the equipment is working and said staff must assess the resident's response to oxygen therapy. The DON said not administering oxygen to a resident in respiratory distress could cause the resident to have a decrease in oxygen saturation causing an increase in difficulty breathing leading to worsening respiratory distress.<br><br>During an interview on [DATE] at 12:15 P.M., the Medical Director said it is his expectation that staff respond appropriately and efficiently to residents requiring oxygenation therapy and said staff must<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | know how to administer oxygen correctly to prevent Residents from experiencing or worsening respiratory distress. The Medical Director said Resident #148 needed oxygen as he/she was in respiratory distress and was not receiving oxygen until a new oxygen tank was applied. The Medical Director said Resident #148 should not have been placed on an oxygen tank that was not functioning appropriately.<br><br>2. Review of the facility's policy Cleaning of Respiratory Equipment (undated) indicated for emergency suctioning equipment:<br><br>-Nursing will rinse and disinfect with the appropriate disinfectant the suction machine every shift.<br><br>-Nursing will rinse the tubing every shift and replace the tubing every 72 hours.<br><br>-After the resident no longer requires suctioning, nursing will return the suction machine to the dirty utility room and post a date note: To be disinfected.<br><br>On [DATE] at 10:34 A.M. the surveyor and Infection Preventionist (IP) observed the Station 3 code cart, located in the utility room. On top of the cart was placed a suctioning machine, a canister, Yankauer tubing, and an Ambu bag.<br><br>A suction machine is a medical device designed to generate negative pressure to create a vacuum that allows for fluid extraction from the mouth and throat. A cannister on the machine collects these secretions from the patient. A Yankauer is a rigid, curved instrument attached to the suction machine made of clear plastic used to remove secretions such as saliva, mucus, blood or vomit from the mouth and throat. It is used to prevent aspiration and maintain a clear airway.<br><br>An Ambu bag is a portable, hand-held device designed for emergency ventilation, also known as a manual resuscitator. It is used to provide positive pressure ventilation for patients who are not breathing or are struggling to breathe.<br><br>The surveyor observed that the suction machine was dirty and the cannister was partially filled with an opaque, yellow, dirty liquid. The Yankauer tubing had been removed from its sterile bag and was faded yellow had light brown substance inside the tubing and was dirty. The Ambu bag had been removed from its sterile bag, and the mouth seal was sticky, yellow and deflated. The IP said the equipment appeared to have been used some time in the past and not cleaned or replaced. The IP said the Ambu bag was not in working condition and would not work if placed on a resident's mouth as the mouthpiece was deflated and sticky.<br><br>On [DATE] at 10:39 A.M. the surveyor and IP observed the Station 1 code cart. On top of the cart there was a suction machine cannister, one Yankauer tubing, and one Ambu bag. The Yankauer tubing had been removed from its sterile bag. The Ambu bag had been removed from its sterile bag, and the mouth seal was sticky, yellow and deflated. The IP said the equipment appeared to have been used some time in the past and not cleaned or replaced. The IP said the Ambu bag was not in working condition and would not work if placed on a resident's mouth as the mouthpiece was deflated and sticky.<br><br>On [DATE] at 10:45 A.M., the surveyor and IP observed the Station 2 code cart. On top of the cart there was a suction machine cannister, one Yankauer tubing, and one Ambu bag. The Yankauer tubing had been removed from its sterile bag. The Ambu bag had been removed from its sterile bag and had (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | expired. There was one open bottle of sterile water that was expired and clear liquid was floating in the bag that contained the expired Ambu bag.<br><br>On [DATE] at 10:52 A.M., the surveyor and IP observed the Station 4 code cart. On top of the cart there was a suction machine cannister, one Yankauer tubing, and two Ambu bags. The Yankauer tubing had been removed from its sterile bag.<br><br>The IP said the expired Ambu bag was no longer considered sterile and should be discarded and the sterile bottle of water should not be open and stored with the Ambu bag. The IP said the equipment was not in working condition and not available if needed in an emergency. The IP said none of the emergency carts located in the facility are stocked with the necessary items needed to respond to an emergency at this time.<br><br>During an interview on [DATE] at 11:13 A.M., Unit Manager #1 said emergency equipment must be checked every day and replaced when it is used or expired. Unit Manager #1 said used dirty equipment is contaminated and cannot be used on residents and said without emergency equipment available it could cause a delay in care. Unit Manager #1 said emergency carts must be accessible and available with working equipment that is in clean condition and not expired. Unit Manager #1 said she would expect equipment to be checked daily and replaced and said used dirty equipment should not be left on the emergency cart. The Unit Manager #1 said Ambu bags that are expired, yellow, sticky and deflated are not in working condition and can't be used in an emergency.