STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225421	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayer Valley Rehab and Nursing	400 Groton Road Ayer, MA 01432

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on record review, and interview, the facility failed to notify the Physician of a change in condition for one Resident (#114) for a sample of three closed resident records reviewed. Specifically, the facility failed to notify Resident #114's Physician of the Resident's change in condition when the Resident died in the facility. Findings include: Review of the facility's Change in Condition Policy, dated [DATE] and revised [DATE], indicated the following: >Full assessment by nursing staff includes but is not limited to: -Full vitals (temperature, respirations, blood pressure and oxygen saturation level). -Level of consciousness. -Respiratory status . >Notify Physician of change and give assessment information. -Receive orders, if any. -If not during normal business hours for provider, place call to provider to update on resident's condition . if there is a significant change. -If unable to reach provider, contact Medical Director or Medical Director Associate. Review of the facility's Death of a Resident Policy, dated [DATE] and revised [DATE], indicated: -When a resident is identified without signs of life, the Physician will be notified of assessment findings. (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: 225421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER: Ayer Valley Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 400 Groton Road, Ayer, MA 01432	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Nursing Code Blue (medical emergency in which one's heart or breathing stops) Policy, [DATE] and revised [DATE], indicated the following: -The facility's policy was to ensure prompt and skilled cardiovascular and cerebral resuscitation of residents who suffer a cardiopulmonary arrest while on the premises. -Exceptions included residents with Do Not Resuscitate (DNR) status. -The facility was required to notify the Physician of the code blue as early as practically possible. Resident #114 was admitted to the facility in [DATE] with diagnoses including Hypertension. Review of Resident #114's electronic medical record (EMR) indicated the following: -An order, dated [DATE], for Full Code (one's directive for healthcare providers to use all available means to resuscitate and support their life). -A Medical Order for Life-Sustaining Treatment (MOLST) form, signed and dated on [DATE] by the Resident and the Nurse Practitioner (NP), to attempt resuscitation for the Resident if cardiac or respiratory arrest occurred. Review of Resident #114's Nursing Progress Note, dated [DATE], indicated the following: -The Resident was not responsive, with no pulse and absent breath sounds. -The Resident was a Full Code. -Facility staff initiated CPR and activated EMS (Emergency Medical Services). -EMS arrived at 3:30 A.M. and took over CPR (cardiopulmonary resuscitation) for the Resident. -EMS reported that the Resident was pronounced dead at 3:45 A.M. per a Physician at an area hospital. -EMS left the facility and facility staff prepared the Resident for pickup by the funeral home. -The Resident's family and the facility's Director of Nursing (DON) were notified. Further review of the Resident's Nursing Progress Note did not include any evidence the Resident's Physician was notified of the Resident's death. Review of Resident #114's February 2025 Physician orders indicated the following: -An order, dated [DATE], for: May do RN (Registered Nurse) pronouncement and release to funeral home. -The order was not created until [DATE]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:57 P.M., Nurse #6 said she worked the overnight shift (11:00 P.M. to 7:00 A.M.) on [DATE], when Resident #114 expired. Nurse #6 said that she assessed the Resident to be unresponsive, without pulse and breath sounds. Nurse #6 said CPR was initiated, and EMS was activated. Nurse #6 said she could not remember what time it was when she assessed the Resident and CPR was initiated, and that EMS took over CPR for the Resident somewhere around 3:15 A.M. Nurse #6 said that EMS provided CPR to the Resident for a while, then stopped. Nurse #6 said one of the EMS personnel informed her that they spoke with a hospital Physician and the hospital Physician said EMS could tell Nurse #6 to pronounce the Resident dead. Nurse #6 said she completed the RN pronouncement form and indicated the hospital Physician as the Physician informed of death. Nurse #6 said she was unsure whether she needed to contact Resident #114's Physician to notify him/her of the Resident's death and that she did not call the Resident's Physician. During an interview on [DATE] at 1:20 P.M., the DON said Nurse #6 should have called Resident #114's Physician or the on-call Provider to notify the Physician of the Resident's death when the Resident expired on [DATE]. During an interview on [DATE] at 2:57 P.M., the Corporate Nurse said that she did not recall entering the order into Resident #114's EMR for RN pronouncement on [DATE], and when she reviewed the record, realized that she did enter the order for the Physician to approve. The Corporate Nurse said the reason she would have entered the order on [DATE] for a death that occurred on [DATE] was if she reviewed the record and identified that an order had not been obtained. The Corporate Nurse also said that Nurse #6 should have notified the Resident's Physician of the Resident's death.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on record review, and interview, the facility failed to resolve a grievance timely for one Resident (#66), out of a total sample of 23 residents. Specifically, for Resident #66, the facility failed to ensure that a reported grievance by the Resident, the Resident's Representative (RR), and the Nurse Practitioner (NP), regarding two missing hearing aids was documented and the grievance process initiated to resolve the concern within a reasonable timeframe. Findings include: Review of the facility policy, titled Resident and Family Concerns and Grievances, revised 10/5/24, indicated: -Residents or their family members, guardian, or representative may voice a grievance to the facility staff in person, by telephone, or via written communication. -The facility shall provide a grievance report form to facilitate the voicing of a grievance if requested by a resident or family members. -The facility will follow up with the resident or their family members, guardian, or representative within 72 hours of the filing of the grievance. -The facility will make reasonable efforts to ensure that all grievances are adequately resolved within thirty (30) calendar days from the day the grievance is received. -The facility will advise the resident of the outcome of the grievance investigation and shall make reasonable efforts to contact the resident's family members to advise them of the outcome of the grievance investigation. -The facility will provide the resident with a written grievance decision. -The facility will document all steps of the grievance resolution in the facility's records, including whether the resident/family was satisfied with the resolution. Resident #66 was admitted to the facility in September 2022 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Major Depressive Disorder, Unspecified symptoms and signs involving cognitive functions following Cerebral Infarction, Metabolic Encephalopathy, and Diabetes Mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #66: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of 15 total possible points. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had clear speech. -was usually understood. Review of Resident #66's clinical record indicated the following: - The Resident completed a Health Care Proxy (HCP- a legal document identifying a resident's preference for surrogate medical decision makers if they become incapacitated) naming Resident Representative (RR) #1 on 9/13/24. -The Resident was determined by a Physician to lack capacity to make health care decisions and the HCP was permanently invoked on 10/29/24. During an interview on 3/4/25 at 10:15 A.M., Resident #66 said that he/she was missing hearing aids, and the facility staff were not responding to him/her anytime he/she would inquire about the missing hearing aids. During an interview on 3/5/25 at 1:28 P.M., RR#1 said he/she had reported the missing hearing aids to the facility staff about four months prior, but the facility had not responded to him/her as yet. Review of Resident #66's Physiatry Progress Note, dated 1/7/25, indicated the Resident still had no hearing aids, therefore communication with the Resident was difficult. The Physiatry Progress Note further indicated that the Physiatrist followed up with the nursing manager about the Resident's hearing aids, as well as the Social Worker (SW), and the Unit Manager (UM) and the Social Worker said a grievance would be initiated for the missing hearing aids. During an interview on 3/5/25 at 2:21 P.N., the SW said she was aware of Resident #66's concern about the missing hearing aids but she had not documented a formal grievance, had not followed the grievance process, and the Resident's concern of the missing hearing aids remained unresolved. The SW further said she should have documented the missing hearing aids as a formal grievance, investigated the concern, and followed up for resolution, but she had not done so.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on record review, and interview, the facility failed to provide care and services in accordance with professional standards of practice for one Resident (#27) out of a total sample of 23 residents, who required a vascular access device (device that provides access to the veins for the delivery of medications or fluids). Specifically, the facility failed to obtain Physician orders for the care and maintenance of Resident #27's midline catheter (a flexible tube inserted through a peripheral vein above the elbow that ends just below the axilla [armpit]) and monitor for catheter related complications. Findings include: Review of the facility policy titled Infusion Therapy Clinical and Pharmacy Services Policies and Procedures for Long-Term Care last revised November 2022, indicated the following: -for midline catheters flush before and after medication administration with a 10 ml (milliliter) barrel syringe with preservative free 0.9% sodium chloride. -change the catheter dressing at least every seven days and immediately if the dressing or site appears compromised. -visually inspect the midline access device every four hours for redness, tenderness, swelling, dislodgement . -for midline catheters, measure the circumference and compare baseline when clinically indicated to assess for edema and possible deep vein thrombosis. -document all procedures in the Treatment Administration Record (TAR). Resident #27 was admitted to the facility in October 2024 with diagnoses including Diabetes Mellitus Type II (DM II) with Diabetic Neuropathy. Review of the Minimum Data Assessment (MDS) dated [DATE], indicated Resident #27 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of seven out of a total possible score of 15. Review of the December 2024 Physician orders indicated the following order initiated on 12/26/24: -Piperacillin Sodium -Tazobactam Sodium Solution, 3.375 grams intravenously (IV) every 6 hours for infection for seven days. -Send Resident to ER (emergency room) for midline placement. Review of the Nursing Progress Note dated 12/26/24 at 8:51 P.M., indicated that Resident #27 had returned from the ER and had a midline catheter placed in his/her right upper arm. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #27's Physician orders failed to indicate any orders for the care and maintenance of Resident #27's midline catheter. Review of the December 2024 and January 2025 Medication Administration Records (MARs) indicated Resident #27 was administered the antibiotic medication from 12/27/24 through 1/2/25 as ordered. Review of the December 2024 and January 2025 Treatment Administration Records (TARs) failed to indicate any documentation that care and services had been provided for Resident #27's midline catheter. During an interview on 3/11/25 at 9:20 A.M., Unit Manager (UM) #1 said that she was on vacation at the time the Resident was on IV antibiotics. UM #1 said she knew he/she had a midline catheter placed on 12/26/25 for antibiotic therapy and that the midline catheter was discontinued on 1/14/25. UM #1 said when she returned from vacation she noticed that there had been no Physician orders for the care of Resident #27's midline catheter. UM #1 said that there should have been orders in place for monitoring the catheter site, dressing changes to the catheter site and for the flushing of the midline catheter. UM#1 said she could not provide any evidence that care and services had been provided for Resident #27's midline catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, interview, and record review, the facility failed to provide respiratory care and services consistent with professional standards of practice, for five Residents (#66, #30, #84, #12 and #75), out of a total sample of 23 residents. Specifically, the facility failed to: 1. For Resident #66: -ensure that the Resident had the appropriate oxygen adaptor to administer oxygen as ordered for use with the Continuous Positive Airway Pressure (CPAP - type of non-invasive device that administers a predetermined level of pressure through a mask worn over the nose and/or mouth to keep the airways open) machine resulting in CPAP therapy not being administered to the Resident as required. -obtain a Physician's order for the required settings for the use of the CPAP device. 2. For Resident #30 and #84, the ensure that the Residents' humidifier bottle attached to the oxygen concentrator contained humidified water. 3. For Resident #12, obtain Physician's orders for oxygen administration and maintenance of oxygen and respiratory equipment. 4. For Resident #75, clean the oxygen concentrator and date and label the Resident's oxygen tubing. Findings include: Review of the facility policy titled, CPAP and BIPAP Usage/Maintenance, revised 10/14/24 indicated the following: -Used to provide to spontaneous breathing with continuous positive airway pressure with or without supplemental oxygen. -To improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. -To promote resident comfort and safety. -Resident using CPAP/BIPAP will require a physician's order to include approved order setting, duration of use and use of humidifier, if necessary and a supporting diagnosis. -Notify the Physician if the resident refuses the procedure. -Document Adherence to treatment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Oxygen Administration and Storage, revised 10/10/24 indicated: -Verify Provider's order for the procedure. -Label tubing connected to the oxygen cylinder with time and date. -Attach the appropriate delivery device. -Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. -The humidifier bottle is to be labeled with the date of application and changed weekly if refillable. If it is disposable (single use) humidification, bottle is to be changed at least weekly and more frequently as it is near empty to maintain humidification. -Filters should be removed and cleaned by rinsing with clear, cool water as needed to maximize flow rate of clean air. Review of the facility policy titled, Physician Orders, revised November 2024 indicated: -Physician orders must be documented clearly in the medical record including the required components of a complete order. -Orders that are missing required components, illegible or are unclear will be clarified prior to implementation. -Clear and complete orders will be transcribed to the appropriate administration record. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf\ indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with physicians' orders or inadequate instruction for oxygen therapy. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia ([PaC02] Partial Pressure of carbon dioxide- high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in PaCO2. -Equipment maintenance and supervision: >All oxygen delivery equipment should be checked at least once daily (continued on next page)

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

>Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply.

