STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225425	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watertown Rehabilitation and Nursing Center	59 Coolidge Hill Road Watertown, MA 02472

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews and records reviewed, the facility failed to ensure staff treated residents in a dignified manner during the dining experience for two Residents, (#44, and #71), out of a total sample of 32 Residents. Specifically: 1. For Resident #44, the facility failed to acknowledge a resident's request for assistance in the day room. 2. For Resident #71, facility failed to provide a dignified dining experience evidenced by staff not communicating with him/her for the duration of the meal. Findings include: Review of the facility policy titled Quality of Life-Dignity, dated as revised February 2020, indicated -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. -Residents are treated with dignity and respect at all times. 1. Resident #44 was admitted to the facility in January 2023 with diagnoses including dysphagia (difficulty swallowing), feeding difficulties, muscle weakness and lack of coordination. Review of Resident #44's most recent Minimum Data Set (MDS) assessment, dated 1/24/25, indicated the Resident did not have a Brief Interview for Mental Status exam completed. The MDS also indicated Resident #44 requires set-up assistance for self-feeding tasks. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/25 from approximately 8:57 A.M. to 9:11 A.M., Resident #44 was observed sitting in the day room after the breakfast meal. A breakfast tray was observed on the table in front of Resident #44. Resident #44 attempted to take a sip from an empty coffee cup and could be heard repeatedly saying Hey over here! as he/she held up the empty coffee cup waving it in the air, attempting to signal staff members who were walking in and out of the day room. A staff member walked over to the table where Resident #44 was sitting and picked up an empty juice cup from the breakfast tray and walked out of the day room. A staff member was observed walking into the day room, past Resident #44 and turned on the television. Resident #44 could be heard repeatedly saying More, no-good, no-good empty, hey, hey! as the staff member continued to remove breakfast trays from the day room. Staff that were in the day room removing trays and did not acknowledge Resident #44. Review of Resident #44's communication care plan last revised 2/3/25, indicated the following: - Encourage resident to continue to make needs known and to call for assistance to ensure safety. - Staff will anticipate and meet needs. During an interview on 5/6/25 at 9:11 A.M., CNA #6 said Resident #44 is behavioral and said he/she does this all the time. During an interview on 5/6/25 at 10:49 A.M., the Director of Nursing said she expects staff provide supervision and communicate with residents during the meals and provide care as needed for each Resident. 2. Resident #71 was admitted to the facility in November 2023 with diagnoses including dysphagia (difficulty swallowing), dementia, diabetes mellitus, and mild cognitive impairment. Review of Resident #71's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated Resident #16 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 1 out of 15. Further review of the MDS indicated Resident #71 speaks Haitian/Creole and is dependent on staff for feeding tasks. On 5/5/25 at 8:34 A.M., Resident #71 was observed sitting in the day room facing a window, with his/her back facing the entry door. The Resident was alone at the table with his/her breakfast tray within reach not set up for consumption. No staff were present in the room to assist the Resident with their meal. At 8:47 A.M. , the surveyor observed Certified Nursing Assistant (CNA) #5 enter the dining room and sat down next to Resident #71. CNA #5 began to feed Resident #71 the breakfast meal. CNA #5 did not attempt to communicate with the Resident. At 9:01 A.M., CNA #5 said Done? Try your milk as he brought a cup containing coffee and not milk, up to the Residents lips. The Resident did not respond and did not drink the coffee. At 9:03 A.M., the surveyor observed CNA #5 open a carton of milk and pour it into a dirty juice cup. CNA #5 held up the cup of milk and said you want to Resident #71. The Resident did not respond and did not drink the milk. CNA #5 proceeded to pick up the breakfast tray and exited the day room. CNA #5 only spoke to Resident #71 in English and made no attempt to communicate with him/her throughout the meal in his/her own language. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 8:33 A.M., Resident #71 was observed sitting in the day room facing a window, with his/her back facing the entry door. The Resident was alone at the table with his/her breakfast tray within reach not set up for consumption. No staff were present in the room to assist the Resident with their meal. At 8:40 A.M. , Nurse #8 was observed walking into the day room and sat down next to Resident #71 and began to feed him/her the breakfast meal. Nurse #8 did not attempt to communicate with the Resident. At 9:03 A.M., Nurse #8 said you don't like egg? as she attempted to feed eggs to Resident #71. Resident #71 did not respond. Nurse #8 only spoke to Resident #71 in English and made no attempt to communicate with him/her throughout the meal in his/her own language. Review of Resident #71's socialization care plan last revised 11/27/24, indicated the following intervention: Exhibit patience when directing conversation or questions to Resident- Resident is French Creole speaking. Review of Resident #71's dementia care plan last revised 11/7/24, indicated the following interventions: - Allow adequeate [SIC] time for response. - Ask simple questions which require yes and no answers when possible. Review of Resident #71's Kardex (a form indicating the level of assistance needed for resident care) indicated the following: -Eating/Nutrition: requires supervision with meals. Communication: Ask simple questions which require yes and no answers when possible. -Face to face communication, repeat if necessary. - Ask simple questions which require yes and no answers when possible. During an interview on 5/6/25 at 8:51 A.M., Certified Nursing Assistant (CNA) #5 said Resident #71 needs help with feeding because he/she can't do it alone because he/she has dementia. CNA #5 said the Resident speaks Haitian/Creole and said a lot of the staff working speak that language. CNA #5 said he speaks Haitian/Creole but did not speak to him/her because he knows what the Resident likes. During an interview on 5/6/25 at 9:13 A.M., CNA #6 said the Resident speaks Creole but does not communicate with staff. CNA #6 said he/she does not have cue cards or use a language line and does not know if the facility has those things. During an interview on 5/6/25 at 10:47 A.M., the Director of Nursing said she expects staff to communicate with residents in his/her preferred language.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interviews, the facility failed to obtain consent for the use of psychotropic medication for one Resident (#82), out of a total sample of 32 residents. Findings include: Review of the facility policy titled Psychotropic Medication Use, dated July 2022, indicated the following: -Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: -Indication for use -Dose (including duplicate therapy) -Duration -Adequate monitoring for efficacy and adverse consequences -Preventing, identifying and responding to adverse consequences. Resident #82 was admitted to the facility in February 2023 with diagnoses including generalized anxiety disorder. Review of Resident #82's most recent Minimum Data Set (MDS) assessment, dated 4/4/25, indicated the Resident scored a 15 out of a 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of Resident #82's physician orders indicated the following order with a start date of 4/10/25: Ativan (an antianxiety medication) give 0.5 milligram (mg) by mouth as needed for pre-med before appointments. Review of Resident #82's care plan date, initiated 10/11/21, indicated the following: I am taking antidepressant, antianxiety and antipsychotic related to bipolar disorder. Intervention: My psychotropic medication consent can be found in my medical records under consents. Review of Resident #82's medical record indicated the following: -Resident #82 had an invoked healthcare proxy in place, indicating he/she did not make his/her own medical decisions. -Review of the Medication Administration Record dated May 2025 indicated the Resident received Ativan on 5/1/25 prior to a medical appointment. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The medical record failed to indicate Resident #82's healthcare proxy was informed of the new order for Ativan and the risks/benefits of the medication in advance of administration of the medication. During an interview on 5/5/25 at 12:04 P.M., Nurse #8 said a consent is required before administering a psychotropic medication. During an interview on 5/5/25 at 12:06 P.M., the Director of Nursing said a psychotropic consent is required for Ativan and before its administered to a resident.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interviews, the facility failed to ensure one Resident, (#82) was free from an unnecessary psychotropic medication, out of a total sample of 32 residents. Findings include: Review of the facility policy titled Psychotropic Medication Use, dated July 2022, indicated the following: -Psychotropic medications are not prescribed or given on an as needed (PRN) basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. -As needed medication for psychotropic medications are limited to 14 days. -For psychotropic medications that are not antipsychotic: if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. Resident #82 was admitted to the facility in February 2023 with diagnoses including generalized anxiety disorder. Review of Resident #82's most recent Minimum Data Set (MDS) assessment, dated 4/4/25, indicated the Resident scored a 15 out of a 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated that the Resident was taking an antianxiety medication. Review of Resident #82's physician orders indicated the following order with a start date of 4/10/25: -Ativan (an antianxiety medication) give 0.5 milligram (mg) by mouth as needed for pre-med before appointments. The medical record failed to indicate a 14 day stop date had been initiated for the PRN ativan. Review of the Medication Administration Record, dated May 2025, indicated the Resident received Ativan on 5/1/25 prior to a medical appointment. During an interview on 5/5/25 at 12:04 P.M., Nurse #8 said a PRN psychotropic requires a 14 day stop date and then must be re-evaluated by the physician. During an interview on 5/6/25 at 10:48 A.M., the Director of Nursing said a PRN psychotropic should have a 14 day stop date unless the physician documents a reason to extend the medication use.