<br><br>During an interview on [DATE] at the Director of Nurses (DON) said it is her expectation that all equipment is in good, clean sterile working condition and readily accessible to residents and said she expects the emergency carts to be checked daily and available in an emergency. The DON said not having the emergency equipment ready could cause a delay in treatment if a resident is having an emergency and staff do not have access to it. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to electronically submit direct care staffing data to the Centers for Medicare and Medicaid Services (CMS) for the entire reporting period, Fiscal Year (FY) Quarter 4 2025 (July 1 - September 30), in accordance with the schedule specified by CMS.Findings include:Review of the facility's policy titled Payroll Based Journal (PBJ), dated as revised February 2024, indicated but was not limited to:Policy: [NAME] Manor is required to submit staffing hours to CMS every 3 months beginning with the data for July, August, September 2016 (This is called 2016 Q4). This is submitted online via the PB&J Data Submission portal.-All data is either uploaded to CMS as a zip file or manually entered.-Fiscal Quarter 4 for Reporting Period 7/1/25 through 9/30/25, due date 11/14/25.During an interview on 12/30/2025 at 9:06 A.M., Human Resource Staff #1 said he missed the deadline and tried to submit the PB&J report after the deadline, but the reporting system would not accept it. Human Resource Staff #1 said quarterly reports should be submitted timely as required by CMS. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to ensure it implemented infection control measures for one of one applicable sampled Resident (#84) with a diagnosis of influenza. Specifically, the facility failed to follow physician orders for droplet precautions and failed to ensure staff utilized appropriate personal protective equipment in Resident #84's room and on the unit.Findings include: Review of the Center for Disease Control guidance titled Interim Guidance for Influenza Outbreak Management in Long-term Care and Post-Acute Care Facilities dated 9/17/24 indicated, but was not limited to, the following: - Implement standard and droplet precautions for all residents with suspected or confirmed influenza. - Wear gloves if hand contact with respiratory secretions or potentially contaminated surfaces is anticipated.- Wear a face mask (e.g., surgical or procedure mask) upon entering the resident's room.- Wear a gown if soiling of clothes with a resident's respiratory secretions is anticipated.- Change gloves and gowns after each resident encounter and performing hand hygiene- Perform hand hygiene before and after touching the resident, after touching the resident's environment, or after touching the resident's respiratory secretions, whether gloves are worn or not.Resident #84 was admitted to the facility in November 2025 and has diagnoses which include Parkinson's disease, renal disease and influenza.Review of Resident #84's Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 11, signifying moderate cognitive impairment. The MDS also indicated the Resident ambulated with a walker or wheelchair and required partial to moderate assistance with activities of daily living.<br>Review of the infection control line listing for December 2025 indicated Resident #84 was diagnosed with the influenza virus on 12/31/25 and was prescribed Tamiflu, an antiviral agent. Review of Resident #84's physician orders dated 12/31/25 indicated: Droplet precautions every shift, days, evenings, nights.On 12/31/25 at 7:43 A.M., the surveyor observed the entrance to Resident #84's bed had a sign posted indicating isolation precautions. The sign indicated droplet and standard contact precautions were in effect. The sign indicated that all staff and visitors entering the room should wear gloves, a gown, a surgical mask or N-95 respirator, and eye protection. At the entrance to the room was a small cart containing surgical masks, gloves and gowns, but no eye protection. Inside the room, Resident #84 was lying in bed awake, coughing and not wearing a mask. A staff member transferred Resident #84's roommate from bed to a wheelchair, and then to the bathroom. The curtain between the two resident beds was open and the staff member wore a surgical mask below her nose and a pair of surgical gloves. The staff person did not wear a gown or eye protection. The staff member then exited the bedroom, removed the gloves and washed her hands. On 12/31/25 at 7:46 A.M., the surveyor observed a staff person walking in the unit hallway and not wearing a surgical mask. The reader may not understand why this is bad. Did staff have to wear a mask while on the unit too? Were there signs or are we focused on just this one resident and just his/her room?On 12/31/25 at 7:50 A.M., the surveyor observed Nurse #3 enter Resident #84's room to obtain vital signs and administer medications. Nurse #3 wore gloves and a surgical mask, but not a gown or eye protection. During an interview with Nurse #3 on 12/31/25 at 7:55 A.M., she said Resident #84 was on droplet precautions because of a diagnosis of influenza. Nurse #3 said that when she entered the Resident's bedroom she should have worn a gown. Nurse #3 said the staff person who assisted Resident #84's roommate should have worn the mask over her nose and mouth and worn a gown because Resident #84 was on droplet precautions and