Resident #66 was admitted to the facility in September 2022 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD).

Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #66:

-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of 15 total possible points

-had clear speech

-was usually understood

-was prescribed oxygen therapy

Review of Resident #66's clinical record indicated the following:

-The Resident completed a Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) naming Resident Representative (RR) #1 on 9/13/24.

-The Resident was determined by a Physician to lack capacity to make health care decisions and the HCP was permanently invoked on 10/29/24.

During an interview on 3/4/25 at 10:15 A.M., Resident #66 said that he/she was supposed to be using a CPAP machine at night.The Resident further said the CPAP machine was in the room, and the facility staff did not know how to use the machine. Resident #66 said the facility had not provided the adaptor that was needed to connect oxygen to the CPAP machine. Resident #66 said the facility staff attempted to place the CPAP mask over the nasal cannula on his/her face but the mask was not a good fit. Resident #66 said that he/she had been asking the facility staff about his/her need to use the CPAP machine but no one seemed to know or understand how to connect oxygen to the CPAP machine.

During an interview on 3/5/25 at 1:28 P.M., RR #1 said he/she was aware that the CPAP machine was not being provided to Resident #66. RR #1 said that he/she had mentioned the concern to the facility staff but had not been informed of any resolution.

Review of Resident #66's March 2025 Physician's orders indicated:

-CPAP Mask Style Full Face Mask Size large, initiated 12/28/23.

-CPAP: Oxygen setting: O2 (oxygen) at 2 liters via CPAP when in use every shift, initiated 12/28/23.