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interviews, and records reviewed, the facility failed to implement a communication care plan for one Resident (#71) out of a total sample of 32 Residents. Findings include: Review of the facility policy titled Translation and/or Interpretation of Facility Services, dated, November 2020, indicated: This facilities language access program will ensure that individuals with Limited English Proficiency (LEP) shall have meaningful access to information and services provided by the facility. Resident #71 was admitted to the facility in November 2023 with diagnoses including dysphagia (difficulty swallowing), dementia, diabetes mellitus, and mild cognitive impairment. Review of Resident #71's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated Resident #16 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of one out of 15. The MDS indicated Resident #71 is dependent on staff for self-care needs and required supervision or touching assistance with eating. Further review of the MDS indicated Resident #71 speaks Haitian - Creole. Review of Resident #71's socialization care plan last revised 11/27/24, indicated the following intervention: Exhibit patience when directing conversation or questions to Resident- Resident is French Creole speaking. Review of Resident #71's communication care plan last revised 11/27/24, indicated the following intervention: Face resident and speak clearly when communicating. Review of Resident #71's dementia care plan last revised 11/7/24, indicated the following intervention: Allow adequeate [SIC] time for response. Ask simple questions which require yes and no answers when possible. Review of Resident #71's Kardex (a form indicating the level of assistance needed for resident care) indicated the following: Communication: Ask simple questions which require yes and no answers when possible. -Face to face communication, repeat if necessary. -Ask simple questions which require yes and no answers when possible. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/25 at 8:47 A.M., the surveyor observed Resident #71 sitting in the day room during the breakfast meal. CNA #5 began to feed Resident #71 the breakfast meal. CNA #5 did not attempt to communicate with the Resident. At 9:01 A.M., CNA #5 said Done? Try your milk as he brought a cup containing coffee and not milk, up to the Residents lips. The Resident did not respond and did not drink the coffee. At 9:03 A.M., the surveyor observed CNA #5 pour juice out into a cereal bowl and proceeded to open a carton of milk and pour the milk into the now empty cup that contained the juice. CNA #5 held up the cup of milk and said you want to Resident #71. The Resident did not respond and did not drink the milk. CNA #5 proceeded to pick up the breakfast tray and exited the day room. CNA #5 spoke to Resident #71 only in English and did not attempt to communicate with Resident #71 in his/her language. On 5/6/25 at 9:03 A.M., Resident #71 was observed sitting in the day room during the breakfast meal. At 8:40 A.M., Nurse #8 began to feed him/her the breakfast meal. Nurse #8 did not attempt to communicate with Resident #71. At 9:03 A.M., Nurse #8 said you don't like egg? as she attempted to feed eggs to Resident #71. Resident #71 did not respond. Nurse #8 spoke to Resident #71 only in English did not attempt to communicate with Resident #71 in his/her language. The surveyor did not observe staff utilize communication boards or attempt to utilize an language line for interpreter services while engaging with Resident #71. During an interview on 5/6/25 at 8:41 A.M., Nurse #8 said the care plan should be followed when providing care and staff should speak to the Resident in his/her preferred language. During an interview on 5/6/25 at 8:53 A.M., Certified Nursing Assistant, (CNA) #5 said Resident #71 needs help with feeding because he/she can't do it alone because he/she has dementia. CNA #5 said the Resident speaks Haitian-Creole and said a lot of the staff working speak that language and should communicate with the Resident in a language they understand. During an interview on 5/6/25 at 9:13 A.M., CNA #6 said Resident #71 speaks Creole but rarely communicates with staff. CNA #6 said he/she does not have communication cards or use a language line and does not know if the facility has those things. During an interview on 5/6/25 at 10:47 A.M., the Director of Nursing said she expects staff to provide the level of care that is needed, and she expects staff to communicate with residents in his/her preferred language when providing care and when assisting with meals.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record review the facility failed to provide services that meet professional standards of quality evidenced by failing to implement physicians orders for one Resident, (#20), out of a total sample of 32 residents. Specifically: For Resident #20, the facility failed to implement a physician's order to obtain vital signs prior to administering metoprolol (a medication that lowers blood pressure). Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility policy titled 'Administering Medications', revised April 2019, indicated: - The following information is checked/verified for each resident prior to administering medications: vital signs, if necessary. 1. Resident #20 was admitted to the facility in April, 2008 with diagnoses including hypertension (high blood pressure). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/4/25, indicated Resident #20 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. Review of Resident #20's physician's order, initiated 6/16/18, indicated: - Metoprolol succ (succinate) ER (extended release) 25 milligram (mg) tab (tablet), give one tablet in morning, hold if SBP (systolic blood pressure) is less than 100 or pulse less than 60, scheduled at 8:00 A.M. On 5/6/25 at 8:59 A.M., the surveyor observed Nurse #7 prepare and administer the following medication to Resident #20: - One Metoprolol succinate ER 25 mg tablet. During a follow up interview on 5/6/25 at 9:05 A.M., Nurse #7 said she did not know what Resident #95's blood pressure or pulse was because she did not obtain vital signs prior to administering the metoprolol. Nurse #7 said she should have obtained vital signs because the physician's order included parameters to hold if blood pressure or pulse were below certain levels. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 12:06 P.M., the Director of Nursing (DON) said nurses should always follow the physician's orders. The DON said if the physician's order included parameters to hold the medication if blood pressure or pulse is below a certain level, then the nurse should have obtained vital signs before administering the medication because that is part of the physician's order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review and interviews, the facility failed to provide assistance with meals for five Residents (#33, #44, #67, #2 and #48) out of a total sample of 32 residents. Findings include: Review of the facility policy titled, Activities of Daily Living (ADL), Supporting, indicated the following: -Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their condition(s) demonstrate that diminishing ADLs are unavoidable. -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of treatment and in accordance with the plan of care, including appropriate support and assistance with: -d. dining (meals and snacks). 1. Resident #33 was admitted to the facility in October 2017 with diagnoses including dysphagia (difficulty swallowing), muscle weakness and lack of coordination. Review of Resident #33's most recent Minimum Data Set (MDS) assessment, dated 4/14/25, indicated the Resident had a Brief Interview for Mental Status exam score of 9 out of a possible 15, indicating he/she had moderate cognitive impairment. The MDS also indicated Resident #33 required set-up assistance for self-feeding tasks. On 5/4/25 at 1:34 P.M., Resident #33 was observed eating lunch in his/her room with no staff present to supervise and was not visible from the hallway. Resident #33 was eating with his/her hands and had a significant amount of food that had fallen onto his/her chest. On 5/5/25 at 8:42 A.M., Resident #33 was given his/her breakfast while lying in bed. Once set-up, the staff member left the room. At 8:51 A.M., Resident #33 was observed eating alone without supervision, and had a significant amount of food that had fallen onto his/her chest. On 5/6/25 at 8:57 A.M., Resident #33 was given his/her breakfast while lying in bed. Once set-up, the staff member left the room. At 9:04 A.M., Resident #33 remained alone, without supervision from staff and was observed with a significant amount of eggs that had fallen onto his/her chest. The Resident had only eaten the eggs, and had not had anything to drink and did not eat the other food on his/her tray. Review of Resident #33's Activity of Daily Living care plan, last revised 11/4/24, indicated the following intervention: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Eating: Continual Supervision/Assist, prefers to eat with hands, utensils encouraged. Review of Resident #33's nutritional care plan, last revised 11/4/24, indicated the following: -Provide prescribed diet and supervise meals/safe swallow strategies a/o (as ordered) -Provide house, regular diet with cut meats a/o; monitor intakes and weights; honor food preferences; assist at meals as needed and provide close supervision; SLP screen as needed. Review of Resident #33's Kardex (a form indicating the level of assistance needed for resident care) indicated the following: Eating: Continual Supervision / Assist prefers to eat with hands, utensils encouraged. During an interview on 5/6/25 at 10:51 A.M., Certified Nursing Assistant (CNA) #2 said she relies on nursing to report a resident's level of care needed and can also look up the Kardex on the computer. CNA #2 said Resident #33 requires supervision and cueing throughout his/her meals. During an interview on 5/6/25 at 10:56 A.M., Nurse #5 said she expects staff to follow the Kardex and care plans of the residents in order to provide the level of care needed. Nurse #5 said Resident #33 is independent with meals after set-up. During an interview on 5/6/25 at 11:00 A.M., the Director of Nursing said she expects residents to receive ADL care at the level of care required and care planned. 2. Resident #44 was admitted to the facility in January 2023 with diagnoses including dysphagia (difficulty swallowing), feeding difficulties, muscle weakness and lack of coordination. Review of Resident #44's most recent Minimum Data Set (MDS) assessment, dated 1/24/25, indicated the Resident did not have a Brief Interview for Mental Status exam completed. The MDS further indicated Resident #44 requires set-up assistance for self-feeding tasks. On 5/5/25 at 8:34 A.M., Resident #44 was observed eating breakfast in the day room with no staff present to supervise and was not visible from the hallway. Resident #44 was eating with his/her hands and had a significant amount of food that had fallen onto his/her chest. Resident #44 was observed holding an empty coffee cup and could be heard saying Hey over here! as he/she held up the empty coffee cup. On 5/6/25 at 8:28 A.M., Resident #44 observed eating breakfast in the day room with no staff present to supervise and was not visible from the hallway. Resident #44 was observed eating alone without supervision and had a significant amount of food that had fallen onto his/her chest. Review of Resident #44's Activity of Daily Living care plan last revised 11/15/24, indicated the following intervention: Resident requires supervision from staff for all meals. Uses lip plate for meals Review of Resident #44's nutritional care plan last revised 8/3/24, indicated the following: -Provide, serve diet as ordered. Monitor intake and record q (every) meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-OT (occupational therapy) to screen and provide adaptive equipment for feeding as needed. Review of Resident #44's Kardex (a form indicating the level of assistance needed for resident care) indicated the following: Eating/Nutrition: Resident requires supervision from staff for all meals. Uses lip plate for meals. During an interview on 5/6/25 at 8:52 A.M., Certified Nursing Assistant (CNA) #5 said Resident #44 needs supervision during meals and will sometimes need help. During an interview on 5/6/25 at 9:02 A.M., Nurse #8 said Resident #44 needs supervision and said the Resident likes to do most of it but needs help sometimes. Nurse #8 said staff follow the Kardex and care plans in order to provide the level of care needed. During an interview on 5/6/25 at 10:49 A.M., the Director of Nursing said she expects staff to not leave residents that require supervision with meals unsupervised and expects residents to receive ADL care at the level of care required and care planned. 