these interventions applied to the entire room. Nurse #3 said she had offered Resident #84 and his/her roommate a mask, but they declined. During an interview with Unit Manager #1 on 12/31/25 at 8:00 A.M., she said staff and visitors entering Resident #84's room need to follow the precautions listed on the isolation sign. Unit Manager #1 said staff and visitors entering the room should wear gloves, a gown and either a surgical mask or an N-95 respirator. Unit Manager #1 said that all staff and visitors to the floor, whether they enter Resident #84's room, or not,<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | should wear a mask to help prevent the spread of infection.During an interview with the Infection Preventionist (IP) on 12/31/25 at 11:00 A.M., she said staff should be wearing full personal protective equipment, including a mask, gloves and gown when entering Resident #84's room because he/she was on isolation precautions. The IP said that anyone entering Resident #84's unit should wear a surgical mask to prevent the spread of the influenza virus. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on record review and interview the facility failed to ensure it offered pneumococcal vaccines to 35 of 71 residents who were eligible for the vaccine. Findings include: Review of the Center for Disease Control (CDC) website indicated to administer PCV15, PCV20 or PCV21 for all adults aged 50 or older who have never received any pneumococcal conjugate vaccine and whose previous vaccination history is unknown.Review of the facility's immunizations records and an audit provided by staff indicated 19 of 35 eligible residents on the 400 unit and 16 of 36 eligible residents on the 300 unit (a total 35 of 71 residents) had not been offered or received the pneumococcal vaccine. Review of the physician's orders of the 71 residents indicated they may have the pneumonia vaccine unless contraindicated. Review of the facility's immunization audit indicated the 35 identified residents were due to receive the pneumococcal vaccine and they did not have a contraindication to receive the vaccine. During an interview with the Infection Preventionist on 12/31/25 at 11:00 A.M., she said there were many residents in the facility who were eligible and due to receive the pneumococcal vaccine and had not declined to receive the vaccine. The Infection Preventionist said the vaccine was available from the pharmacy, but the facility had not yet facilitated payments for these. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure invitations to attend care plan meetings were provided to one Resident (#20) out of a total of 31 sampled Residents. Findings include: Resident #20 was admitted to the facility in November 2020 with diagnoses including chronic obstructive pulmonary disease and shortness of breath. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she is cognitively intact as evidenced by a score of 15 out a possible 15 on the Brief Interview for Mental Status Exam (BIMS). Review of Resident #20's care plans indicated:Problem: I have an (sic) HCP (Health Care Proxy) that is not activated, 6/20/25.Interventions: Staff will educate me and all surrogate decision makers regarding their roles. During an interview on 12/30/2025 at 7:53 A.M., Resident #20 said that he/she had initially declined attending his/her care plan meetings but wanted to start attending. Resident #20 said that she had told multiple staff and the nurse supervisor, but he/she has still not been invited to attend. Resident #20 said he/she wasn't sure when he/she first told staff he/she wanted to attend, but it was a while ago. During an interview on 12/30/2025 at 9:00 A.M., Social Worker #1 said that the Receptionist is responsible for sending out invitations to residents and their representatives for care plan meetings. Social Worker #1 said that Resident #20 does not attend his/her own care plan meetings. Social Worker #1 said that she was not aware Resident #20 told staff he/she wanted to attend, and he/she should have been invited. During an interview on 12/30/2025 at 9:06 A.M. The Receptionist said she sends out invitations to resident representatives and alert and oriented residents in the building. The Receptionist said she sent out an invitation to Resident #20's activated health care proxy last month (November 2025) to attend the December 2025 care plan meeting. During a follow up interview on 12/30/2025 at 1:16 P.M., Social Worker #2 said that Residents have the right to attend their care plan meetings and Resident #20 does not have an activated healthcare proxy. Social Worker #2 said she was not aware the Receptionist was sending invitations to Resident #20's family member and Resident #20 should have been invited. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a resident group meeting, interviews, and record reviews, the facility failed to ensure concerns from the Resident Council were thoroughly documented to ensure the residents felt their concerns were acted upon timely and included the facility response to the group.Findings include:Review of the facility's policy titled Grievance Policy, undated, indicated but was not limited to the following:-It is the policy of [NAME] Manor Nursing Center to assist residents, their representative, other interested family members or advocates in filing grievance or complaints when such request are made. -The Grievance Policy refers to documenting an acting on specific complaints or concerns voiced by residents, staff, and families. Listening to concrete needs, addressing them with appropriate team members(s) and resolving them are the principal components and nature of this policy.