-BIPAP: clean reservoir per manufacturer's instructions every night shift on Sundays, initiated 2/20/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #66's December 2023 Physician's orders indicated: -CPAP AUTO: Pressure Settings: Home settings. Hours of Usage - HS to AM every shift, initiated 12/28/23. Further review of the December 2023 Physician's orders failed to indicate an order for AutoCPAP pressure settings as required. Review of updated Physician orders revised by the facility on 3/5/25 at 11:09 A.M., indicated: -CPAP face mask, humidifier, oxygen at 2 liters per minute (LPM), pressure settings: min 4.0 max 20.0. Further review of the updated Physician orders failed to indicate the appropriate mask type and the frequency of use for CPAP therapy. Review of Resident #66's Care Plan Report indicated: -the Resident had a diagnosis of Sleep Apnea -the following interventions: BIPAP/CPAP/VPAP SETTINGS: titrated pressure: (SPECIFY) cm H20 via (SPECIFY): nasal pillow, nose mask or full face mask) (SPECIFY FREQ), initiated 12/28/23 and revised 3/4/25. On 3/5/25 at 9:30 A.M., the surveyor and Nurse #3 reviewed Resident #66's CPAP machine. During an interview at the time, Nurse #3 said she did not work the overnight shift and had no idea whether the machine was a BIPAP or CPAP machine. Nurse #3 further said she did not know whether oxygen could be connected to the machine for the Resident's use, or what port the oxygen tubing would be attached to on the machine. On 3/5/25 at 9:35 A.M., the surveyor and the Assistant Director of Nursing (ADON) observed the Resident's CPAP machine. During an interview at the time, the ADON said she was unsure whether the machine was a BIPAP or a CPAP machine. The ADON also said she was unsure how the oxygen tubing would be attached to the machine. The ADON further said that she would have to ask another staff member and would update the surveyor. On 3/5/25 at 10:02 A.M., the surveyor, the ADON and the Staff Development Coordinator (SDC) observed Resident #66's machine. During an interview at the time, the SDC said she was unsure whether the machine was a BIPAP or CPAP, and that there was no way an oxygen tubing could be attached to the machine. During an interview on 3/5/25 at 11:45 A.M., the Medical Record Supply Staff said the Resident's machine was a [NAME] G3 machine and that it was a CPAP machine. The Medical Record Supply Staff said when an order was obtained by a Nurse, he would provide the PAP (Positive Airway Pressure) machine to the Nurse and the Nurse was expected to set the PAP machine up based on the settings ordered for the Resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/25 at 12:25 P.M. the Clinical Nurse Support (CNS) said she was unaware that Resident #66 was not receiving his/her CPAP treatment. The CNS said the Nurses documented the CPAP as being administered at night and the Nurses should not document as administered if the CPAP was not provided. The CNS said the facility should have provided the oxygen adaptor needed for the CPAP machine to properly function for the Resident, but they had not. During an interview on 3/5/25 at 2:28 P.M. Unit Manager (UM) #2 said she was asked to review the settings in the CPAP machine and update the Physician's orders with the settings on 3/5/25 at 11:09 A.M. UM #2 said she was not the Unit Manager for the South 2 Unit and that the manager for that unit was out sick. UM #2 further said she should have called the Physician to obtain orders for the settings, but she did not. 2a. Resident #30 was admitted to the facility in December 2021 with diagnoses of Chronic Systolic and Diastolic Congestive Heart Failure and COPD. Review of Resident #30's March 2025 Physician's orders indicated: -humidified oxygen to be given at 2 LPM (liters per minute) via nasal cannula, initiated 2/23/25. On 3/4/25 at 10:20 A.M., the surveyor observed that Resident #30 was awake, and lying in bed. Resident #30 was observed to have a nasal cannula in his/her nostrils with oxygen set at 2 LPM via an oxygen concentrator. The surveyor observed that an empty humidifier bottle was attached to the oxygen concentrator and dated 2/24/25. On 3/5/25 at 8:15 A.M., the surveyor observed that Resident #30 was awake, alert, and lying in bed. Resident #30 was observed to have a nasal cannula in his/her nostrils with oxygen set at 2 LPM via an oxygen concentrator, and the humidifier bottle attached to the oxygen concentrator was empty and dated 2/24/25. 2b. Resident #84 was admitted to the facility in November 2024 with diagnoses including COPD. Review of Resident #84's Physician orders indicated: -oxygen at 3 liters via nasal cannula for COPD, initiated 12/23/24. On 3/4/25 at 10:04 A.M., the surveyor observed that Resident #84 was awake, and lying in bed. The surveyor observed that the Resident had a nasal cannula in his/her nostrils with oxygen set at 3 LPM via an oxygen concentrator. The surveyor observed that the Resident's oxygen concentrator had an empty humidifier bottle attached and the bottle was undated. On 3/5/25 at 8:16 A.M., the surveyor observed that Resident #84 was awake, and lying in bed. The Resident was observed with a nasal cannula in his/her nostrils with oxygen set at 3 LPM via oxygen concentrator. The surveyor observed that an empty humidifier bottle was attached to the oxygen concentrator and was undated. During an interview on 3/5/25 at 8:31 A.M., the SDC said that she was the acting Unit Manager (UM) on the South 2 unit. The SDC said Resident's #30 and #84 were supposed to be on humidified oxygen and that the humidifier bottles should have been replaced, but they had not been replaced. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45429 3. Resident #12 was admitted to the facility in May 2022 with diagnoses including Dementia and COPD. Review of Resident #12's Minimum Data Set (MDS) assessment dated [DATE], indicated: -the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. -the Resident had received oxygen therapy. Review of the Resident's comprehensive medical record indicated: -No Physician's orders for oxygen administration or oxygen and respiratory equipment maintenance. -Physician's orders to keep the head of the bed elevated at 30 degrees as needed for shortness of breath. -a Care Plan indicating that the Resident was at risk for respiratory complications related to COPD. -a Care Plan intervention to observe the Resident's respiratory status and assess for changes. -a discontinue date of 2/19/25 for oxygen at 2 L (liters) via nasal cannula documented on the February 2025 Medication Administration Record (MAR) -a Nurse's Progress Note dated 2/19/25 indicating the Resident had been noncompliant with the oxygen and new orders to wean the patient off oxygen. -a Nurse's Progress Note dated 2/23/25 indicating that the Resident continued to remove the oxygen from their nose. On 3/4/25 at 9:19 A.M., the surveyor observed Resident #12 lying in bed with oxygen flowing at 2 LPM (Liters Per Minute) via nasal cannula. The surveyor observed that the nasal cannula included the date 2/25/25 written on white tape and attached to the tubing. During an interview at the time, Resident #12 said that he/she did not have any concerns with his/her oxygen and that the staff changed the tubing weekly. On 3/5/25 at 9:44 A.M., the surveyor observed Resident #12's room and found that the oxygen concentrator, nasal cannula and tubing were no longer in the Resident's room. On 3/5/25 at 9:45 A.M., the surveyor observed Resident #12 seated next to Nurse #1 in the Unit dining area with no oxygen in use. During an interview at the time, Nurse #1 said that they typically place the Resident's oxygen on in the evenings because he/she had been non-compliant with oxygen use. Nurse #1 also said that she was unaware the Resident's oxygen supplies were no longer in his/her room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/25 at 9:48 A.M., Unit Manager (UM) #2 said that the Physician recommended that staff wean Resident #12 off the oxygen on 2/19/25. UM #2 said that the Resident should not have been wearing the oxygen without a Physician's order. UM #2 further said that the Nurse assigned to the Resident had not been aware that the oxygen had been discontinued. 51571 4. Resident #75 was admitted to the facility in October 2021 with diagnoses including Dysphagia, Oropharyngeal Phase and Chronic Diastolic Congestive Heart Failure. Review of the facility policy titled Policy and Procedure Oxygen Administration and Storage initiated 10/16/23, revised 10/10/24, indicated the following: -Label the tubing connected to the oxygen cylinder with time and date. -The nasal canula and/or mask should be changed weekly or when soiled. -Filters should be removed and cleaned by rinsing with clear, cool water as needed to maximize flow rate of clean air. Review of the New Life Elite Oxygen Concentrator Service Manual, dated 03/06, retrieved at https://oxygenalliance.org/wp-content/uploads/2024/03/Airsep-NewLife-Elite-ServiceManual.pdf indicated: -To ensure accurate output and efficient operation of the oxygen concentrator, the user must clean the gross particle filter weekly, as described below: >Remove the dirty air intake particle filter from the back of the unit, and install the clean filter stored in the pocket on the back of the unit. >Wash the dirty filter in warm soapy water and rinse. >Use a soft absorbent towel to remove excess water. >Place the clean air intake gross particle filter in the pocket on the back of the unit. Review of the Minimum Data Set (MDS) Assessment, dated 1/15/25, indicated Resident #75: -was rarely/never understood and had short and long term memory loss. -had a memory impairment during the reference period. -received oxygen therapy during the reference period. Review of Resident #75's March 2025 Physician's orders, included the following: -change oxygen tubing weekly, date and initial and place in bag every night shift (11:00 P.M.-7:00 A.M) every Sunday, initiated 2/7/22. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-clean filter on oxygen concentrator weekly, every night shift, every Sunday, initiated 2/20/25. -oxygen at 2 LPM via nasal cannula to maintain oxygen saturation level (measures the percentage of oxygen in the blood) over 92 percent (%), initiated 5/9/24. Review of Comprehensive Respiratory Care Plan, initiated 5/9/24 and revised 7/25/24, indicated Resident #75 had an alteration to his/her respiratory system which required oxygen therapy and included the following intervention: -Administer oxygen via NC (nasal cannula) at 2 LPM. Review of Resident #75's March 2025 Medication Administration Record (MAR), indicated: -Change oxygen tubing weekly, date, initial and place in a bag every night shift, every Sunday. Review of Resident #75's March 2025 Treatment Administration Record (TAR), indicated: -oxygen concentrator filter was cleaned on 3/2/25 as evidenced by the Nurse's signature of completion on the TAR. On 3/4/25 at 10:27 A.M., the surveyor observed Resident #75 lying in bed with eyes closed and oxygen being delivered via nasal cannula. The surveyor observed that the oxygen was set at 2 LPM on the oxygen concentrator which had a humidifier bottle attached. The surveyor observed that the oxygen tubing was not dated or labeled. On 3/5/25 at 10:15 A.M., the surveyor observed Resident #75 lying in bed, and was awake. The Resident was observed using 2 LPM oxygen via nasal cannula which was connected to the oxygen concentrator. Resident #75's oxygen tubing was not dated or labeled. During an interview on 3/5/25 at 2:47 P.M., Nurse #3 said that the 11:00 P.M - 7:00 A.M. shift Nurses were responsible for changing the oxygen tubing weekly on Sundays and ensure that the tubing was dated and labeled. The surveyor and Nurse #3 observed Resident #75 oxygen tubing and found there was no visible label and/or date on the tubing. Nurse #3 said that she was unable to indicate when the oxygen tubing was last changed and she will change the oxygen tubing, date, and label today. On 3/5/25 at 3:10 P.M., the surveyor observed Resident #75 lying in bed with eyes closed. The surveyor observed that the oxygen tubing was labeled and dated 3/5/25. During an interview on 3/5/25 at 3:44 P.M., the Staff Development Coordinator and Educator (SDC) said that oxygen tubing for residents requiring oxygen therapy are changed once a week on Sundays by the 11:00 P. M. - 7:00 A.M. shift Nurses. The SDC said that the expectation for Nurses is that they will change the oxygen tubing, date, and label the tubing and then report in change of shift report. On 3/6/25 at 7:55 A.M., the surveyor observed Resident #75 lying in bed with eyes closed, his/her oxygen was set to 2 LPM via the nasal cannula on the oxygen concentrator with humidification. The surveyor observed that the oxygen concentrator air intake particle filter on the back of the device had a layer of dust. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 9:07 A.M., Nurse #7 said that the oxygen concentrator filters and oxygen tubing are changed weekly on Sundays by the 11:00 P.M. -7:00 A.M. shift Nurses. The surveyor and Nurse #7 observed the air intake particle filter on the back of the oxygen concentrator, and Nurse #7 said that the filter is dirty and should have been changed, as it prevents air flow to the concentrator, but the filter was not changed. During an interview on 3/6/25 at 12:46 P.M., the SDC said that the filters on the oxygen concentrators are to be cleaned every week by the 11:00 P.M. -7:00 A.M. shift Nurses to help keep the air clean. The SDC also said that the expectation for Nurses on the 11:00 P.M. -7:00 A.M. shift is to clean the filters on the oxygen concentrators and change the oxygen tubing weekly.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 45429 Based on interview, and record review, the facility failed to develop a comprehensive Trauma Informed Care Plan for one Resident (#2), out of a total sample of 23 residents. Specifically, for Resident #2, the facility failed to complete an assessment and ensure that a comprehensive Trauma Informed Care Plan was developed relative to the Resident's history of Post-Traumatic Stress Disorder (PTSD). Findings include: Review of the facility policy for Trauma Centered Care last revised 11/5/24 indicated: -the initial (admission) intake, assessment, and documentation process includes questions designed to sensitively and respectfully explore prior (including early childhood) and current trauma-related experiences. -the screening and assessment process is sufficiently thorough and focused on trauma-related issues to allow for determination of a diagnosis associated with trauma, such as PTSD. -the facility routinely assists residents to develop a plan that is designed to prevent and manage a crisis. All staff directly involved in the residents' treatment is informed about the resident plan and how they can support it. -the facility provides trauma-related information that will assist other service providers to develop a service plan that will promote effective care and reduce the likelihood of re-traumatization. -the facility ensures that staff are educated and trained in using trauma informed care approaches to prevent and manage incidents that create serious emotional distress for both residents and staff. Resident #2 was admitted to the facility in June 2024 with diagnoses including Post Traumatic Stress Disorder (PTSD) and Bipolar Disorder. Review of Resident #2's Behavioral Healthcare Notes dated 9/17/24 and 10/15/24, indicated that the Resident was diagnosed with Post Traumatic Stress Disorder. Review of the Minimum Data Set (MDS) assessment, dated 11/28/24, indicated that Resident #2: -was cognitively intact as evidenced by a Brief interview of Mental Status (BIMS) score of 15 out of a possible score of 15. -exhibited verbal, physical and other behavioral symptoms directed at others (e.g., threatening others, screaming at others, cursing at others). -was diagnosed with Bipolar Disorder and PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's Comprehensive Care Plan failed to indicate documentation that a Trauma Informed Care Plan had been developed for Resident #2, until 3/4/25, when the facility survey started. During an interview on 3/6/25 at 9:14 A.M., Social Worker (SW) #1 said Trauma Assessments should be completed for residents on admission which will then trigger the care plan if applicable. SW #1 also said that a Trauma Assessment should have been completed on Resident #2, and it was not completed.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 45429 Based on interview, and record review, the facility failed to provide Physician visits at the required frequency for five Residents (#10, #28, #45, #51 and #68) for an applicable sample of six residents, out of a total sample of 23 residents. Specifically, the facility failed to provide alternating routine 60-day visits between the Physician and the Nurse Practitioner (NP) for Resident's #10, # 28, #45, #51 and #68, as required. Findings include: 1. Resident #10 was admitted to the facility in September 2022 with diagnoses including Dementia. Review of Resident #10's clinical record indicated that the Resident was seen by a Physician on 6/30/24. Further review of the clinical record indicated that Resident #10 was not seen again by the Physician until 10/20/24 (112 days after the previous Physician visit). 2. Resident #28 was admitted to the facility in March 2024 with diagnoses including Dementia. Review of Resident #28's clinical record indicated that the Resident was seen by a Physician on 4/20/24. Further review of the clinical record indicated that Resident #28 was not seen again by the Physician until 10/20/24 (183 days after the last Physician visit). 3. Resident #45 was admitted to the facility in March 2022 with diagnoses including Dementia. Review of Resident #45's clinical record indicated that the Resident was seen by a Physician on 5/14/24. Further review of the clinical record indicated that Resident #45 was not seen again by the Physician until 10/4/24 (143 days after the last Physician visit). 4. Resident #51 was admitted to the facility in March 2018 with diagnoses including Dementia. Review of Resident #51's clinical record indicated that the Resident was seen by a Physician on 5/24/24. Further review of the clinical record indicated that Resident #51 was not seen again by the Physician until 10/20/24 (149 days after the last Physician visit). 5. Resident #68 was admitted to the facility in March 2024 with diagnoses including Dementia. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #68's clinical record indicated that the Resident was seen by a Physician on 4/20/24. Further review of the clinical record indicated that Resident #68 was not seen again by the Physician until 10/9/24 (172 days after the last Physician visit). On 3/12/25 at 3:13 P.M., the surveyor and the Corporate Nurse reviewed the Practitioner notes for Resident's #10, # 28, #45, #51 and #68. During an interview at the time, the Corporate Nurse said that each of the Resident's (#10, # 28, #45, #51 and #68) should have been seen by a Physician between the time periods documented here for each Resident and they had not been seen by a Physician.

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47901

Based on observation, interview, and record review, the facility failed to ensure that three Licensed Nurses (Nurse #3, ADON [Assistant Director of Nurses] and SDC [Staff Development Coordinator]) out of three Nurses, had the specific competencies and skills sets necessary to provide respiratory care and services that were consistent with professional standards of practice for one Resident (#66), out of a total sample of 23 residents.

Specifically, for Resident #66, the facility failed to ensure that Nurse #3, the ADON and the SDC had the knowledge, competency and skills necessary to:

-order and provide an inline adaptor for the Resident's Continuous Positive Airway Pressure (CPAP - type of non-invasive device that administers a predetermined level of pressure through a mask worn over the nose and/or mouth to keep the airways open) machine to connect oxygen as ordered for CPAP therapy

-obtain and implement appropriate CPAP pressure settings as required when the settings were not ordered, resulting in the Resident's inability to use the CPAP machine during sleep.

Findings include:

Review of Facility Assessment, revised 2/19/25, indicated:

-The facility provides special treatments and conditions such as Oxygen therapy, BIPAP/CPAP.

-Management of medical conditions such as COPD.

-Has resources to provide competent resident support and care.

-Provide monthly training and competencies and adjusted based on current needs and occurrences within the facility.

-Provide physical equipment like ventilators.

Resident #66 was admitted to the facility in September 2022 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD).

Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #66:

-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of 15 total possible points

-had clear speech

-was usually understood

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was prescribed oxygen therapy -utilized non-invasive mechanical ventilation Review of Resident #66's clinical record indicated: -The Resident completed a Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) naming Resident Representative (RR) #1 -The Resident was determined by a Physician to lack capacity to make health care decisions and the HCP was permanently invoked on 10/29/24. During an interview on 3/4/25 at 10:15 A.M., Resident #66 said that he/she was supposed to be using a CPAP machine at night. Resident #66 further said the CPAP machine was in the room, but the facility staff did not know how to use the machine. Resident #66 said the facility had not provided the adaptor needed to connect oxygen to the CPAP machine, and he/she had been asking the facility staff about his/her need to use the CPAP machine at night. During an interview on 3/5/25 at 1:28 P.M., Resident Representative #1 said he/she was aware that Resident #66 was not provided CPAP therapy, and had mentioned the concern to the facility staff. Review of Resident #66's March 2025 Physician's orders indicated: -CPAP Mask Style Full Face Mask Size large, initiated 12/28/23. -CPAP: Oxygen setting: O2 at 2 liters via CPAP when in use every shift, initiated 12/28/23. Review of Resident #66's December 2023 Physician's orders indicated: -CPAP AUTO: Pressure Settings: Home settings. Hours of Usage HS to AM every shift, initiated 12/28/23. Review of updated Physician orders revised by the facility on 3/5/25 at 11:09 A.M., indicated: -CPAP face mask, humidifier, oxygen at 2 liters per minute (LPM) pressure settings: min 4.0 max 20.0. Review of Resident #66's Care Plan Report indicated that the Resident had Sleep Apnea and included the following interventions: -BIPAP/CPAP/VPAP SETTINGS: titrated pressure: (SPECIFY) cm H20 via (SPECIFY): nasal pillow, nose mask or full face mask) (SPECIFY FREQ), initiated 12/28/23 and revised 3/4/25. On 3/5/25 at 9:30 A.M., the surveyor and Nurse #3 reviewed Resident #66's CPAP machine. During an interview at the time, Nurse #3 said she did not work the overnight shift and had no idea whether the machine was a BIPAP or CPAP. Nurse #3 further said that she did not know whether oxygen could be connected to the machine or to what port the oxygen tubing would be attached for the Resident's use. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 9:35 A.M., the surveyor and the Assistant Director of Nursing (ADON) observed the Resident's CPAP machine, and the ADON said she was unsure whether the machine was a BIPAP or a CPAP. The ADON also said she did not know how she would attach oxygen tubing to the machine. The ADON said she would have to ask another staff member and would update the surveyor. On 3/5/25 at 10:02 A.M., the ADON and the Staff Development Coordinator (SDC) observed Resident #66's machine. The SDC said she was unsure whether the machine was a BIPAP or CPAP, and that there was no way an oxygen tubing could be attached to the machine. During an interview on 3/5/25 at 12:25 P.M. the Clinical Nurse Consultant (CNS) said Nurse #3, the ADON, and the SDC, had not been assessed for competency on the use of a BIPAP or CPAP machine. During an interview on 3/6/25 at 11:15 A.M., the SDC said that not all CPAP machines were the same and the nursing staff should have been trained on the use of the CPAP machine, and have competencies assessed when Resident #66 had a Physician's order for use of the CPAP machine. The SDC further said that nursing competencies should have been assessed, but they were not.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 42761 Based on record review, and interview, the facility failed to complete a performance review at least once every 12 months for one Certified Nurses Aide (CNA) #2 out of a sample of five CNAs reviewed. Specifically, the facility failed to ensure that a performance review was completed as required, for CNA #2 when CNA #2 had been employed at the facility for greater than 12 months. Findings include: Review of the facility's Performance Appraisal Policy, dated 11/1/15 and revised 11/5/24, indicated the following: -It is the facility policy that employees receive annual performance appraisals. -Annual reviews assist supervisors in appraising employees of progress and potential as well as areas that need to be strengthened. -Department Directors should review the evaluation with the employee and confirm performance goals for the next year. -Performance evaluations are to be reviewed by the Human Resource Director and . filed in the employee's personnel file. Review of the facility's list of CNAs employed at the facility for greater than one year as of 3/7/25, indicated that CNA #2 had been employed at the facility since 11/27/23. Review of CNA #2's Staff Performance Review Form, dated 11/1/24, indicated the following: -CNA #2's performance had been evaluated. -The Performance Review included an area for the employee signature. -The employee signature line was blank. During an interview on 3/7/25 at 1:30 P.M., the Human Resources Director (HRD) said that CNAs' performance was required to be evaluated every year. The HRD said that he tracked when the performance reviews were due and provided the Staff Performance Review Forms to the Department Director when staff performance reviews needed to be completed. The HRD said that the Department Directors were required to review the annual performance evaluations with their staff, and that staff were to sign the Performance Review Form to indicate acknowledgement of the performance review. The HR Director said that once the Performance Review Form was signed, the Department Directors were required to return the Performance Review Forms to him so that the Performance Review Forms could be filed in the employees' files. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayer Valley Rehab and Nursing	400 Groton Road Ayer, MA 01432