3. Resident #67 was admitted to the facility in January 2023 with diagnoses including dementia, diabetes mellitus, and anxiety. Review of Resident #67's most recent Minimum Data Set (MDS) assessment, dated 2/25/25, indicated the Resident was unable to complete a Brief Interview for Mental Status exam. The MDS further indicated Resident #67 requires set-up assistance for self-feeding tasks and requires a mechanically altered diet (change in texture of food or liquids). On 5/4/25 at 8:54 A.M., Resident #67 was given his/her breakfast while lying in bed. Once set-up, the staff member left the room. At 8:56 A.M., Resident #67 was observed eating alone without supervision, and had a significant amount of food that had fallen onto his/her chest. A cup of orange juice was observed spilled on to the breakfast tray and on the Residents shirt. On 5/5/25 at 8:39 A.M., Resident #67 was given his/her breakfast while sitting in the day room. Once set-up, the staff member left the day room. A container of milk was left unopened on the table. The surveyor observed Resident #67 picking up the closed container of milk, bringing it to his/her lips and attempting to drink from the closed milk container. The Resident began shaking the milk container and again attempted to drink from the milk container. Resident #67 was observed eating alone without assistance or supervision and had a significant amount of food that had fallen onto his/her chest. On 5/6/25 at 8:36 A.M., Resident #67 was given his/her breakfast while lying in bed. Once set-up, the staff member left the room. At 8:44 A.M., Resident #67 remained alone, without supervision from staff and was observed with a significant amount of food that had fallen onto his/her chest. Review of Resident #67's Activity of Daily Living care plan last revised 3/25/24, indicated the following intervention: Eating: The resident requires (1) staff participation to eat. Review of Resident #67's nutritional care plan last revised 8/31/24, indicated the following: Provide Diet as ordered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #67's Kardex (a form indicating the level of assistance needed for resident care) indicated the following: Eating/Nutrition: The resident requires (1) staff participation to eat. During an interview on 5/6/25 at 8:45 A.M., Certified Nursing Assistant (CNA) #3 said Resident #67 does not need supervision or assistance and can eat alone in his/her room. During an interview on 5/6/25 at 9:04 A.M., Nurse #8 said Resident #67 needs assistance because he/she has dementia and needs help with eating. Nurse #8 said staff must follow the Kardex and care plan in order to provide the level of care needed. During an interview on 5/6/25 at 10:50 A.M., the Director of Nursing said she expects staff to provide ADL care at the level of care required and that which they are care planned for and said Resident #67 should not be eating alone and without assistance. 4.) Resident #2 was admitted to the facility in April 2023 with diagnoses including dysphagia (difficulty swallowing), failure to thrive, and malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/4/25, indicated Resident #2 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #2 required supervision or touching assistance with eating. Review of Resident #2's active physician's order, initiated 2/18/25, indicated: - Regular diet, mechanical soft texture, thin consistency, for sitting up at a 90 degree angle, small sips and bites, 1:1 f (feed). Review of Resident #2's active plan of care related to activities of daily living deficit, revised 4/20/25, indicated: - EATING: Resident #2 is supervised after set-up. Review of Resident #2's kardex (a form indicating the level of assistance needed for resident care), dated 5/6/25, indicated the following: - EATING: Resident #2 is supervised after set-up. Review of Resident #2's dietary progress note, dated 3/11/25, indicated - Spoke with Resident who reports that ongoing cough is interfering with intake as he/she often feels like he/she is going to choke during meals. Advised Resident to eat slowly and chew food thoroughly. On 5/4/25 at 9:28 A.M., the surveyor observed Resident #2 eating breakfast alone in his/her room. Resident #2 says that his/her food is chopped up because he/she is at risk for choking. Resident #2 coughed twice during this observation. Resident #2 said he/she has had this cough for months, but it recently had been getting worse and would like to see the doctor again about it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/4/25 from 1:36 P.M. to 1:43 P.M., Resident #2 was eating alone in his/her room. There were no staff in the adjacent hallway or within view of the Resident. During an observation on 5/5/25 at 8:51 A.M. to 9:01 A.M., Resident #2 was eating alone in his/her room. There were no staff in the adjacent hallway or within view of the Resident. Resident #2 coughed four times during this observation. At 8:53 A.M., the Resident said sometimes he/she feels like he/she might choke when eating because of the cough. Resident #2 said staff never supervises him/her with meals. During an interview on 5/5/25 at 9:15 A.M., Certified Nurse Assistant (CNA) #8 said Resident #2 does not require supervision with meals and is never supervised with meals. CNA #8 said Resident #2 has had a cough for a long time. CNA #8 said it is expected that staff provide the level of assistance or supervision that is indicated on the Resident's care plan and kardex. CNA #8 said supervision with meals means staff must be in the room with the Resident for the entire meal, not in the hallway. During an interview on 5/5/25 at 9:25 A.M., Nurse #10 said Resident #2 does not require supervision with meals. Nurse #10 said Resident #2 has had a cough for a long time. Nurse #10 said it is expected that staff provide the level of assistance or supervision that is indicated on the Resident's care plan and kardex. During an interview on 5/6/25 at 10:54 A.M., the Director of Nursing (DON) said it is expected that staff provide the level of assistance or supervision that is indicated on the Resident's care plan and kardex. The DON said supervision with meals means staff must be sitting in the room with the Resident for the entire meal, not in the hallway. The DON visualized Resident #2's active care plan, kardex, and physician's order with the surveyor and said staff should have provided supervision with meals for Resident #2. 5. Resident #48 was admitted to the facility in June 2018 with diagnoses that included muscle wasting and atrophy, dysphagia following cerebral infarct and epilepsy. Review of Resident #48's most recent Minimum Data Set (MDS) Assessment, dated 4/28/25, indicated a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating that the Resident had severe cognitive impairment. The MDS further indicated that the Resident was dependent on staff for eating. On 5/5/25 at 8:24 A.M., the surveyor observed the Certified Nurses Aide (CNA) bring the breakfast tray into the Resident's room, set up the breakfast, and leave the room. The Resident was observed behind a closed curtain and not visible from the hallway. The surveyor entered the Resident's room and observed the Resident sitting up in bed with breakfast set up in front of the Resident on the bedside table. The Resident was not initiating eating and was observed looking at the tray. On 5/5/25 at 8:40 A.M., Resident #48 remained alone in room behind a curtain not visible from the hallway. The surveyor entered the room to observe the Resident. The Resident had not initiated eating any of his/her breakfast. On 5/5/25 at 8:51 A.M., 27 minutes after the Resident received his/her tray, a CNA went in to check on the resident and was encouraging him/her to eat. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/5/25 at 12:32 P.M., Resident #48 was observed in bed with a curtain pulled around the bed. There were no staff present and Resident #48 was observed eating mashed potatoes with his/her hands. On 5/6/25 at 8:45 A.M., the surveyor observed the CNA bring in Resident #48's breakfast tray and set up the tray. The CNA left the room. The surveyor observed the Resident sitting up in bed with the breakfast tray in front of him/her. The Resident had eggs in his/her mouth but was not chewing. The curtain was pulled around the bed, and the Resident was not visible from the hallway. During an observation on 5/6/25 from 8:51 A.M. to 9:06 A.M., Resident #48 remained alone in his/her room eating, not visible to staff. At 9:06 A.M., a CNA went to remove the Resident's tray, 21 minutes after initially setting up the tray for the Resident. Review of Resident #48's active Activities of Daily Living care plan, updated 12/11/23 indicated, the Resident has ADL Self-Care Deficit as evidenced by: Needs assistance with ADLs complicated by CVA (cerebrovascular accident) with left hemiparesis, Degenerative joint disease, with interventions that include, Eating: extensive assist of one. [sic] Review of Resident #48's Kardex (a form that lets staff know how much assistance a resident requires) in the Electronic Medical Record indicated: Eating: extensive assist of one. During an interview 5/6/25 at 9:06 A.M., CNA #1 said that staff utilize the Kardex from the computer that is accessible through the CNA charting. CNA #1 said that Resident #48 does not require assistance with meals and can feed him/herself. CNA #1 said that when he went into the Resident's room to take the tray out from breakfast he tried to help him/her eat, but said that he/she was coughing on the food and couldn't eat it. During an interview on 5/6/25 at 12:25 P.M., the Director of Nurses said that Resident #48 requires assistance with meals and she would expect that staff are assisting residents per the care plan and Kardex instructions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, record review and interview the facility failed to provide quality care for one Resident (#105) out of a total sample of 32 residents. Specifically, for Resident #105 a new bruise was not identified during daily care. Findings include: Resident #105 was admitted to the facility in November 2023 and has diagnoses that include morbid obesity and type II diabetes mellitus. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/12/25, indicated that on the Brief Interview for Mental Status exam Resident #105 scored a 15 out of a possible 15 indicating intact cognition. The MDS further indicated that Resident #105 had no behaviors and required substantial to maximal assistance with upper body dressing. Review of Resident #105's active Physician's orders indicate an order for Weekly skin assessment every Thursday, with a start date of 11/16/23. During an observation and interview on 5/4/25 at 8:26 A.M., the surveyor observed a fading bruise, the size a half dollar/quarter on Resident #105's left forearm. Resident #105 said that he/she was unsure how he/she sustained the bruise and said I must have bumped it on something, but said that it doesn't hurt. Review of the most recent skin assessments for Resident #105 indicate the following skin assessments: - An assessment, dated 4/28/25, that failed to indicate Resident #105 had any bruises. - An assessment, dated 5/5/25, that failed to indicate Resident #105 had any bruises. Review of Resident #105's active care plans indicated the following: - An Activities of Daily Living (ADL) care plan with interventions that include: * Monitor skin integrity and observe for redness, open areas, scratches, cuts, bruises and report changes to Nurse, start date 11/14/24. * SKIN INSPECTION: Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse, start date 11/14/24. * DRESSING: The resident requires staff participation to dress, start date 11/17/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 9:32 A.M., Certified Nursing Assistant (CNA) #3 said that Resident #105 requires total assistance with ADL care and does not have any behaviors of resisting care. CNA #3 said that she observes Resident #105's skin during care and if there are new areas or bruises she would report it to the nurse. CNA #3 was not aware that Resident #105 has any bruises at this time but said that she had not yet cared for the Resident today and last cared for him/her on Saturday (5/3/25) at which time the Resident had no bruises on his/her forearm. CNA #3 and the surveyor observed Resident #105's arm together and the CNA said that the bruise should have already been reported to a nurse by whomever had cared for the Resident since 5/3/25. During an interview on 5/6/25 at 9:45 A.M., Nurse #7 said that it is the expectation that CNA's observe all resident's skin with care and that if any new areas or bruises are noted that they be reported to the nurse, who will then assess the bruise, notify the physician of the bruise and investigate to determine a root cause of how the bruise was sustained. Nurse #7 said that this should be documented in the medical record and the bruise would be monitored for changes by nursing. The surveyor and Nurse #7 observed Resident #105's left forearm together and she said that no one had made her aware of the bruise. Additionally, no one had noted it on the skin assessment the previous day. During an interview on 5/6/25 at 11:02 A.M., the Director of Nursing said that it is the expectation that CNA's observe skin daily with care and notify the nurse's of any changes. The Director of Nursing said that nursing should have observed the bruise when conducting a skin assessment on 5/5/25 and that the bruise should be documented on the weekly skin assessment form.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to ensure physicians orders for the care of pressure ulcers were implemented for one Resident (#69 and #110) out of a total sample of 32 residents. Specifically, For Resident #69, the facility failed to ensure the wound physicians orders were completed. Findings include: Review of the facility policy titled Pressure Injury Risk Assessment, dated as revised March 2020, indicated the following: The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk for developing new pressure injuries or worsening of existing injuries (PIs) (pressure injuries). Resident #69 was admitted to the facility in August 2020 with diagnoses including paraplegia, pressure ulcer of sacral region (base of the spine) stage four, pressure ulcer of unspecified buttocks, and acquired absence of left leg below knee. Review of Resident #69 most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15, which indicated Resident #69 had moderately impaired cognition. Review of Resident #69's most recent Norton risk Assessment, dated 4/12/25, indicated the Resident was at high risk for skin breakdown. Review of Resident #69's pressure ulcer care plan last revised on 4/21/25, indicated: -Stage 4 Pressure Ulcer Left Ischium. -Stage 4 Pressure Ulcer Right Ischium. -Stage 4 Pressure Ulcer Sacrum. -Stage 4 Pressure Ulcer right lateral superior calf. -Stage 4 - Right lower lateral calf. -Stage 4 - Right lateral foot. -Right lateral thigh wound (non-pressure) right heel wound. - Please complete skin checks by a licensed nurse weekly as ordered. - Provide treatment as ordered. - Wound doctor visits as ordered. - Please check my dressings and if soiled or falling off replace as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #69's weekly wound assessment tool, dated 4/8/25, indicated the Resident had acquired a pressure ulcer on his/her sacrum, Length 1.9 cm (centimeters), Width 2.5 cm., Depth 0.4 cm. Additional description: See wound physician notes. Review of Resident #69's active physician orders indicated the following: -Measure wounds weekly and complete weekly wound assessment for each wound every day shift every Thursday. Start date 2/1/24. -Weekly Skin Check every day shift every Friday for monitoring. Start Date 2/02/24. - Barrier cream to coccyx, buttocks and hips every shift. Start Date 1/31/24. Review of the wound physician's note dated 4/15/25, indicated Resident #69 has a sacral wound measuring 2.4 cm (centimeters) in length by 2.6 cm in width by 0.6 cm in depth. Wound progress exacerbated due to infection. Wound with increased smell and drainage concerning for infection. Recommend antibiotics. Review of the Nursing Progress note dated 4/15/25, indicated, sacrum wound smell appeared to be infected. New recommendation for antibiotic from wound doctor and approved by NP (Nurse Practitioner) for doxycycline (oral antibiotic) 100mg bid (twice daily) x14 days and flagyl 500mg crushed and apply to sacral wound daily x 14 day. Review of the Nurse Practitioner Note dated 4/15/25 indicated, Acute chronic condition wound infection reviewed wound MD visit summary agreed with recommendation. Sacral decubitus ulcer, stage 4. Continue to follow with wound MD and daily treatment. Review of Resident #69's active physician orders indicated the following: -Doxycycline Hyclate Oral Tablet 100 MG (Doxycycline Hyclate) Give 1 tablet by mouth two times a day for wound infection for 14 Days. Start Date 4/14/25. -Cleanse with normal saline, pat dry, apply flagyl then hydrofera blue foam, apply gauze f/b (followed by) ABD pad and retention every day shift for sacrum wound for 14 Days. Start Date 4/15/25. Review of the Nurse Practitioner Note dated 4/22/25 indicated, Acute chronic condition wound infection reviewed wound MD visit summary agreed with recommendation. Sacral decubitus ulcer, stage 4. Continue to follow with wound MD and daily treatment. Review of the Wound Physician's notes dated 4/21/25 and 4/28/25, indicated Resident #69 had a sacral wound with signs of infection. The notes indicated the following treatment recommendations: Methylene blue foam apply once daily; Metronidazole (an antibiotic medication used to treat infections) sprinkled. Apply once daily and as needed: if saturated, soiled, or dislodged. Gauze sponge non-sterile apply once daily; ABD pad apply once daily; Tape (retention) apply once daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the infection control progress note dated 4/29/25, indicated: Continues on ABX(s) (antibiotics) Doxycycline Hyclate Oral Tablet100 MG (Doxycycline Hyclate). Give 1 tablet by mouth two times a day for wound infection for 14 Days. Flagyl Oral Tablet 500MG (Metronidazole). Give 1 tablet enterally in the morning, apply to wound on sacrum for 14 Days. Review of Resident #69's medical record failed to indicate new treatment orders were implemented to the sacrum wound as recommended by the Wound physician and the NP on 4/28/25. The following orders were discontinued on 4/28/25: -Doxycycline Hyclate Oral Tablet100 MG (Doxycycline Hyclate). Give 1 tablet by mouth two times a day for wound infection for 14 Days. Initiated on 4/14/25 and discontinued on 4/28/25. -Cleanse with normal saline, pat dry, apply flagyl then hydrofera blue foam, apply gauze f/b (followed by) ABD pad and retention every day shift for sacrum wound for 14 Days. Initiated on 4/15/25 and discontinued on 4/28/25. On 5/4/25 at 9:14 A.M., Resident #69 was observed lying in bed. Resident #69 said he/she has a wound to his coccyx area that is sore and said he/she is seen by the wound doctor every Monday. During an interview on 5/6/25 at 12:03 P.M., the Wound Physician said Resident #69 developed more drainage and odor to the sacrum wound and required the use of crushed flagyl to be applied and said she continued the medications for an additional 14 days and expected the orders to be implemented to decrease the risk of the infection worsening. During an interview on 5/6/25 at 12:28 P.M., Nurse #8 said the Wound Physician comes weekly to assess residents with wounds and provides written recommendations. Nurse #8 said she would expect the Wound Physician's recommendations to be implemented immediately. Nurse #8 said she completed the dressing change to Resident #69's sacrum and applied Santyl, DermaBlue Foam, and an ABD pad, (not the Wound Physician's treatment recommendations). Nurse #8 said the Resident had an infection to the area with an odor and was on antibiotics. Nurse #8 reviewed the active physician treatment orders with the surveyor and Nurse #8 said she does not see any documentation related to wound care for Resident #69's sacrum since the order was discontinued, (on 4/28/25). On 5/6/25 at 1:56 P.M., the Director of Nurses (DON), Nurse #8, and two surveyors observed Resident #69's wounds. The DON said she was not aware of the recommendations not being implemented and said Resident #69 should have treatment orders in place for the sacrum wound. The DON said the Wound Physician comes weekly to assess residents with wounds and provides recommendations. The DON said the nurses and supervisors communicate the recommendations to the NP (Nurse Practitioner) to obtain new orders and must ensure the orders are implemented. The DON said the orders should have been implemented after the NP was notified but they were not. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watertown Rehabilitation and Nursing Center	59 Coolidge Hill Road Watertown, MA 02472

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/25 at 3:29 P.M., Nurse Practitioner (NP) #1 said she spoke with the Wound Physician about the treatment recommendations made on 4/28/25, and said it is her expectation that staff implemented the wound treatment orders for dressing changes with Metronidazole for another 14 days. The NP said she also spoke with the Nurses regarding the orders and said she extended Doxycycline to be given twice daily along with the Metronidazole to be applied to the wound daily. The NP said the orders for wound treatment with antibiotics were extended to treat the infected wound and said treatment and antibiotics should have been ordered and implemented on 4/28/25.