-The Record of Resident and Family Concerns will be the only form utilized to document grievance and/or recommendations through an orderly and timely process. -The Record of Resident and Family Concerns will be readily available in all nursing units and in other departments as appropriate. -The Record of Resident and Family Concerns will be completed by the person receiving the grievances and/or recommendation and its disposition will be coordinated by the Social Services Department. Review of Resident Council minutes, dated October 2025, indicated the following: -Missing long winter coat.Review of the Resident Council minutes, dated November 2025, contained no additional follow-up notes.Resident group was held on 12/30/25 at 2:00 P.M., with the following concerns reported: -Three out of 10 participating residents reported missing clothing that has been reported to staff and not followed up on or reimbursed. Reporting this as an ongoing issue that is discussed during every meeting but not resolved.-Five out of 10 participating residents said when issues are reported they are not documented or resolved. Residents reported the same issues discussed month after month and they feel the facility does not respond to grievances brought up in the group meeting. Review of the Grievance logs for 2024 and 2025 failed to indicate any grievances had been filed for the issues reported in resident council meetings. September 2025: no documented grievances.October 2025: no documented grievances.November 2025: no documented grievances.December 2025: no documented grievances. During an interview on 12/31/25 at 7:52 A.M., the Social Worker who is also the Facility Grievance Officer, said grievance forms are not currently located on the nursing units and said he would expect the forms to be accessible on all units so residents, visitors and staff can report issues to be followed up on. The Social Worker said he was not aware of any grievances since he started at the facility about seven weeks ago and said he could not find any grievance forms from August through December 2025. The Social Worker said he would expect staff to complete the grievance forms and submit them for review and follow up and said the facility must track concerns and respond to them timely. During an interview on 12/31/25 at 11:16 A.M., the Administrator said he expects the facility to follow up on grievances as they come up and said the forms are available if needed and said residents, and visitors can ask staff to fill out a form if they have a concern. The Administrator said staff take care of issues reported during resident council meetings and do not need to fill out grievance forms for every issue. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents had the right to voice and formulate grievances, have those grievances responded to promptly, and be provided a resolution to their grievance. Specifically, 1. For Resident #16, the facility failed to follow the grievance process after Resident #16 reported he/she was missing sneakers.2. Failed to ensure residents had access to grievance/concern forms to submit grievances anonymously, should they choose not to alert a staff member to their concern.Findings include:Review of the facility's policy titled Grievance Policy, undated, indicated but was not limited to the following:-It is the policy of [NAME] Manor Nursing Center to assist residents, their representative, other interested family members or advocates in filing grievance or complaints when such request are made. -The Grievance Policy refers to documenting an acting on specific complaints or concerns voiced by residents, staff, and families. Listening to concrete needs, addressing them with appropriate team members(s) and resolving them are the principal components and nature of this policy.-The Record of Resident and Family Concerns will be the only form utilized to document grievance and/or recommendations through an orderly and timely process. -The Record of Resident and Family Concerns will be readily available in all nursing units and in other departments as appropriate. -The Record of Resident and Family Concerns will be completed by the person receiving the grievances and/or recommendation and its disposition will be coordinated by the Social Services Department. 1. Resident #16 was admitted to the facility in April 20245 with diagnoses including unspecified dementia, muscle weakness and depression.Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #16 is cognitively intact as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status Exam.Review of grievance binder indicated the following grievance form for Resident #16 dated 12/2/25: Documentation of Concern: HCP called asking where Resident #16's shoes were. Advised that staff will look for shoes. Notified: Social Services, Other; Laundry. Facility Action and Follow-up: Staff conference 12/19/25 DNS (Director of Nursing Services), SS (Social Services, Administrator.Social Work Intervention: Social Worker reached out to HCP to enquire about cost of shoes. $49.99. Amount given to Administrator& DNS.During an interview on 12/31/25 at 9:31 A.M., Resident #16 said he/she had shoes in her room, but they went missing and they (the facility) never replaced them and said she told the staff about the missing sneakers.During an interview on 12/31/25 at 8:02 A.M., Certified