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 2:30 P.M., the Director of Nursing (DON) said there was no evidence the performance review dated 11/1/24, was ever reviewed with CNA #2. On 3/11/25 at 11:41 A.M., the surveyor placed a telephone call to CNA #2. CNA #2 did not answer the phone and the message on the phone indicated the voicemail box was full and could not accept messages at that time.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on interview, and record review, the facility failed to ensure that recommendations made by the Consultant Pharmacist during a monthly Medication Regimen Review (MRR) were reviewed by the Physician as required for two Residents (#9 and #11), out of a total sample of 23 residents. Specifically, the facility failed to: 1. For Resident #11, act upon the Consultant Pharmacist recommendation dated 11/27/23, to monitor serum Dilantin levels routinely every six months, putting the Resident at risk for elevated serum Dilantin levels and resulting in hospitalization to manage Dilantin toxicity. 2. For Resident #9, act upon the Consultant Pharmacist recommendations dated 10/16/24 and 12/15/24, to update the Physician's order for Breztri (combination inhaler consisting of inhaled steroid, anticholinergic and long acting beta adrenergic agonist medications) to instruct the Resident to rinse mouth after use to prevent the development of oral thrush (Candida Albicans) from inhaled steroid use. Findings include: Review of the facility policy titled Policy and Procedure Medication Regimen Review, initiated 11/1/15 and revised 11/5/24, indicated: -The Consultant Pharmacist shall review the medication regimen of each resident at least monthly. -Routine medication regimen reviews will be completed monthly. Additional reviews may be done as the request of the Physician and/ or the recommendation of the Interdisciplinary Team. -The Consultant Pharmacist will communicate his/her findings and recommendations in writing on a medication regimen review report. -Information on the medication regimen reviews and written recommendations will be reviewed by the Director of Nursing (DON). -The medication recommendations are sent to the Primary Provider to address the recommendation. 1. Resident #11 was admitted to the facility in September 2023 with diagnoses including Epilepsy, Benign Paroxysmal Vertigo of the Left Ear, and Metabolic Encephalopathy. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #11 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. Review of the Federal Drug Administration Fact sheet for Dilantin, last revised March 2021, indicated: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Serum blood level determination may be necessary for optimal dosage adjustments. -The clinically effective Dilantin blood concentration range is 10 to 20 mcg/mL (micrograms per milliliter). -The most common adverse reactions are nervous system reactions including ataxia, slurred speech, decreased coordination, nystagmus and mental confusion. Review of a Consultant Pharmacist's Medication Regimen Review (MRR) document dated 11/27/23, indicated the following: -Resident is receiving Dilantin. Please consider Dilantin level with Resident's next scheduled lab and every 6 months thereafter. -Further review of the MRR indicated a Physician reviewed the Pharmacist's Medication Regimen Review document and a recommendation was forwarded to the Interdisciplinary Team (IDT). Review of Resident #11's Physician orders indicated the following: -Phenytoin Sodium Extended Capsule (Dilantin) 100 mg (milligrams). Give three (3) capsules by mouth one time a day for seizures. Initiated 9/8/23 and discontinued 10/22/24. -Phenytoin Sodium Extended Capsule (Dilantin) 100 mg (milligram). Give three (3) capsules by mouth two times a day for seizures. Initiated 10/22/24 and discontinued 3/10/25. -Phenytoin Sodium Extended Capsule (Dilantin)100 mg. Give two (2) capsules by mouth two times a day for seizures. Initiated 3/11/25. Further review of Resident #11's Physician's orders did not indicate any ongoing orders to monitor and obtain serum laboratory values for Dilantin levels. During an interview on 3/10/25 at 4:54 P.M., the Corporate Nurse said that Resident #11 had not had a serum Dilantin level obtained since 9/22/23 but should have had serum Dilantin level monitoring annually. The Corporate Nurse said that she did not know why the Pharmacy recommendation dated 11/27/23 for ongoing serum Dilantin level monitoring had not been implemented. Review of the Serum Dilantin level obtained by the facility on 3/10/25 after the surveyor investigation and interview, indicated that Resident #11 had a critically high serum Dilantin level of 35.7 mcg/ml. Review of a Physician progress Note dated 3/11/25 at 10:50 A.M., indicated the following: -Resident #11 had experienced moderate cognitive decline and altered mental status. -Resident #11 was unsteady and swaying back and forth. -Assessment/Plans indicated Dilantin toxicity with confusion -Transfer to hospital. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/25 at 10:15 A.M., the Consultant Pharmacist said that she has been reviewing records for the facility since December 2023. The Consultant Pharmacist said she provides all the recommendations to the DON and the DON forwards the recommendations to the Unit Managers (UMs). The Consultant Pharmacist said that serum Dilantin levels are usually monitored every three to twelve months, and the frequency of monitoring depends on the needs of the residents. The Consultant Pharmacist said that she has not recommended a serum Dilantin drug level to be obtained for Resident #11 because the Resident's clinical record indicated that he/she was stable and was not experiencing any adverse effects on the current Dilantin dosage. The Consultant Pharmacist said that the Medication Regimen Recommendation dated 11/27/23 was made by the previous Consultant Pharmacist. During an interview on 3/12/25 at 12:57 P.M., Physician #1 said that he reviews monthly Pharmacy Recommendations with the Nurse, determines whether he agrees or disagrees with the recommendations and writes the appropriate orders. The Physician further said that he was unaware of the Consultant Pharmacist Recommendation dated 11/27/23 and does not recall ever ordering a serum Dilantin level to be obtained for Resident #11. Physician #1 said that a serum Dilantin level should have been ordered and obtained a couple of months after the Resident was admitted to the facility to help establish a serum Dilantin baseline level. Physician #1 said that the Consultant Pharmacist should have notified him of the need to monitor serum Dilantin levels. 51571 2. Resident #9 was admitted to the facility in October 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #9's March 2025 Active Physician's orders indicated: -Breztri Aerosphere (Budesonide-Glycopyrrolate-Formoterol Fumarate) Inhalation Aerosol 160-9-4.8 micrograms (mcg).1 puff inhale orally one time a day for Shortness of Breath (SOB), initiated 10/11/24. Review of Resident #9's Pharmacist Progress Notes indicated the following: -10/16/24: Medication regimen reviewed. Recommendations made, please see report for details. -12/15/24: Medication regimen reviewed. Recommendations made, please see report for details. Review of Resident #9's Clinical Record indicated a Consultant Pharmacist Recommendation to Nursing indicated the following: -10/16/24: Resident receiving Breztri. In order to help prevent the development of thrush, please update order to instruct Resident to rinse mouth after use. -12/15/24: Resident receiving Breztri. In order to help prevent the development of thrush, please update order to instruct Resident to rinse mouth after use. Further review of Resident #9's medical record failed to indicate that the Physician had reviewed the 10/16/24 and 12/15/24 Pharmacy Recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/7/25 at 1:55 P.M., Nurse #4 said when a Physician orders an inhaler for a Resident, before she administers the medication, she checks the Physician order and uses the five rights of medication administration (right person, right drug, right dose, right time, right drug) for accuracy. Nurse #4 said prior to administering the inhaler to the Resident, she cleans the mouthpiece of the inhaler, administers the inhaler, and cleans the mouth of the inhaler, and stores it back in the medication cart. During an interview on 3/7/25 at 2:10 P.M., the Assistant Director of Nursing (ADON) said the DON was responsible for processing Pharmacy Consultant Recommendations. The ADON said the DON reviews the Pharmacy Recommendations by unit and distributes the recommendations to the UMs for a follow-up review with the Physician. The ADON said the Nurses on the unit will notify the Physician of the Pharmacy Recommendations and the UM will update the Resident record to reflect the recommendations made by the Pharmacy Consultant. The ADON said that the expectation for nursing staff administering inhalers to a resident was the Nurses will instruct the Resident to rinse their mouth after the administration of the inhaler to prevent the development of thrush. During an interview on 3/7/25 at 2:15 P.M.,with the Staff Development Coordinator (SDC) and DON, the DON said that Pharmacy Recommendations were given to the Physician, and the Physician will sign and indicate if they agree or disagree with the recommendation. The DON said that she kept a master list of all the Pharmacy Consultant Recommendations and distributed the recommendations to the UMs. The DON also said that the UM on the unit was responsible for updating Pharmacy Recommendations in the electronic medical record (EMR) after the recommendations were reviewed by the Physician. The surveyor, the SDC and the DON reviewed Resident #9's October 2024 and December 2024 Pharmacy Consultant Recommendations and the DON said that the Pharmacy Recommendations should have been added to the Resident's orders in October 2024 and December 2024.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 51571 Based on interview, and record review, the facility failed to ensure that one Resident (#104) out of a total sample of 23 residents, was free from a significant medication error when an anticoagulation medication was not administered and monitoring laboratory testing of the medication was not completed as ordered by the Physician. Specifically, for Resident #104, the facility failed to ensure that Warfarin Sodium (a blood thinner or anticoagulant medication used to prevent blood clots and reduce risk of heart attack and stroke) was administered to the Resident as ordered and that Prothrombin Time/International Normalized Ratio Lab work (PT/INR - blood test that measures how quickly the blood clots, helping to assess the function of blood clotting factors and monitor the effectiveness of blood thinning medications like Warfarin Sodium) laboratory test was drawn as ordered by the Physician, increasing the risk for heart complications and formation of blood clots. Findings include: Review of the facility policy titled, Administering Medication, initiated 11/1/15 and revised 3/19/24, indicated the following: -The Director of Nursing Services is responsible for the supervision and direction of all personnel with medication administration duties and functions. -Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time, and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standards. -Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication shall chart in the Electronic Medical Record (eMAR) and sign off for that particular drug and document a rationale. -If the medication was not administered the missed dose/medication error protocol shall be followed. Review of the facility policy titled Policy & Procedure Medication Errors, initiated 11/1/15 and last revised 11/5/24, indicated the following: -It is the policy of this facility to establish and follow a uniform process of medication error management, in regard to reporting medication errors and ensuring accurate and appropriate use of medications. -The nurse that has noted the Medication Error will contact the Director of Nursing, Physician, Resident/Power of Attorney (POA)/Guardian and the Facility Pharmacy. This facility feels that reporting of errors or potential errors will help us to identify and remediate problem processes or to identify areas of needed staff or individual staff education. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It is the responsibility of every employee to report any known, suspected, or potential medication error. -It is the responsibility of nursing administration to monitor these reports and initiate any appropriate action. -All medication errors are to have a risk management for unusual occurrence completed. Annual & PRN (as needed) medication error training will be maintained. Review of the facility policy titled Policy & Procedure Anticoagulant Therapy, initiated 11/1/15 and last revised 5/5/24, indicated the following: -To ensure that residents on anticoagulant therapy, upon a physician's order, will be monitored to ensure the maintenance of safe laboratory parameters as established by the attending physician. The protocol for managing anticoagulant therapy will assist in reducing the risk of negative effects from the use of anticoagulant medications. -The Anticoagulant Flow Record should reflect: a. date of the most recent laboratory draw, if applicable b. the results of the most recent laboratory draw, if applicable c. current medication and dose orders d. date of the next scheduled laboratory draw, if applicable e. parameters for abnormal results and physician notification -With each medication administration opportunity, the licensed nurse or certified medication technician will review the Medication Administration Record and Anticoagulant Flow Record to ensure consistency in medication dose orders, laboratory results are documented, the physician has been notified of laboratory results, and the next laboratory draw date is identified prior to administering the medication. Resident #104 was admitted to the facility January 2025 with diagnoses including Atrial Fibrillation (Afib), Cerebrovascular Accident (CVA), Hypertension, and Metabolic Encephalopathy. Review of Resident #104's Anticoagulant Care Plan, initiated 1/3/25 and last revised 1/3/25, indicated the Resident was receiving Anticoagulant therapy due to Afib and included the following interventions initiated 1/3/25: -Administer medication and treatment as ordered by Medical Director (MD) and monitor for side effects to current medication regimens. -Labs will be monitored per MD orders. Review of Resident #104's Minimum Data Set (MDS) Assessment, dated 1/10/25, indicated: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of seven out of 15 total possible points. -The Resident did not demonstrate behaviors of rejection of medications, labs and care during the reference period. -The Resident received anticoagulant therapy during the reference period. Review of Resident #104's January 2025 Physician's orders, indicated: -Warfarin Sodium Tablet 6 mg (milligrams), Give 1 tablet by mouth one time a day for Afib for one day, initiated 1/8/25. -PT/INR lab draw one time a day for PT/INR until 1/9/25. Order initiated 1/6/25 to start on 1/9/25. -Patient is on Warfarin (Coumadin), please check order one time a day, initiated 1/3/25. Review of Resident #104's January 2025 Medication Administration Record (MAR) indicated: -Warfarin Sodium Tablet 6 mg, give 1 tablet by mouth one time only for Afib for one day, order initiated 1/8/25, was left blank (not administered) on 1/9/25. -PT/INR scheduled for 1/9/25 scheduled for 5:00 A.M., was blank (not administered) on 1/9/25. -STAT (immediately) PT/INR scheduled for 1/11/25, was blank (labs not drawn) on 1/11/25 -Further review of the January 2025 MAR indicated no orders for Warfarin Sodium administration on 1/10/25. Review of Resident #104's Nursing Progress Notes, dated 1/11/25 at 2:52 P.M., indicated: -Physician on-call was notified that Resident #104 received his/her last dose of Warfarin Sodium on 1/8/25 with Physician orders as follows: >Get immediate (STAT) INR -No evidence that the PT/INR scheduled for 1/9/25 and the STAT order for 1/11/25, were drawn as ordered by the Physician. Further review of Resident #104's Nursing Progress Notes, dated 1/11/25 at 4:57 P.M., indicated: -Restart Warfarin Sodium 6 mg -Obtain INR tomorrow (1/12/25) Review of Resident #104's Nursing Progress Notes, dated 1/11/25 at 8:15 P.M., indicated: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PT/INR was not done -Patient received Warfarin Sodium (Coumadin) 6 mg tonight -Next INR in AM Review of Resident #104's PT/INR Lab Report dated, 1/12/25 indicated: -PT/INR value of 1.4 Low -Reference Interval 2.0 - 3.5 Further review of Resident #104's clinical records, dated 1/13/25 indicated: -The Resident is subtherapeutic -PT/INR 1.6 on Warfarin Sodium (Coumadin) 10 mg for Afib -Goal 2-3 -Increase Warfarin Sodium (Coumadin) from 10 mg to 10.5 mg once a day (QD) -Repeat INR Thursday (1/17/25) -PT/INR value 3.3 dated 1/17/25 During an interview on 3/7/25 at 9:50 A.M., Unit Manager (UM) #2 said Resident #104 did not receive a Warfarin Sodium dose on 1/9/25 as ordered by the Physician. UM #2 said she could not provide evidence that the Physician was notified when the Resident did not receive a Warfarin Sodium medication dose on 1/9/25. During an interview on 3/07/25 at 2:32 P.M., Nurse #5 said she communicated concerns that arose during her shift (7:00 A.M.