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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. Based on observations, record review and interviews, the facility failed to ensure respiratory care was provided consistent with professional standards of care for one Resident (#42) out of a sample of 32 residents. Specifically for Resident #42, the facility failed to ensure oxygen was administered in accordance with the physician's orders and the oxygen equipment was kept clean. Findings include: Review of the facility policy titled Oxygen Administration, dated 2001, indicated the following: -Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. -Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. Resident #42 was admitted to the facility in April 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and shortness of breath. Review of Resident #42's most recent Minimum Data Set (MDS) assessment, dated 4/24/25, indicated the Resident has a Brief Interview for Mental Status exam score of 15 out of a possible 15, indicating he/she is cognitively intact. The MDS also indicated Resident #42 is dependent on staff for self-care and mobility tasks. On 5/4/25 at 8:21 A.M. and 1:42 P.M., Resident #42 was observed lying in bed wearing an oxygen nasal canula. The oxygen concentrator was set to 4 liters per minute. The concentrator filter was filled with dust. On 5/5/25 at 5:38 A.M., 8:29 A.M. and 11:08 A.M., Resident #42 was observed lying in bed wearing an oxygen nasal canula. The oxygen concentrator was set to 4 liters per minute. The concentrator filter was filled with dust. On 5/6/25 at 6:33 A.M., Resident #42 was observed lying in bed wearing an oxygen nasal canula. The oxygen concentrator was set to 4 liters per minute. The concentrator filter was filled with dust. Review of Resident #42's physician orders indicated the following order: Oxygen at 0-2 Liters/Minute via Nasal Cannula as needed, every shift for shortness of breath, low sats (saturation). Review of Resident #42's COPD care plan, last revised 7/27/24, indicated the following intervention: Provide Oxygen therapy as needed to maintain SpO2 (oxygen saturation levels) within parameters. (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 5/6/25 at 6:41 A.M., Nurse #4 said nursing should be checking oxygen levels every two hours to ensure the oxygen is on and at the right level. Nurse #4 said Resident #42 has a diagnosis of COPD, wears oxygen and is ordered to use two liters as needed. Nurse #4 said a resident with a diagnosis of COPD should not have oxygen levels more than ordered secondary to a risk of carbon dioxide retention. Nurse #4 said she did not check Resident #42's oxygen level during the overnight shift. Nurse #4 said she does not believe the Resident would change the oxygen level on his/her own. Nurse #4 said it is the responsibility of the nursing staff to ensure oxygen filters are clean and was unaware of Resident #42's dirty filter. During an interview on 5/6/25 at 11:00 A.M., the Director of Nursing said oxygen orders should be followed as prescribed by the physician and a resident should not receive more oxygen than ordered. The Director of Nursing said the oxygen concentrators are expected to be clean and the nursing or housekeeping staff are responsible for this.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record reviews for three Residents (#95, #20, and #53) out of four residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. Three out of three nurses observed made 4 errors out of 32 opportunities resulting in a medication error rate of 12.5%. Specifically, 1.) For Resident #95, the nurse administered the incorrect dose of vitamin B6 and failed to administer scheduled xarelto (a blood thinner). 2.) For Resident #20, the nurse failed to ensure the correct dose of metoprolol (a blood pressure lowering medication) was administered when she did not ensure blood pressure and pulse were within acceptable parameters as indicated in the physician's order. 3.) For Resident #53, the nurse administered the incorrect dose of polyethylene glycol (a laxative medication). Findings include: Review of the facility policy titled 'Administering Medications', revised April 2019, indicated: - Medications are administered in accordance with prescriber orders, including any required time frame. - The following information is checked/verified for each resident prior to administering medications: vital signs, if necessary. 1. Resident #95 was admitted to the facility in July 2022 with diagnoses including a history of stroke with residual hemiparesis (weakness on one side of the body). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident #95 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #95's active physician's orders indicated: - Vitamin B6 tablet 100 milligram (mg), give one tablet one time a day, initiated 1/31/24, scheduled at 9:00 A. M. - Xarelto tablet 10 mg, give one tablet one time a day, initiated 8/24/22, scheduled at 9:00 A.M. On 5/6/25 at 8:36 A.M., the surveyor observed Nurse #9 prepare and administer the following medication to Resident #95. Nurse #9 said all Resident #95's medications due to be administered that morning had been administered. - One vitamin B6 50 mg tablet, instead of 100 mg as ordered by the physician. - Nurse #9 failed to prepare and administer Xarelto 10 mg tablet as ordered by the physician. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/25 at 12:06 P.M., the Director of Nursing (DON) said all medications should be given as ordered. During a follow-up interview on 5/6/25 at 12:27 P.M., Nurse #9 said she was unaware she had not administered the xarelto 10 mg tablet to Resident #95. Nurse #9 said Resident #95 had not declined or received the xarelto 10 mg tablet after the surveyor observed the medication administration this morning. Nurse #9 said the xarelto should have been administered. Nurse #9 further said she should have administered two tablets of vitamin B6, instead of one tablet, because the tablets in the medication cart are only 50 mg. 2.) Resident #20 was admitted to the facility in April 2008 with diagnoses including hypertension (high blood pressure). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/4/25, indicated Resident #20 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. Review of Resident #20's physician's order, initiated 6/16/18, indicated: - Metoprolol succ (succinate) ER (extended release) 25 milligram (mg) tab (tablet), give one tablet in morning, hold if SBP (systolic blood pressure) is less than 100 or pulse less than 60, scheduled at 8:00 A.M. On 5/6/25 at 8:59 A.M., the surveyor observed Nurse #7 prepare and administer the following medication to Resident #20: - One Metoprolol succinate ER 25 mg tablet. During a follow up interview on 5/6/25 at 9:05 A.M., Nurse #7 said she did not know what Resident #95's blood pressure or pulse was because she did not obtain vital signs prior to administering the metoprolol. Nurse #7 said she should have obtained vital signs because there were parameters to hold if blood pressure or pulse were below certain levels. During an interview on 5/6/25 at 12:06 P.M., the Director of Nursing (DON) said if there was a physician's order that included parameters to hold the medication if blood pressure or pulse is below a certain level, then the nurse should have obtained vital signs before administering the medication to ensure the correct dose was given. 3.) Resident #53 was admitted to the facility in January 2016 with diagnoses including an intestinal obstruction and failure to thrive. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/25/25, indicated Resident #53 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of 15. On 5/6/25 at 10:15 A.M., the surveyor observed the Assistant Director of Nursing (ADON) prepare and administer the following medication to Resident #53: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Polyethylene glycol 3350 powder, filled approximately halfway to 17 gram (gm) indicator line in the bottle cap (which is used to measure the dose). Instructions on the polyethylene glycol bottle indicate instructions that 17g (cap filled to line). Review of Resident #53's physician order, initiated 4/25/24, indicated: - Miralax powder (Polyethylene glycol 3350), give 17 gram one time a day, scheduled for 9:00 A.M. During a follow up interview on 5/6/25 at 10:20 A.M., the ADON said he was unaware that the 17 gram line on the polyethylene glycol bottle cap was where it was. The ADON showed the surveyor he filled in an area in the cap below the 17 gm indicator line, which appeared to be a cap thread used to close the bottle. The ADON inspected the bottle closely and said he now sees the 17 gm indicator line is higher than what he administered. The ADON said he only gave an insufficient dose of polyethylene glycol. During an interview on 5/6/25 at 12:06 P.M., the Director of Nursing (DON) said all medications should be given as ordered. The DON said the nurse should have filled the polyethylene glycol to the 17 gm indicator line in order to administer the correct dose. Refer to F760.