Nursing Assistant (CNA) #2 he was not aware of any missing sneakers for Resident #16.During an interview on 12/31/25 at 8:15 A.M., Charge Nurse #3 said she does not recall a grievance form being completed on Resident #16 and was not aware of missing sneakers. During an interview on 12/31/25 at 8:58 A.M., Social Worker #2 said she notified the Administrator and Director of Nurses about the missing shoes and said she would expect the Administrator to follow up to reimburse the resident but did not know if that had been done. During an interview on 12/31/25 at 11:16 A.M., the Administrator said he expects the facility to follow up on grievances as they come up and said he would reimburse the resident for the $49.99 if he/she could submit proof of the cost of the missing shoes and said he was not aware of the status of the missing shoes. 2. During a tour of the facility on 12/30/25 at 8:00 A.M., the surveyor was unable to find any information regarding the grievance process posted in resident care areas. The surveyor observed information regarding how to file grievance near the Social Services office which was not accessible to all residents.Review of the facility grievance binder on 12/30/25 at 8:25 A.M., contained no documented grievances during the months of September 2025, October 2025 and November 2025.During an interview on 12/31/25 at 8:01 A.M., Certified Nursing Assistant (CNA) #2 said he will tell the nurses if residents have issues or are reporting missing items and said he is not aware of any forms on the unit.During an interview on 12/31/25 at 8:07 A.M., Nurse #3 said she is not aware of any grievance forms and said if a resident<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | reports a concern or is missing items she would tell the charge nurse.During an interview on 12/31/25 at 8:14 A.M., Charge Nurse #3 said grievance forms in a drawer behind nurse's station that are filled out if there is an issue and said concerns should go to the unit manager for follow up. During an interview on 12/31/25 at 8:57 A.M., Social Worker #1 said if residents report concerns to staff, then staff are expected to fill out a grievance form and submit it for review by the management team and said she emails concerns to the Director of Nurses, Administrator and new Social Worker for follow up. SW #1 said forms are only located by the social services office and are filled out by staff if issues are reported and said she was not sure why the forms were not being filled out during the month of August to December and said staff would tell the Director of Nurses if there were any resident issues. During an interview on 12/31/25 at 10:52 A.M., the Social Worker #2 who is also the Facility Grievance Officer, said grievance forms are not currently located on the nursing units and said he would expect the forms to be accessible on all units so residents, visitors and staff can report issues to be followed up on. The Social Worker #1said he was not aware of any grievances since he started at the facility about seven weeks ago and said he could not find any grievance forms from August through December 2025. Social Worker #1 said he would expect staff to complete the grievance forms and submit them for review and follow up and said the facility must track concerns and respond to them timely. Social Worker #1 said he was not aware of the issues reported during resident council and said he was not aware of the two December grievances that had not been followed up on. During an interview on 12/31/25 at 11:16 A.M., the Administrator said he expects the facility to follow up on grievances as they come up and said the forms are available if needed and said residents, and visitors can ask staff to fill out a form if they have a concern. The Administrator said staff take care of issues reported during resident council meetings and do not need to fill out grievance forms for every issue. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to implement interventions related to fall care plans for one Resident (#62) out of a total of 31 sampled Residents. Findings include: Resident #62 was admitted to the facility in September 2019 with diagnosis including non-traumatic brain dysfunction, dementia and history of falls. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #62 was unable to participate in the Brief Interview for Mental Status Exam and staff assessed him/her as having severely impaired cognitive skills. The MDS also indicated Resident #62 required assistance with transfers, bathing, dressing and toileting. Review of Resident #62 Fall Risk assessment dated [DATE] indicated he/she was identified as being at high risk for falls. Review of Resident #62's Risk for falling care plan dated 3/24/24 indicated the following intervention: Place call don't fall signs in room and bathroom, 6/12/25. On 12/29/25 at 11:13 A.M., the surveyors observed Resident #62 attempting to toilet himself/herself in the bathroom. There was no sign in place indicating call don't fall per the plan of care.On 12/29/25 at 5:07 P.M., the surveyors observed Resident #62 lying in bed. There were no signs in the room indicating call don't fall per the plan of care. On 12/30/25 at 7:34 A.M., the surveyor observed Resident #62's room. There were no signs in the room indicating call don't fall per the plan of care.During an interview on 12/30/25 at 2:10 P.M., Unit Manager #1 said that Resident #62 is a fall risk and has had multiple falls in the past. Unit Manager #1 said that after a