-3:00 P.M.) to the Physician on-call, who would respond quickly to nursing concerns when contacted. Nurse #5 said she contacted the Physician on 1/11/25 when she identified the error relative to Resident #104's missed Warfarin Sodium dose and the missed PT/INR test on 1/9/25. Nurse #5 further said she obtained a one-time dose of Warfarin Sodium 6 mg to be administered on 1/11/25 and a Stat PT/INR to be drawn on 1/11/25. During an interview on 3/11/25 at 12:24 P.M., the Clinical Nurse Support (CNS) said there was no evidence that a medication error report was completed for Resident #104 after the missed dose of Warfarin Sodium on 1/9/25. The CNS further said the missed dose of Warfarin Sodium on 1/9/25 was a medication error, and a medication error report should have been completed. During an interview on 3/11/25 at 12:40 P.M., the Director of Nursing (DON) said that the Stat PT/INR ordered by the Physician on-call scheduled for 1/11/25 for Resident #104 was not drawn because the facility did not have a Stat lab service for overnight and weekend hours. The DON further said that the STAT PT/INR ordered for 1/11/25 was discontinued and the lab work was re-entered and drawn on 1/12/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 1:24 P.M., Physician Assistant (PA) #1 said that Nurse #5 had entered a concern dated 1/11/25 that the Resident's last dose of Warfarin Sodium was on 1/8/25 and there was no evidence that a new PT/INR lab had been ordered for the Resident. PA #1 said the last PT/INR that she was able to locate in Resident #104's clinical record indicated an INR value of 1.5 but she was unable to determine the date the lab work was drawn. PA #1 further said Resident #104 was chronically managed with Warfarin Sodium for a diagnosis of Afib and the missed doses of Warfarin Sodium medication increased the risk of a blood clot which would be dangerous for the Resident. PA #1 said that she reviewed Resident #104's medical record, and she observed that Nurse #5 had contacted another Physician on-call, and had discontinued the Stat PT/INR that she ordered on 1/11/25 to 1/12/25. PA #1 said Residents who are chronically managed on Warfarin Sodium, the goal for PT/INR value should be 2 - 3. PA #1 said that Resident #104 was subtherapeutic as his/her PT/INR level of 1.4 on 1/12/25 was low and she was unsure of the reason behind the low PT/INR level for the Resident. During an interview on 3/11/25 at 1:50 P.M., the DON said that Resident #104 had missed Warfarin Sodium doses on 1/9/25 and 1/10/25. The DON said that a risk management and medication error report for the missed doses of the Warfarin Sodium medication on 1/9/25 and 1/10/25 should have been completed when nursing staff identified the missed doses, but this was not done.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42761 Based on observation, interview, and record review, the facility failed to provide food and drink at a safe and appetizing temperature to residents on the North One Unit and for two Residents (#77 and #76) residing on the South Two Unit. Specifically, facility failed to: -Provide residents on the North One Unit with hot food, at a safe an appetizing temperature, when the food was meant to be hot. -Provide Resident #77 and Resident #76 with hot food and cold drinks at safe and appetizing temperatures, when the food was meant to be hot, and the drinks were meant to be cold. Findings include: Review of the facility's Food Quality and Palatability Policy, dated May 2014 and revised September 2017, indicated the following: -Food will be prepared by methods that conserve nutritive value, flavor, and appearance. -Food will be palatable, attractive, and served at a safe and appetizing temperature. Review of the facility's Meal Distribution Policy, dated May 2014 and revised September 2017, indicated: -Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. Review of the facility's Food Preparation Policy, dated May 2014 and revised September 2017, indicated the following: -The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F (*F/Fahrenheit) and/or less than 135 degrees F, or per state regulation. -Temperature for Time/Temperature Control for Safety (TCS) foods will be recorded at time of service and monitored periodically during meal service periods. Review of the facility's Meal Time Schedule, undated, indicated the following: -The breakfast tray line started in the kitchen at 7:35 A.M. -The first breakfast meal cart for the North One Unit was scheduled to be delivered to the Unit at 7:43 A.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ayer Valley Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Groton Road Ayer, MA 01432	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The second breakfast meal cart for the North One Unit was scheduled to be delivered to the Unit at 7:51 A. M. -The first breakfast meal cart for the South Two Unit was scheduled to be delivered to the Unit at 8:16 A.M. -The second breakfast meal cart for the South Two Unit was scheduled to be delivered to the Unit at 8:24 A. M. Review of the facility's Food Committee Meeting Minutes, dated 1/13/25, indicated a concern for late meal cart delivery to the South Two Unit. Review of the facility's Resident Council Minutes, dated 2/19/25, indicated: -Breakfast trays were taking too long to be passed out to Residents, so food was cold. Review of the Resident Council Response Form, dated 2/20/25, indicated an all hands-on-deck approach would be utilized for meal tray pass. During the Resident Council Group Meeting on 3/5/25 at 11:22 A.M., with eight residents present, the following concerns were shared by residents with surveyor #1: -The food is terrible. -Breakfast is consistently cold. -Food is often unappetizing looking. -Meat is too tough to eat. On 3/6/25 at 7:30 A.M., surveyor #2 observed the following in the facility's Main Kitchen: -The breakfast food had been prepared and was stored, covered with foil, in metal bins in the steam table. -The Food Temperature Log had been completed as follows for food items in the steam table: -Eggs 197*F -Ground ham 188*F -Regular texture ham 187*F -Fortified hot cereal 183*F -Oatmeal 184*F -Pancake 180*F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Puree pancake 193*F -Hot beverage 175*F -Orange juice 36*F -Milk 37*F -There was one [NAME] and two Dietary Aides in the Main Kitchen. -The [NAME] was removing food items from boxes and placing the items into the walk-in refrigerator. -Dietary Aide #1 was moving food carts into the food service area of the Kitchen. -Dietary Aide #2 was moving cold beverages from inside of the stand-up refrigerator to a cart in the food services area of the Kitchen. During an interview at the time, the [NAME] said that the facility's food delivery had come in that morning and that she needed to put the food items away. The [NAME] said that the food items for breakfast had been cooked, placed in the steam table, and the food temperatures had been recorded. The [NAME] said that the tray line would start soon. During an interview on 3/6/25 at 7:46 A.M., the [NAME] said that she was the [NAME] for that day and that two Dietary Aides (#1 and #2) were working with her. The [NAME] said that it was typical that staff in the Kitchen worked with one [NAME] and two Dietary Aides and that they were supposed to have three Dietary Aides. The [NAME] said they never have three Dietary Aides in the morning for the breakfast tray line. At this time, surveyor #2 requested from the [NAME] that test trays needed to be conducted for the North One and South Two Units. On 3/6/25, at 7:51 A.M., surveyor #2 observed the following in the facility's Main Kitchen: -The tray line began at 7:51 A.M. (21 minutes after the scheduled time) -Dietary Aide #2 prepared trays with utensils and drinks. -Dietary Aide #1 called resident diets off to the [NAME] who was plating the residents' food. -The first breakfast meal cart for the North One Unit was filled at 7:58 A.M. (15 minutes later than scheduled) and Dietary Aide #1 left the Main Kitchen with the cart. During an interview at the time, the [NAME] said, This is where it gets fun only having two Dietary Aides. Now Dietary Aide #1 has to leave to bring the cart to the Unit, so we wait for him to return. -Dietary Aide #1 returned to the Kitchen at 8:02 A.M., and the tray line resumed. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The second breakfast meal cart for the North One Unit was filled at 8:05 A.M. (14 minutes later than scheduled) and Dietary Aide #1 left the Kitchen with the cart. The meal cart was observed to be an open rack-style cart and was not enclosed. -The District Food Service Director entered the Kitchen at this time and replaced the [NAME] in the tray line. -The District Food Service Director (FSD) instructed the [NAME] to go to the Units for the test tray procedure and the [NAME] left the Kitchen. -The first breakfast meal cart was filled and was delivered to the North Two Unit at 8:19 A.M. by Dietary Aide #1. -The second breakfast meal cart was filled and was delivered to the North Two Unit at 8:33 A.M. by Dietary Aide #1. -The first breakfast meal cart for the South Two Unit was filled at 8:45 A.M. (29 minutes later than scheduled) and delivered to the Unit by Dietary Aide #1. -The [NAME] returned to the Kitchen and the District FSD said that he had run out of regular texture and puree pancakes to serve at 8:54 A.M. -The [NAME] heated pre-made pancakes and made puree pancakes in the Robo Coupe (blender style food preparation device). -The [NAME] was observed to sprinkle some cinnamon into the Robo Coupe where pancakes were being pureed. The [NAME] said the puree pancakes were so bland that she needs to add a little flavor. -The second breakfast meal cart for the South Two Unit was filled at 8:58 A.M. (34 minutes later than scheduled) and delivered to the Unit by Dietary Aide #1. -An additional three-tier open style metal cart was filled with breakfast meals and delivered to the South Two Unit at 9:02 A.M. On 3/6/25 at 8:00 A.M., surveyor #3 observed the following on the North One Unit: -The first breakfast meal cart was delivered to the Unit at 8:00 A.M. -The second breakfast meal cart was delivered to the Unit at 8:06 A.M. -Seven staff members were observed to complete meal tray pass and the last resident tray was passed at 8:07 A.M. At this time, the [NAME] took temperatures of the food items on the North One Unit test tray and surveyor #2 tasted the food items as follows: -Fortified cereal 98*F, lukewarm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oatmeal 112*F, lukewarm and bland. -Ground ham 108*F, lukewarm. -Puree eggs 110*F, lukewarm and bland with a processed taste. -Puree cooked ham 102*F, cool feeling in mouth. On 3/6/25 at 8:21 A.M., surveyor #4 observed the following on the South Two Unit: -The first breakfast meal cart was delivered to the Unit at 8:48 A.M. -The second breakfast meal cart was delivered to the Unit at 8:59 A.M. -An additional cart with three tiers was delivered to the Unit containing three meals at 9:03 A.M. -The last resident meal was passed at 9:07 A.M. At this time, the [NAME] took temperatures of the food items on the South Two Unit test tray and surveyor #3 tasted the food items as follows: -Puree eggs 119*F, watery and bland. -Ground ham 110*F, very salty, rubbery feeling and warm. -Puree cooked ham 111*F, very salty and watery, warm. -Scrambled eggs 101*F, bland, cool, and does not taste like eggs. -Puree pancake 121*F, sweet, thick, and lumpy. -Regular texture ham 108*F, salty, rubbery feeling, and cool. -Oatmeal 102*F, bland and cool. -Orange juice 52*F, not cold. -Milk 52*F, not cold. During an interview on 3/6/25 at 8:25 A.M., Certified Nurses Aide (CNA #1) said that residents sometimes complain of cold food. CNA #1 also said that she has heard residents complain about the quality of the food. CNA #1 said that the food taste and quality had gone down hill and that the food was not very good. CNA #1 said that some administrative staff assist with tray pass, but that the number of administrative staff who assisted with tray pass that morning was not the number who usually participated at the same time. During an interview on 3/6/25 at 8:59 A.M., Resident #76 said his/her breakfast that day was cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 8:55 A.M., Resident #77 said his/her breakfast was cold, just as it has always been. During an interview on 3/6/25 at 9:10 A.M., Dietary Aide #2 said that the open rack that was delivered to the North One Unit was a rack purchased to replace an older enclosed-style food cart that had been in disrepair and could not be fixed. Dietary Aide #2 said there had been ongoing resident complaints about cold food throughout the facility for a long time, and recently. Dietary Aide #2 said he had worked at the facility for a long time and knew the residents well, and that residents reported complaints of cold food often. During an interview on 3/6/25 at 9:15 A.M., the [NAME] said most of resident food complaints reported to her were from residents who resided on the South Two Unit. The [NAME] also said the residents on the South Two Unit were the last in the facility to receive their meals. The [NAME] said the cooked food which had been in the steam table for longer than scheduled could have contributed to cold food for the residents.