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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. Based on observation, interviews, and record review, the facility failed to ensure three Residents (#80, #95, and #76) were free from significant medication errors, out of a total sample of 32 residents. Specifically, 1.) For Resident #80, the facility failed to ensure insulin (an injectable hormone that lowers the level sugar in the blood) was administered before meals as ordered by the physician. 2.) For Resident #95, the facility failed to ensure the nurse administered xarelto (a blood thinner that treats or prevents blood clots). 3.) For Resident #76, the facility failed to ensure insulin was administered timely in accordance with physician orders. Findings include: Review of the facility policy titled 'Administering Medications', revised April 2019, indicated: - Medications are administered in accordance with prescriber orders, including any required time frame. - Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). During initial screening on 5/4/25 beginning at approximately 8:00 A.M., multiple residents expressed concerns about late medication administration including: - One resident said in the evening the nurses are always forgetting his/her medications and giving them late. He/she said he/she often has to ask for them and that it is late at night before he/she receives them. - Another resident said their medications are late because there are not enough nurses. - Resident #80 expressed concerns about medications being administered late, including late insulin. 1.) Resident #80 was admitted to the facility July 2024 with diagnoses including diabetes, diabetic neuropathy (nerve damage caused by diabetes), and renal impairment from stage four chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/28/25, indicated Resident #80 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS also indicated Resident #80 required insulin injections every day during the look back period of seven days. Review of Resident #80's physician's order, initiated 2/27/25, indicated: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Humalog KwikPen Subcutaneous (under the skin) Solution Pen-Injector 100 unit/milliliter (ml) (Insulin Lispro), Inject as per sliding scale: if 151-200 = 2 unit; 201-250 = 4 unit; 251-300 = 6 unit; 301-350 = 8 unit; 351-400 = 10 unit; 401-500 = 10 unit call MD (physician) subcutaneously before meals, scheduled at 7:00 A. M., 11:00 A.M., and 4:00 P.M. According to the U.S. Food and Drug Administration prescribing information for insulin lispro, dated 1/6/17, indicated: - Insulin lispro is a rapid-acting human insulin. - Insulin lispro should be administered within 15 minutes before a meal or immediately after a meal. - Warnings and Precautions: Hypoglycemia: May be life-threatening. Monitor blood glucose and increase monitoring frequency with changes to insulin dosage, use of glucose lowering medications, meal pattern, physical activity; in patients with renal or hepatic impairment. On 5/4/25 at 8:09 A.M, Resident #80 said his/her insulin is frequently late. Resident #80 said this was very concerning to him/her because it needs to be given timely, but the nurses can't get to it because they are too busy. On 5/6/25 at 9:23 A.M., the surveyor observed Resident #80 eating breakfast. Resident #80 said he/she had not received his/her insulin injection yet. Review of Resident #80's Medication Administration Audit Report, dated as run at 11:24 A.M., failed to indicate the following order had been documented as administered: - Humalog KwikPen Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Lispro), Inject as per sliding scale: if 151-200 = 2 unit; 201-250 = 4 unit; 251-300 = 6 unit; 301-350 = 8 unit; 351-400 = 10 unit; 401-500 = 10 unit call MD subcutaneously before meals, scheduled for 5/6/24 at 7:00 A.M. During an interview on 5/6/25 at 12:27 P.M., Nurse #9 said she always documents insulin at the time of administration, and if the Resident declined the insulin, she would have indicated this in the Residents medical record. Nurse #9 said she documented the insulin at the time she administered it this morning. Review of Resident #80's Medication Administration Record (MAR) on 5/6/25 at 12:40 P.M., indicated the following order was documented as administered by Nurse #9 at 11:38 A.M., which was 2 hours and 15 minutes after the surveyor observed Resident #80 eating his/her breakfast meal, and 4 hours and 38 minutes after scheduled administration time. Review facility document titled 'Truck Delivery Report, located in the survey binder, indicated: - Breakfast truck, 2nd floor, scheduled to be delivered at 8:20 A.M. - Lunch truck, 2nd floor, scheduled to be delivered at 12:30 P.M. - Dinner truck, 2nd floor, scheduled to be delivered at 6:10 P.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #80's Medication Administration Audit Report indicated to following late administration times for the physician order Humalog KwikPen Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Lispro), Inject as per sliding scale: if 151-200 = 2 unit; 201-250 = 4 unit; 251-300 = 6 unit; 301-350 = 8 unit; 351-400 = 10 unit; 401-500 = 10 unit call MD (physician) subcutaneously before meals: - Scheduled Date/Time: 5/1/25 4:00 P.M., Administration documented at 7:07 P.M., which was 3 hours and 7 minutes after scheduled administration time and/or 57 minutes after scheduled meal delivery. - Scheduled Date/Time: 5/1/25 7:00 A.M., Administration documented at 2:37 P.M., which was 7 hours and 37 minutes after scheduled administration time and/or 6 hours and 17 minutes after scheduled meal delivery. - Scheduled Date/Time: 5/2/25 11:00 A.M., never documented as administered. - Scheduled Date/Time: 5/2/25 4:00 P.M., Administration documented at 10:13 P.M., which was 6 hours and 13 minutes after scheduled administration time and/or 4 hours and 3 minutes after scheduled meal delivery. - Scheduled Date/Time: 5/3/25 11:00 A.M., Administration documented at 3:12 P.M., which was 4 hours and 12 minutes after scheduled administration time and/or 2 hours and 42 minutes after scheduled meal delivery. - Scheduled Date/Time 5/3/25 4:00 P.M., Administration documented at 7:25 P.M., which was 3 hours and 25 minutes after scheduled administration time and/or 1 hour and 15 minutes after scheduled meal delivery. - Scheduled Date/Time 5/5/25 11:00 A.M., Administration documented at 2:35 P.M., which was 3 hours and 35 minutes after scheduled administration time and/or 2 hours and 5 minutes after scheduled meal delivery. - Scheduled Date/Time 5/5/25 at 4:00 P.M., Administration documented at 9:42 P.M., which was 5 hours and 42 minutes after scheduled administration time and/or 3 hours and 32 minutes after scheduled meal delivery. Review of Resident #80's medical record, dated 5/1/25 to 5/6/25, failed to indicate any rationale for late insulin administration. During an interview on 5/6/25 at 8:36 A.M., Nurse #9 said nurses are expected to administer all medications within one hour before or after scheduled administration time. Nurse #9 said if a physician order states medications should be given before meals, then they should always be given before meals. During an interview on 5/6/25 at 12:06 P.M., the Director of Nursing (DON) said all medications should be given within one hour before or after scheduled administration time. The DON said if medications are refused, that should be documented in the medical record. The DON further said if the physician's order indicates that insulin should be given before meals, it should always be given before meals. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) Resident #95 was admitted to the facility in July 2022 with diagnoses including a history of stroke with residual hemiparesis (weakness on one side of the body). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident #95 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #95's active physician's orders, initiated 8/24/22, indicated: - Xarelto tablet 10 mg, give one tablet one time a day, scheduled at 9:00 A.M. On 5/6/25 at 8:36 A.M., the surveyor observed Nurse #9 prepare and administer morning medications to Resident #95. Nurse #9 said all Resident #95's medications due to be administered that morning had been administered. Nurse #9 failed to prepare and administer Xarelto 10 mg tablet as ordered by the physician. During an interview on 5/6/25 at 12:06 P.M., the Director of Nursing (DON) said all medications should be given as ordered. During a follow-up interview on 5/6/25 at 12:27 P.M., Nurse #9 said she was unaware she had not administered the xarelto 10 mg tablet to Resident #95. Nurse #9 said Resident #95 had not declined or received the xarelto 10 mg tablet after the surveyor observed the medication administration this morning. Nurse #9 said the xarelto should have been administered. During a follow-up interview on 5/6/25 at approximately 2:00 P.M., the DON inquired about the xarelto being omitted during Resident #95's medication administration that morning. The DON said this was a significant medication error and she needed to be certain it was not given. 