resident has a fall the care plan is updated with new interventions, but she was unsure how to access the care plans. Unit Manager said that interventions utilized in the past related to falls included testing for a urinary tract infection, rehab consults and placing call don't fall signs in his/her room because the resident does not remember to call for assistance. Unit Manager #1 said the signs should have been in place since it was implemented and she was not aware the signs were not in the room. Unit Manager #1 said interventions on resident care plans should be in place. During an interview on 12/30/25 at 2:20 P.M., Certified Nurses Aid (CNA) #3 said she had been caring for Resident #62 for a year and a half. CNA #3 said that Resident #62 is a fall risk and has had some falls in the past. CNA #3 did not respond to questions related to the placement of the call don't fall sign as an intervention. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225419 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belmont Manor Nursing Home, IN | 34 Agassiz Avenue<br>Belmont, MA 02478 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement treatment recommendations related to pressure ulcers for one Resident (#48), out of a total of 31 sampled Residents. Specifically, the facility failed to implement a). heel booties (a device utilized to reduce pressure on the heels) as indicated by the Nurse Practitioner and b). failed to implement the use of skin prep timely to a deep tissue injury (DTI; a skin injury caused by pressure) as indicated by the Wound Physician. Findings include:Resident #48 was admitted to the facility in September 2021 with diagnoses including unspecified dementia and osteoarthritis. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #48 is severely cognitively impaired as evidenced by a score of two out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). Additional review of the MDS indicated Resident #48 is at risk for the development of pressure ulcers. Review of Resident #48's care plans indicated: Problem: Resident has increased risks of complications r/t (related to) left foot wound, initiated 10/31/25. Interventions: Treatment to area per MD orders, 10/31/25. a. Review of the Nurse Practitioner Note dated 10/22/25 indicated: since BLE (bilateral lower extremities) are rigid and his/her left foot presses into Right foot, informed nursing he/she should be wearing heel booties to off load pressure at all times, avoid tight fitting shoes (slippers were fitting ok tonight). Nursing aware to order heel booties to off load pressure. Review of the physician orders and care plans failed to indicate the booties were implemented. On 12/29/2025 at 8:30 A.M., the surveyor observed Resident #48 in bed. Resident #48 was unable to participate in the interview process. Resident #48 appeared thin and frail and was resting on an air mattress (a specialty mattress utilized to reduce pressure.) There were no heel booties in place. The Nurse Practitioner no longer practiced at the facility and was unavailable for interview. During an interview on 12/31/25 at 11:59 A.M., Nurse #2 said that Resident #48 had developed wounds, but she could not recall if he/she utilized booties. Nurse #2 then reviewed the clinical record and said heel booties were not ordered. On 12/31/25 at 12:02 P.M., Resident #48 was observed in a reclining wheelchair. He/she was not wearing heel booties. During an interview on 12/31/25 at 12:03 P.M., Certified Nursing Aid (CNA) #1 said she takes care of Resident #48 and he/she has never had heel booties. During an interview on 12/31/2025 at 9:00 A.M Nurse #1 said she had been covering Resident #48's unit while Unit Manager #2 was out on medical leave. Nurse #1 and the surveyor reviewed the Nurse Practitioner note and said that nursing should have implemented the use of heel booties for Resident #48. During an interview on 12/31/2025 at 9:22 A.M., the Director of Nursing said that the Nurse Practitioner should have put in an order for the use of heel booties. b. Review of the Wound Physician note dated 10/23/25, indicated: Unstageable DTI of the left distal medial foot, undetermined thickness. DTI with intact skin. 1 CM (centimeter) X .08. Treatment: skin prep, apply once daily and as needed. Review of the physician orders failed to indicate the skin prep was implemented until 10/29/25; six days after the Wound Physician made his recommendation. During an interview on 12/31/25 at 12:03 P.M., Certified Nursing Aid (CNA) #1 said she takes care of Resident #48 and he/she has never had heel booties. During an interview on 12/31/2025 at 8:52 A.M., The Wound Physician said that he rounds the facility weekly with nursing staff who then input his treatment recommendations as orders. The Wound Physician said he was not aware of a delay in the use of skin prep. During an interview on 12/31/2025 at 9:00 A.M. Nurse #1 said she had been covering Resident #48's unit while Unit Manager #2 was out on medical leave. Nurse #1 said that the Wound Physician rounds with the nursing staff and then faxes over his recommendations which are then put into the record as orders. Nurse #1 said that she was not aware of a delay in implementing skin prep to Resident #48's wound. During an interview on 12/31/2025 at 9:22 A.M., the Director of Nursing said that Unit Managers input the treatment recommendations made by the Wound Physician as orders into the clinical record and she was not aware of a delay in implementing skin prep for Resident #48. |