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F 0805

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44337

Based on observation, interview, and record review, the facility failed to provide food that was designed to meet the individual needs of one Resident (#10) out of a total sample of 23 residents.

Specifically, the facility failed to ensure that Resident #10 was provided with the Physician's prescribed diet consistency of Nectar/Mildly thickened liquids (diet in which a thickening agent is added to thin liquids making them safer for a resident to swallow) when the Resident was at risk for aspiration and was offered thin consistency liquids with a breakfast meal.

Findings include:

Review of the International Dysphagia Diet Standardization Initiative (IDDSI), last updated July 2019, indicated:

- nectar-thick liquids, also known as mildly thick, are easily pourable, flows from a spoon more slowly than water, and have a consistency similar to fruit nectar or thick cream soup.

Resident #10 was admitted to the facility in March 2023 with diagnoses including Dementia and Dysphagia, oropharyngeal Phase.

Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of ten out of a total possible score of 15.

Review of a Speech Language Pathology (SLP) swallow evaluation dated 2/24/23, indicated Resident #10 was recommended for a soft diet with mildly thick liquids due to risk of aspiration (accidental entry of liquid into the airway).

Review of Resident #10's March 2025 active Physician orders indicated the following diet order initiated on 5/9/24:

-Low Concentrated Sweets,

-Dysphagia Advanced texture,

-Nectar/Mildly Thick Consistency liquids,

-Carb Controlled Diet.

Review of Resident #10's Care Plan last revised 2/28/25, indicated:

-a care plan focus of Dysphagia

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-with an intervention in place to monitor Resident for signs and symptoms of aspiration i.e. coughing, watery eyes, choking, and moist sounding voice. On 3/6/25 at 8:15 A.M., the surveyor observed Certified Nurses Aide (CNA) #1 bring Resident #10's breakfast tray into his/her room. During an interview and observation on 3/6/25 at 8:25 A.M., CNA #1 said that she had brought Resident #10 his/her breakfast meal and made sure everything was set up on the tray for the Resident. CNA #1 said that Resident #10 was on a dysphagia-advanced diet with nectar thick liquids and that the orange juice and milk come from the kitchen already thickened but that the coffee does not come thickened on the meal trays. CNA #1 said she thickened the coffee on Resident #10's breakfast tray with the packet of powdered thickener included on the tray. CNA #1 said that she knows how to thicken liquids to the correct consistency because she has been a CNA for a long time and the facility provided education on altered diet texture when she was hired five years ago. CNA #1 said that nectar thick/mildly thick liquids are thicker than water and drop off a spoon slowly. The surveyor and CNA #1 observed the Resident's breakfast tray at this time, and observed the orange juice and milk on the Resident's tray to be thickened and the coffee to be of a thin consistency. The surveyor observed CNA #1 remove a spoonful of coffee from the Resident's coffee cup, which was half consumed, and empty the spoonful of coffee back into the coffee cup. The spoonful of coffee was observed to be of thin consistency and poured quickly back into Resident #10's cup. CNA #1 said that the consistency of the Resident's coffee was too thin and had not been thickened to a nectar/mild consistency and should have been made thicker. During an interview on 3/6/25 at 9:13 A.M., Unit Manager (UM) #1 said that the CNA's typically thicken liquids for residents who require thickened liquids. UM #1 said Resident #10 requires nectar/mild thick liquids because the Resident had been identified as an aspiration risk. UM #1 said that if the liquids are not thick enough then Resident #10 could aspirate.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on record review, and interview, the facility failed to ensure that specialized rehabilitation services were provided to one Resident (#51) out of a total sample of 23 residents. Specifically, for Resident #51, the facility failed to ensure that a speech and language therapy evaluation was completed timely, when it was identified that the Resident had an unintended weight loss. Findings include: Resident #51 was admitted to the facility in March 2018 with diagnoses including Dementia. Review of the facility policy titled Rehabilitation Services in Skilled Nursing Facility, dated 1/31/25 indicated: -rehabilitation services, including physical therapy, occupational therapy, and speech-language therapy, will be delivered by licensed and qualified staff in accordance with best practices, resident-centered care and regulatory guidelines. -rehabilitation services will be provided based on the established care plan. -regular communication will occur between the rehabilitation team, nursing staff and attending physician to ensure coordination of care. -the facility will conduct periodic audits of therapy documentation and outcomes to ensure service effectiveness and adherence to standards of care. During an interview on 3/4/25 at 9:00 A.M., Resident #51 said that he/she had been having difficulty eating. Review of Resident #51's weights documented in the electronic medical record (EMR) indicated: -12/12/24, the Resident weighed 181.4 pounds (lbs.) -3/3/25, the Resident weighed 166.8 lbs.(8.05 % significant weight loss in three months). Review of Resident #51's Dietary Progress Note dated 2/5/25, indicated: -the Resident had an unintended weight loss. -a nutrition intervention of a referral to the Speech Language Pathologist (SLP). -a nutrition intervention of downgraded meal texture to dysphagia advanced (moist bite-sized foods that are not too hard, sticky or crunchy) until the Resident could be seen by the SLP. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's Minimum Data Set (MDS) assessment dated [DATE] indicated: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. -The Resident had not received speech-language therapy in the seven day look back period. Review of Resident #51's Dietary Progress Note dated 3/5/25, indicated: -the Resident was last seen by the Registered Dietician (RD) on 2/5/25 at which time their diet texture was downgraded to dysphagia advanced (while awaiting SLP consult). -nutrition supplements were added and fortified foods were added. -the Resident had not yet been seen by the SLP. Review of the Resident's medical record indicated no documentation that the Resident had been seen by the SLP as requested by the RD on 2/5/25. During an interview on 3/6/25 at 12:04 P.M., the Rehabilitation Director said that once a referral is made in the facility for rehabilitation, the Resident should be seen within 72 hours of the referral. During an interview on 3/6/25 at 12:22 P.M., the Rehabilitation Director said that Resident #51 was referred to their department for speech-language therapy on 2/5/25. The Rehabilitation Director also said that the Resident should have been seen by the SLP and had not been seen by the SLP to date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, record review, and interview, the facility failed to maintain accurate medical records relative to the application of Continuous Positive Airway Pressure (CPAP - type of non-invasive device that administers a predetermined level of pressure through a mask worn over the nose and/or mouth to keep the airways open) for one Resident (#66) out of a total sample of 23 residents. Specifically, the facility staff documented that CPAP therapy was being applied to Resident #66 at hours of sleep when the Resident was not being provided the CPAP treatment nightly as ordered. Findings include: Review of the facility policy titled Charting and Documentation, revised 11/5/24, indicated: -To maintain a medical record to serve as a legal document that details the services provided to the resident, an any changes in the resident's medical or mental condition, through charting and documentation. -An electronic treatment administration record shall be maintained which records resident care procedures and/or treatments ordered by the physician that is performed. Review of the facility policy titled CPAP and BIPAP Usage, revised 10/14/24, indicated: -Document the following in the resident's medical record: >time therapy was initiated. >mode and settings for the device >Oxygen saturation after application. >any complications observed. -Notify the Physician if the resident refuses the procedure. Resident #66 was admitted to the facility in September 2022 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #66: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of 15 total possible points -had clear speech (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was usually understood -was prescribed oxygen therapy -utilized non-invasive mechanical ventilation Review of Resident #66's clinical record indicated: -The Resident completed a Health Care Proxy naming Resident Representative (RR) #1 on 9/13/24. -The Resident was determined to lack capacity to make health care decisions by a Physician and the HCP was permanently invoked on 10/29/24. During an interview on 3/4/25 at 10:15 A.M., Resident #66 said that he/she was supposed to be using a CPAP at night, that the CPAP machine was in his/her room, and the facility staff did not know how to use the machine. Resident #66 said the facility had not provided the adaptor that was needed to connect oxygen to the CPAP machine, and that he/she had been asking the facility staff about his/her need for the CPAP machine at night. During an interview on 3/5/25 at 1:28 P.M., Resident Representative #1 said he/she was aware of the Resident not being provided the CPAP machine at night. Review of Resident #66's March 2025 Physician's orders indicated: -CPAP Mask Style Full Face Mask Size large, initiated 12/28/23. -CPAP: Oxygen setting: O2 at 2 liters via CPAP when in use every shift, initiated 12/28/23. -BIPAP: clean reservoir per manufacturer's instructions every night shift on Sundays, initiated 2/20/25. Review of Resident #66's December 2023 Physician's orders indicated: -CPAP AUTO: Pressure Settings: Home settings. Hours of Usage HS to AM every shift, initiated 12/28/23. Review of Resident #66's Treatment Administration Records (TARs) from 12/28/23 to 3/4/25 indicated that the CPAP had been signed off by the Nurses as being administered to the Resident as ordered. On 3/5/25 at 11:15 A.M., the surveyor and the Staff Development Coordinator (SDC) reviewed Resident #66's TAR. During an interview at the time, the SDC said the Nurses had documented on the TAR that they had administered the CPAP treatment to the Resident. During an interview on 3/5/25 at 2:37 A.M., the Clinical Nurse Support (CNS) said she was unsure why the Nurses would document the use of the CPAP as administered and that she would investigate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 3/11/25 at 9:53 A.M., the CNS said if Resident #66 did not wear the CPAP at night, nursing staff were expected to document in the medical record and include the reason that the CPAP was not worn. The CNS said she interviewed three-night shift Nurses and each one indicated the Resident refused but none of the three Nurses documented the refusal or the reason for the refusal but rather signed the TAR as CPAP being administered. The CNS further said the Nurses should have notified the Physician of the CPAP not being administered, but they did not.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 42761 Based on record review, and interview, the facility failed to have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. Specifically, the facility failed to ensure that a written transfer agreement was updated when the Local Area Hospital listed on the facility transfer agreement was closed 8/31/24, increasing the risk for residents of the facility not to be admitted timely and appropriately to a hospital when transfer was determined by the attending Physician to be medically appropriate. Findings include: Review of the facility's Transfer and Affiliation Agreement indicated the facility, and [Local Area Hospital #1] had entered into the Agreement on 1/11/24. Review of the mass.gov website indicated the [Local Area Hospital #1] had been closed since 8/31/24. During an interview on 3/12/25 at 4:00 P.M., the Administrator said that he was aware [Local Area Hospital #1] was closed. The Administrator said that he thought the facility had written transfer agreements in place with two other hospitals and that he was unable to locate the transfer agreements at that time. The Administrator then provided the survey team with a written transfer agreement between the facility and [Local Area Hospital #2], effective date 3/12/25. The Administrator said that he was unable to locate evidence a written transfer agreement was in effect between the time [Local Area Hospital #1] closed on 8/31/24 and when the transfer agreement was initiated with [Local Area Hospital #2] on 3/12/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47901 Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice for two Residents (#44 and #75) out of a total sample of 23 residents, increasing the risk of contamination and the spread of infection to other residents within the facility. Specifically, the facility failed to: 1. For Resident #44, ensure that staff appropriately followed Enhanced Barrier Precautions (EBP's: the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), while providing high contact care for an indwelling urinary catheter. 2. For Resident #75, ensure that Nurse #3 used the appropriate PPE during medication administration procedure via the Resident's gastrostomy tube (g-tube -tube inserted through the abdominal wall into the stomach). Findings include: Review of the facility policy titled Policy and Procedure Enhanced Barrier Precautions, initiated 3/27/24 and revised 10/28/24, indicated the following: -It is this facility policy that Enhanced Barrier Precautions (EBP) are used to prevent transmission of infectious organisms spread by direct or indirect contact with the patient or the patient's environment. EBP is used during high contact care activities for resident's chronic wounds or indwelling medical device, regardless of MDRO (multi-drug-resistant organisms) status, in addition to residents who have an infection or colonization with a CDC (Centers for Disease Control) targeted or other epidemiologically important MDRO when contact precautions do not apply. -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. -Gloves and gown are applied prior to performing the high contact resident care activity. >High contact resident care activities include but are not limited to: -Dressing -Bathing/showering -Providing hygiene >Device care or use: -Central line (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Urinary catheter -Feeding tube >Indwelling medical devices, Examples include but are not limited to: -Central lines -Urinary catheters -Feeding tube >Gowns -Staff will wear a clean, non-sterile gown to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood or body fluids, secretions, or excretions, and during specific high contact resident care activities. -Soiled gowns will be removed promptly and discarded appropriately in wastebasket/ laundry receptacle in room. -Wash hands after removal of gloves and gown to avoid transfer of microorganisms to other residents or environment. Resident #44 was admitted to the facility in August 2024 with diagnoses including Urinary Tract Infection (UTI), acute cystitis with Hematuria, Neuromuscular Dysfunction of the Bladder and Paraplegia. Review of Resident #44's March 2025 Care Plan indicated: -Resident had an indwelling catheter due to incontinence and preventing wound healing, Neurogenic bladder initiated 9/12/24. -Infection, initiated 3/4/25, infection due to UTI. -Midline (a long tube, thin, flexible tube inserted into a large vein the upper arm, used for administering medications or fluids for longer periods) initiated 3/4/35, midline due to infection. Review of Resident #44's Minimum Data Set (MDS) Assessment, dated 3/7/25, indicated that the Resident: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 points. -had an indwelling urinary catheter. -required substantial/maximal assistance with personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's March 2025 Physician's orders included: -12 Fr (Fr-French scale or system used to size catheters) 10 ml (milliliters) Foley (urinary) catheter to continuous drainage every shift, initiated 3/4/25. -Cleanse wound at right outer side of foot and apply skin prep daily until resolved, initiated 3/4/25. -Infection precautions, initiated 3/4/25: >enhanced barrier >staff wear gown/gloves when in direct patient contact every shift >signage on door On 3/4/25 at 9:00 A.M., the surveyor did not observe an Enhanced Barrier Precaution signage on the Resident's bedroom door, there was no personal protective equipment (PPE) or a waste receptacle for PPE in the resident's room nor in the hallway outside of the room. During an interview on 3/4/25 at 9:02 A.M., Resident #44 said he had returned to the facility from the hospital the previous day after being hospitalized with a UTI. Resident #44 said he/she had a midline for intravenous antibiotic medications related to his/her infection. The Resident further said he/she had a urinary catheter. On 3/4/25 at 9:46 A.M., the surveyor observed the Physician speaking to Resident #44 and performed a physical assessment using his stethoscope on the Resident's skin. The Physician was not observed to be wearing either gloves and/or gown. On 3/4/25 at 10:26 A.M., the surveyor observed the Staff Development Coordinator (SDC) and Nurse #2 enter the Resident's room and then later exit the room. The SDC and Nurse #2 were not observed to be wearing gown or gloves and did not perform hand hygiene using hand sanitizer or handwashing. On 3/4/25 at 10:32 A.M., the surveyor observed Nurse #2 enter Resident #44's room. Nurse #2 was observed to be wearing gloves and picked up the Resident's foley catheter drainage bag and placed the drainage bag into a privacy bag. Nurse #2 then removed her gloves, sanitized her hands, and exited the Resident's room after providing urinary catheter care. During an interview on 3/4/25 at 10:33 A.M., Nurse #2 said Resident #44 had a midline for intravenous medication and had an indwelling foley catheter. Nurse #2 said the Resident should have been on Enhanced Barrier Precaution (EBP), and an EBP sign should have been observed at the door. Nurse #2 further said she should have worn a gown when she touched the Resident's indwelling urinary catheter, but she did not put on a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 10:36 A.M., the Infection Preventionist (IP) said Resident #44 had a Physician's order for EPB, there should have been an EBP sign, PPE supplies, and a waste receptable at the Resident's room doorway, but there was not. The IP further said the Physician, SDC, and Nurse #2 should have worn gloves and gown when providing high contact care to the Resident, but they did not. 51571 2. Resident #75 was admitted to the facility in October 2021 with diagnoses including Dysphagia, oropharyngeal phase. Review of Minimum Data Set (MDS) Assessment, dated 1/15/25, indicated Resident #75: -was rarely/never understood. -was severely cognitively impaired as evidenced by staff assessment indicating that the Resident had a memory impairment and rarely/never understood. -had feeding tube in place. -was receiving enteral feeding via the feeding tube Review of Resident #75's Comprehensive Enteral Feeding Care Plan, initiated 10/27/21 and revised 1/31/23, indicated: -Enteral feeding as ordered, initiated 10/27/21. -Enhanced Barrier Precautions (EBP), initiated 10/27/21. Review of Resident #75's April 2024 Physician orders indicated: -Infection Precautions initiated 2/20/25: >Enhanced Barrier. >Staff wear gown/gloves when in direct patient contact every shift: >Signage on door. >Gowns and gloves required for the following high contact care activities: dressing, bathing/showering, transfer, changing linens, providing hygiene, changing briefs/assist with toileting, device care/use and/or wound care. -Enteral Feed Order every shift. Make sure that tube feeding is running at 75 Cubic Centimeter (cc - unit of volume equivalent to one milliliter [ml])/hour of Glucerna 1.2 and 30 cc/hour of water. Patient is off of the tube feeding from 12:00 P.M. - 4:00 P.M. daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 10:26 A.M., the surveyor observed EBP signage posted outside Resident #75's door. The Resident was observed lying in bed with eyes closed, and tube feeding with a hydration bag hanging on an intravenous (IV) pole that was set to 75 cc/hour. On 3/5/25 at 12:19 P.M., the surveyor observed the following during medication pass process for Resident #75 completed by Nurse #3: -EBP signage indicating the use of gown and gloves during care for the Resident. -A plastic container with personal protective equipment (PPE) supplies outside of the Resident's room. -Nurse #3 washed her hands, prepared the Resident's medication and gathered supplies needed to administer the medication. -Nurse #3 entered the Resident's room, placed all supplies on the bedside table and used hand sanitizer to clean her hands and donned (put on) gloves but did not a gown. -Nurse #3 elevated the head of the bed, adjusted the Resident's clothing to his/her chest area exposing his/her abdomen to access the Resident's G-tube and administer Resident #75 medications. During an interview at the time, Nurse #3 said that a gown was required when providing care to Resident #75 because he/she was on EBP precautions due to the G-Tube. Nurse #3 further said that she should have worn a gown during the medication administration, but she did not. Nurse #3 said that wearing a gown protects the Resident and prevents transfer of germs to the Resident during care. During an interview on 3/5/25 at 3:44 P.M., the Staff Development Coordinator (SDC) said the expectation for nursing staff when providing care for a Resident with EBP signage posted outside the door was to utilize the PPE supplies such as gowns, gloves, eye shield provided for care areas identified on the signage including dressing, bathing/showering, transferring, changing linens, providing hygiene, device care such as G-tube or indwelling urinary catheter. The SDC further said nursing staff had been educated that PPE prevents transmission of germs to the residents during care. The SDC said Nurse #3 spoke to her and said that she did not put on a gown during the medication administration process for Resident #75 and she should have. During an interview on 3/6/25 at 7:45 A.M., the Assistant Director of Nursing/Infection Control Nurse (ADON/IP) said all nursing staff had been educated that prior to entering any Resident room that had an EBP sign on the door, staff should pause, look at the sign to assess PPE materials that will be needed to provide care for Residents. The ADON/IP also said that her expectation for nursing staff was to refer to the EBP sign to identify the type of PPE required during Resident care to prevent transfers of germs to the resident during care. The ADON/IP further said nursing staff were to sanitize their hands prior to putting on the PPE when entering the resident's room and remove the PPE and dispose the PPE in the trash can provided in the resident's room after the care was completed and use hand hygiene before exiting the room.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interview, and record review, the facility failed to offer pneumococcal immunizations in accordance with Centers for Disease Control (CDC) guidance to one Resident (#28) of five applicable residents, out of a total sample of 23 residents. Specifically, the facility failed to offer an up-to-date Pneumococcal Vaccine to Resident #28 when Resident #28's pneumococcal immunization was not up to date, and administration of the Pneumococcal Vaccine was not documented as clinically contraindicated for the Resident. Findings include: Review of the facility's Pneumococcal Vaccination Policy, dated 11/1/15 and revised 10/28/24, indicated the following: -It is the policy of this facility to reduce the overall incidence of pneumococcal pneumonia by immunizing high-risk persons in accordance with CDC guidance. -All admitted residents will be offered the pneumococcal vaccine in line with CDC recommendations . -Prior to administering the pneumococcal vaccine, each resident or the resident's legal representative shall receive education regarding the risks, benefits, and potential side effects of the immunization. -Evidence of education is to be documented in the individual resident's medical record. -Consent form must be signed, prior to administration, by the resident or responsible party after reviewing the vaccine information statement (VIS). Review of the CDC guidance titled Pneumococcal Vaccine Timing for Adults, most recently revised October 2024, indicated the following complete pneumococcal immunization schedule for adults [AGE] years of age and older: -Prior immunization of PCV13 (pneumococcal vaccine that protects against 13 types of pneumococcal bacteria) only at any age: administer one dose of PCV20 (pneumococcal vaccine that protects against 20 types of pneumococcal bacteria) or PCV21 (pneumococcal vaccine that protects against 21 types of pneumococcal bacteria) at or after one year following the individual's dose of PCV13. Resident #28 was admitted to the facility in March 2024 with diagnoses including Hypertension, Cerebrovascular Accident (CVA), and Dementia. Review of Resident #28's clinical record indicated the following: -The Resident was greater than [AGE] years of age. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident received one dose of PCV13 on 5/19/15. -The Resident had not received any other doses of Pneumococcal Vaccines. -There was no evidence the Resident had been offered a dose of PCV20 or PCV21 vaccine since being admitted to the facility. -The clinical record included no evidence the Pneumococcal Vaccine was contraindicated for the Resident. During an interview on 3/6/25 at 4:37 P.M., the Corporate Nurse said that there was no evidence an updated Pneumococcal Vaccine had been offered to Resident #28.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interview, and record review, the facility failed to offer updated COVID-19 immunizations for three Residents (#45, #51, and #10) of five applicable residents, out of a total sample of 23 residents. Specifically, the facility failed to provide evidence that the 2024-2025 COVID-19 immunization was offered to Residents #45, #51, and #10 when the Residents were not up to date with their COVID-19 immunizations and the immunizations were not documented as contraindicated for the Residents increasing the Residents' risk for acquiring COVID-19 associated illness. Findings include: Review of the facility's COVID-19 Vaccination Policy, dated 10/16/23 and revised 10/28/24, indicated the following: -It is the policy of this facility to have an infection control program that addresses a need to reduce the overall incidence of COVID-19 by offering to immunize all . residents. -All residents . are to be offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident has already been immunized. -In situations where COVID-19 vaccination requires multiple doses, the resident, representative, . is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine before requesting consent for administration of any additional doses. -The resident's medical record includes documentation that indicates, at a minimum, the following: >That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine >Each dose of COVID-19 vaccine administered to the resident >If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal -See Centers for Disease Control and Prevention (CDC) for recommendations related to vaccine timing. Review of the CDC guidance titled Staying Up to Date with COVID-19 Vaccines, dated 1/7/25, indicated the following: -Everyone ages 6 months and older should get a 2024-2025 COVID-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The COVID-19 vaccine helps protect you from severe illness, hospitalization , and death. -It is especially important to get your 2024-2025 COVID-19 vaccine if you are ages 65 and older, are at high risk for severe COVID-19, or have never received a COVID-19 vaccine. -Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine. -People ages [AGE] years and older are up to date with COVID-19 vaccination when two doses of any 2024-2025 COVID-19 vaccines have been administered six months apart. -While it is recommended to get 2024-2025 COVID-19 vaccine doses 6 months apart, the minimum time is 2 months apart, which allows flexibility to get the second dose prior to typical COVID-19 surges. a) Resident #51 was admitted to the facility in March 2018 with diagnoses including Dementia. Review of Resident #51's clinical record indicated: -The Resident was [AGE] years of age or older. -The Resident's most recent COVID-19 vaccine was received on 10/20/22. -There was no evidence the facility had offered an updated 2024-2025 COVID-19 vaccine to the Resident. -There was no evidence that administration of the COVID-19 vaccine was contraindicated. b) Resident #45 was admitted to the facility in March 2022 with diagnoses including Cancer and Dementia. Review of Resident #45's clinical record indicated the following: -The Resident was [AGE] years of age or older. -The Resident's most recent COVID-19 vaccine was received on 10/20/22. -There was no evidence the facility had offered an updated 2024-2025 COVID-19 vaccine to the Resident. -There was no evidence that administration of the COVID-19 vaccine was contraindicated. c) Resident #10 was admitted to the facility in September 2022 with diagnoses including Chronic Lung Disease, Diabetes Mellitus, Hypertension, and Dementia. Review of Resident #10's clinical record indicated the following: -The Resident was [AGE] years of age or older. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident's most recent COVID-19 vaccine was received on 11/29/23. -There was no evidence the facility had offered an updated 2024-2025 COVID-19 vaccine for the Resident. -There was no evidence that administration of the COVID-19 vaccine was contraindicated. During an interview on 3/5/25 at 3:42 P.M., the Director of Nursing (DON) said that all residents were to be offered updated COVID-19 vaccinations unless the vaccine was medically contraindicated, or the resident had already been vaccinated. The DON said that if a resident or their representative declined the COVID-19 vaccine, or if the vaccine was medically contraindicated, the declination or contraindication would be recorded and included in the resident's clinical record. During an interview on 3/6/25 at 4:37 P.M., the Corporate Nurse said that there was no evidence that updated 2024-2025 COVID-19 vaccines had been offered for Residents #51, #45, and #10.