3. Resident #76 was admitted to the facility in December 2024 with diagnoses including spinal stenosis, diabetes mellitus, Chronic Obstructive Pulmonary Disease, Bipolar Disorder and suicidal ideations. Review of the most recent MDS assessment, dated 4/21/25, indicated a Brief Interview for Mental Status score of 12 out of 15, indicating moderate cognitive impairment. On 5/5/25 at 8:45 A.M., The surveyor observed Resident #76 in his/her room eating breakfast, almost all of the food was gone. Resident #76 said that the nurse did not check his blood sugar this morning. On 5/5/25 at 8:46 A.M., the surveyor observed the nurse walk by Resident #76. The Resident told the nurse, You never checked my blood sugar this morning. Review of Resident's blood sugars in the Electronic Medical Record (EMR) indicated a blood sugar of 103 on 5/5/25 at 8:47 A.M. Review of Resident #76's physician's orders indicated the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fiasp Solution (a fast acting insulin, and a newer formulation of NovoLog with niacinamide (vitamin B3) added. Niacinamide helps to increase the speed of the initial absorption of insulin, resulting in an onset of appearance in the blood approximately 2.5 minutes after administration) 100 unit/ml (milliliter) (Insulin Aspart (w/Niacinamide)) Inject as per sliding scale 101-150= 8 units; 151-200 = 10 units; 201-250 = 12 units; 251-300 = 14 units; 301-350 = 16 units; 351+ = 20 units, subcutaneously (under the skin) three times a day related to diabetes (scheduled to be administered at 7:30 A.M., 11:30 A.M., and 4:30 P.M.), dated 1/31/24. -Fiasp Solution 100 unit/ml (milliliter) (Insulin Aspart (w/Niacinamide)) Inject as per sliding scale: 0-200 = 0; 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; 401-450 = 10 units; 451+ = 12 units and call MD, subcutaneously (under the skin) at bed time related to diabetes (scheduled to be administered at 9:00 P.M.), dated 1/31/24. Review of the Medication Administration Record indicated that eight units of Fiasp Solution (Insulin Aspart w/ Niacinamide) were administered for the 7:00 A.M. dose on 5/5/25. Review of the Medication Admin Audit Report for schedule date 5/5/25 indicated the following: -The Fiasp solution scheduled for administration at 7:30 A.M. was administered at 8:47 A.M., 1 hour and 17 minutes after the scheduled administration time. -The Fiasp solution scheduled for administration at 11:30 A.M. was administered at 1:24 P.M., 1 hour and 56 minutes after the scheduled administration time. -The Fiasp solution scheduled for administration at 4:30 P.M. was administered at 7:20 P.M., 2 hours and 50 minutes after the scheduled administration time. On 5/4/25 at 8:02 A.M., Resident #76 said that in the evening the nurses are always forgetting his/her medications and giving them late. He/she said he/she often has to ask for them late at night before he/she receives them. During an interview on 5/6/25 at 12:09 P.M., the Director of Nurses said that medications should be given an hour before or an hour after the scheduled time, and insulin should be given with meals if that is how it is ordered to be given.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #92 was admitted to the facility in February 2022 with diagnoses including dysphagia and hemipelgia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #92 is cognitively intact as evidenced by a score of 14 out of a possible 15 on the Brief Interview for Mental Status Exam (MDS). On [DATE] at 7:09 A.M., the surveyor observed an open container of Nicotine lozenges on the over bed table. There were two new lozenges and two half dissolved lozenges on top of the table. Resident #92 said that staff give him/her a hard time about his/her nicotine lozenges. Review of Resident #92 clinical record indicated the following: -A self administration of medication evaluation, dated [DATE], indicating Resident #92 is unable to self-administer his/her medications. -A physician's order indicating: Nicotine Mini Mouth/Throat Lozenge, 4 MG. One Lozenge in the cheek every four hours as needed for smoking AND one lozenge in the cheek every hour for quit (sic) smoking. Hold if Resident is asleep. During an interview on [DATE] at 8:51 A.M., Nurse #2 said that Resident #92 cannot self administer medications. Nurse #2 said that Resident #92's nicotine lozenges are kept in the medication cart and nursing staff deliver them to him/her per the physicians order. During an interview on [DATE] at 9:07 A.M., Regional Nurse #1 said medications should not be left at bedside. Based on observation and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically: 1.) The facility failed to ensure medications and biologicals were labeled and stored according to manufacturer's guidelines in four of four medication carts observed. 2.) The facility failed to ensure nicotine lozenges were not left unsecured at the residents bedside, for one Resident (#92) out of a total sample of 32 residents. Findings include: Review of the facility policy titled 'Medication Labeling and Storage', revised February 2023, indicated: - Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. - If the facility has discontinued, outdated, or deteriorated medication or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 1. On [DATE] at 8:35 A.M., the surveyor and Nurse #9 observed the following in the 2nd floor low side medication cart: - One open and undated bottle of proheal liquid protein. This bottle was three quarters full and had sticky, hardened residue around the opening. The proheal bottle label indicated to discard 60 days after opening date. During a follow up interview on [DATE] at 8:37 A.M., Nurse #9 said proheal has a shortened expiry date once opened and should have been dated when it was opened. On [DATE] at 9:27 A.M., the surveyor and Nurse #7 observed the following in the 4th floor low side medication cart: - 32 loose pills in drawers of medication cart. - One open and undated bottle of prostat liquid protein. The prostat bottle label indicated to discard 3 months after opening. During a follow up interview on [DATE] at 9:29 A.M., Nurse #7 said there should not be loose pills in the medication cart. Nurse #7 also said prostat has a shortened expiry date once opened and should have been dated when it was opened. On [DATE] at 9:36 A.M., the surveyor and Nurse #5 observed the following in the 3rd floor high side medication cart: - 48 loose pills in the drawers of medication cart. During a follow up interview on [DATE] at 9:38 A.M., Nurse #5 said there should not be loose pills in the medication cart. On [DATE] at 10:20 A.M., the surveyor and the Assistant Director of Nursing (ADON) observed the following in the 3rd floor low side medication cart: - 15 loose pills in drawers of medication cart. - One open and undated bottle of prostat liquid protein. The prostat bottle label indicated to discard 3 months after opening. - One insulin glargine-yfgn insulin pen, dated as opened [DATE] and date as expired [DATE]. - One unlabeled and undated injection syringe filled with clear liquid stored loosely in a drawer of medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on [DATE] at 10:22 A.M., the ADON said there should not be loose pills in the medication cart. The ADON said prostat has a shortened expiry date once opened and should have been dated when it was opened. The ADON said insulin should be discarded when expired and not be available in the medication cart. The ADON said the syringe was filled with insulin he had drawn up for a resident earlier in the shift but had not given it to him/her yet. The ADON said it should not have been stored in the medication cart that way. During an interview on [DATE] at 12:06 P.M., the Director of Nursing (DON) said prostat and proheal should have been dated when they were opened because they have shortened expiry date once opened. The DON said there should not be loose pills in the medication cart. The DON said insulin should be discarded 28 days after opening, or when dated as expired. The DON said insulin should not be prefilled and stored loosely in the medication cart unlabeled and undated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, record review and interview the facility failed to ensure dental services were provided for one Resident (#105) out of a total sample of 32 residents. Findings include: Resident #105 was admitted to the facility in November 2023 with diagnoses that include morbid obesity and type II diabetes mellitus. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/12/25, indicated that on the Brief Interview for Mental Status exam Resident #105 scored a 15 out of a possible 15 indicating intact cognition. The MDS further indicated that Resident #105 had no behaviors and no dental issues. During an interview on 5/4/25 at 8:26 A.M., Resident #105 said that he/she would like to see the dentist because he/she has pain in his/her left lower molar and has told staff that he/she needs to see the dentist. Resident #105 showed the surveyor the molar which was black in appearance. Review of Resident #105's active Physician's orders indicated the following order: Consults: Podiatry, Dental, Audiology, Optometry or Ophthalmology, dated 11/9/23. Review of the record indicated that there was a consent form in Resident #105's record to see the dentist that was blank and had not been completed. Review of Resident #105's active care plans indicated the following: - An Nutrition care plan with interventions that include: * Dental consults prn (as needed), start date 11/13/23. - An Activities of Daily Living (ADL) care plan with interventions that include: * Mouth care q (each) am (morning) and hs (at night), start date 11/14/24. * PERSONAL HYGIENE/ORAL CARE: The resident requires staff participation with personal hygiene and oral care, start date 11/17/23. During a follow-up interview on 5/06/25 at 8:08 A.M., Resident #105 said that he/she had not seen a dentist since before COVID and that he/she needed to be seen by the dentist that comes to the facility, but had not. Resident #105 said that he/she is not sure if he/she has told staff that he/she needed to be seen but did mention it to the Ombudsman. Resident #105 said that his/her teeth are starting to rot and that at times small pieces fall off while he/she is eating. Resident #105 said that he/she has developed sensitivity to cold beverages and experiences pain on and off in his/her mouth. During an interview on 5/6/25 at 9:32 A.M., Certified Nursing Assistant (CNA) #3 said that Resident #105 requires total assistance with ADL care but brushes his/her own teeth. CNA #3 said that Resident #105 does not have any behaviors of resisting care and that she was unaware that Resident #105 had dental pain. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 9:45 A.M., Nurse #7 said that dental consents are obtained upon admission, that the dentist comes in every few months and that the Medical Records Director coordinates who gets seen. Nurse #7 was unaware that Resident #105 had not been seen by the dentist since admission. During an interview on 5/6/25 at 11:07 A.M., the Director of Nursing (DON) said that consents to be seen by the facility's dental provider are obtained upon admission, are then sent to the provider and the Medical Records Director requests the residents get added to the list to be seen. She said that the dentist and dental hygienist are in the facility sometimes twice month and if a resident refused to be seen it would be documented in the medical record. The DON said that it is her expectation that residents such as Resident #105, who has resided in the facility for over a year, be seen by the dentist. The DON said she and the Ombudsman talk about this (Resident #105 needing to be seen by the dentist) all the time and that she was unaware that the consent to be seen by the dentist was not completed. During an interview on 5/6/25 at 11:52 A.M., the Medical Records Director said that she was not aware until yesterday, (5/5/25), that Resident #105 did not have a dental consent and she would obtain it today (5/6/35), and then Resident #105 could be seen by the dentist during their next visit in June 2025.

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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. Based on observation, record review and interview, the facility failed to ensure resident records were complete and accurate for two Residents (#105 and #95) out of a total of 32 sampled residents. Specifically: 1. For Resident #105, the facility failed to accurately document a weekly skin assessment. 2. For Resident #95, the nurse inaccurately documented miralax (a laxative) as administered when it was not. Findings include: The facility policy titled Charting and Documentation dated as revised July 2017, indicated the following: 3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. 1. Resident #105 was admitted to the facility in November 2023 with diagnoses including morbid obesity and type II diabetes mellitus. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/12/25, indicated that on the Brief Interview for Mental Status exam, Resident #105 scored a 15 out of a possible 15 indicating intact cognition. The MDS further indicated that Resident #105 had no behaviors and required substantial to maximal assistance with upper body dressing. Review of Resident #105's active Physician's orders indicated an order for Weekly skin assessment every Thursday, with a start date of 11/16/23. During an observation and interview on 5/4/25 8:26 A.M., the surveyor observed a fading bruise the size a half dollar/quarter on Resident #105's left forearm. Resident #105 said that he/she was unsure how he/she sustained the bruise and said, I must have bumped it on something. Review of the most recent skin assessments for Resident #105 indicate the following assessments: - An assessment, dated 4/28/25, that failed to indicate Resident #105 had any bruises. - An assessment, dated 5/05/25, that failed to indicate Resident #105 had any bruises. Review of Resident #105's active care plans indicated the following: - An Activities of Daily Living (ADL care plan with interventions that include: * Monitor skin integrity and observe for redness, open areas, scratches, cuts, bruises and report changes to Nurse, start date 11/14/24. * SKIN INSPECTION: Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse, start date 11/14/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* DRESSING: The resident requires staff participation to dress, start date 11/17/23. During an interview on 5/6/25 at 9:32 A.M., Certified Nursing Assistant (CNA) #3 said that Resident #105 requires total assistance with ADL care and does not have any behaviors of resisting care. CNA #3 said that she observes Resident #105's skin during care and if there are new areas or bruises she would report it to the nurse. CNA #3 is not aware that Resident #105 has any bruises at this time but said that she had not yet cared for the Resident today and last cared for him/her on Saturday (5/3/25) at which time the Resident had no bruises on his/her forearm. During an interview on 5/6/25 at 9:45 A.M., Nurse #7 said that it is the expectation that CNA's observe resident's skin with care and that if any new areas or bruises are noted that they be reported to the nurse. Nurse #7 said that it is the expectation that weekly skin checks be accurate and any bruises should be noted on the weekly skin assessment document. The surveyor and Nurse #7 observed Resident #105's left forearm together and she said that the bruise should have been noted on yesterday's skin assessment. During an interview on 5/6/25 at 11:02 A.M., the Director of Nursing said that it is the expectation that skin assessments be accurate and that bruises be documented on the weekly skin assessment form. 2. Resident #95 was admitted to the facility in July 2022 with diagnoses including a history of stroke with residual hemiparesis (weakness on one side of the body). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident #95 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #95's active physician's orders, initiated 1/31/24, indicated: Miralax Oral Packet 17 gm (gram), give one packet one time a day, scheduled for 9:00 A.M. On 5/6/25 at 8:36 A.M., the surveyor observed Nurse #9 prepare and administer scheduled morning medication to Resident #95. Resident declined scheduled miralax during this observation and it was not administered. Review of Resident #95's Medication Administration Record (MAR), dated 5/6/25, indicated the following physician order was documented as administered: - Miralax Oral Packet 17 gm (gram), give one packet one time a day, scheduled for 9:00 A.M. During an on 5/6/25 at 12:27 P.M., Nurse #9 said she did not administer miralax to Resident #95 because he/she had declined it. Nurse #9 said she should have documented it as not administered or refused on the MAR but did not. During an interview on 5/6/25 at 12:06 P.M., the Director of Nursing (DON) said the miralax should not have been documented as administered if it was not. The DON said if miralax was declined then it should have been documented as not administered or refused on the MAR.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review and interviews, the facility failed to ensure a current hospice plan of care was present in the medical record and coordinated with facility staff for one Resident (#48) out of a total sample of 32 residents. Findings include: Review of the facility policy titled Hospice Program revised July 2017, indicated the following but not limited to: Hospice services are available to residents at the end of life. 5. Hospice providers who contract with this facility: a. Must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency. 6. The agreement with the hospice provider will be signed by the facility representative and a representative from the hospice agency before hospice services are furnished to any resident. Resident #48 was admitted to the facility in June 2015 with diagnoses including Cerebrovascular Disease. Review of Resident #48 Minimum Data Set (MDS) assessment, dated 1/29/25, indicated the Resident scored a 0 out of possible 15 on the Brief Interview for Mental Status, indicating he/she had severe cognitive impairment. Review of Resident #48's medical record indicated the following: -A physician's order dated 1/27/25: Admit to hospice on 1/23/25. -A facility care plan: I require hospice services d/t (due to) end stage disease process, dated 1/28/25. Review of the medical record failed to indicate the hospice agency's plan of care was available to the staff at the facility. During an interview on 05/6/25 at 10:48 A.M., the Director of Nursing said she cannot give an exact timeline for when the hospice plan of care is provided to the facility, but it's usually given right away. During an interview on 05/6/25 at 11:13 A.M., Social Worker #1 said she does not know how soon the hospice should provide the plan of care.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observation, record review and interviews, the facility failed to ensure its staff implemented the facility smoking policy for one Resident (#64) out of a total sample of 32 resident. Specifically, the facility failed to ensure staff stored Resident #64's smoking materials in a locked area. Findings include: Review of facility policy, untitled, but provided to the surveyors when the smoking policy was requested, dated 2024, indicated the following: -To ensure compliance with regulatory guidelines and safety protocols, the Facility prohibits smoking except for in specifically designated areas. -Residents are not permitted to have any smoking paraphernalia in their room or on their person. All smoking paraphernalia should be given to the nursing staff for safekeeping. Nursing staff should maintain records of residents' property and distribute it accordingly. Nursing staff are required to confirm the resident's status in the smoking log before distributing smoking materials to the resident. Resident #64 was admitted to the facility in April 2025 with diagnoses that include chronic kidney disease stage 4 and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set (MDS) Assessment, dated 4/14/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicating that the resident was cognitively intact. The MDS further indicated current tobacco use. On 5/4/25 at 8:23 A.M., the surveyor observed Resident #64 in bed, awake. There was a pack of cigarettes on his/her bedside table. On 5/4/25 at 11:26 P.M., the surveyor observed Resident #64 sitting on the side of the bed. On the Resident's nightstand was a package of cigarettes and a lighter. The Resident said that he/she is allowed to smoke independently. On 5/4/25 at 1:33 P.M., the surveyor observed Resident #64 coming off the elevator, onto the third floor unit, with a pack of cigarettes and a lighter in his/her hand. The Resident went past the nurses station where two nurses were. The surveyor did not observe any staff request to store the Resident's smoking materials, and the Resident returned to his/her room with smoking materials. Review of Resident #64's most recent Smoking Evaluation, dated 4/7/25, failed to indicate whether or not the Resident can smoke independently or requires staff supervision or assistance. Review of Resident #64's active care plan indicated that the Resident likes to smoke related to smoking history. The care plan further indicated that the Resident can smoke independently with interventions that indicated, Resident will comply with the facility smoking policy, and Smoking materials to be kept by facility staff. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 7:28 A.M., Nurse #2 said that residents are not allowed to keep smoking materials in their rooms, and they are stored downstairs with security. During an interview on 5/6/25 at 11:51 A.M., Certified Nursing Assistant #1 said that some residents are allowed to keep smoking materials, including cigarettes and lighters in their room, but not all residents. During an interview on 5/6/25 at 12:31 P.M., the Director of Nurses said that no residents are allowed to have smoking materials, including cigarettes or a lighter in there room. She said she would expect staff are storing supplies for residents when they come back in from smoking to prevent accidents from occuring in the facility.