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	04/28/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interview the facility failed to implement an Antibiotic Stewardship Program to promote and monitor the appropriate use of antibiotics.Findings include:Review of the facility policy titled Antibiotic Stewardship, dated as revised December 2016, indicated but was not limited to: Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program.The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. During the survey period the surveyor requested infection control and antibiotic stewardship information. The facility did not implement a program for antibiotic stewardship and did not implement a system to monitor antibiotic use. Based on records reviewed, one resident was treated with antibiotics for pneumonia without an appropriate indication for use. One resident was treated with antibiotics for UTI (urinary tract infection) without an appropriate indication for use, and one resident was treated with antibiotics for eye redness without an appropriate indication for use.The facility failed to have any documented information related to tracking, follow up or review with the physician or nurse practitioner following the initiation of the antibiotics for any active physician antibiotic orders prescribed. During an interview on 4/28/26 at 7:49 A.M., Nurse #8 said we do not have line listings on the unit for infections or antibiotics and said the staff tell the Director of Nurses if someone has an infection. Nurse #8 said he is not familiar with the antibiotic stewardship program and does not track or review start and stop dates of antibiotics. During an interview on 4/28/26 at 7:53 A.M., the Nursing Supervisor said she does not review the antibiotic usage or communicate with the providers regarding start and stop dates and said the Director of Nurses (DON) tracks infections and would manage the antibiotic stewardship program. During an interview on 4/28/26 at 12:13 P.M., the Director of Nurses (DON) said the facility is not implementing the antibiotic stewardship program and said we need to do better at monitoring the use of antibiotics, reviewing start and stop dates and indication of use for the antibiotics prescribed. The DON said she does not have any information regarding the program as it has not been implemented.During an interview on 4/28/26 at 12:15 P.M., the Regional Nurse said she expects the facility to have an effective ongoing antibiotic stewardship program in place.

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

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

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F 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. Based on observation and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure medications were dated once opened according to manufacturer's guidelines, failed to ensure an unopened insulin injector pen was stored properly and failed to ensure access to the medication storage room was limited to authorized personnel on one of three units. Findings include:Review of the facility policy titled Medication Labeling and Storage dated 2001 indicated that the facility stores all medications and biologicals in locked compartments . only authorized personnel have access to keys. Further review indicated that the medication label includes the expiration date when applicable. 1. On 4/28/26 at 12:20 P.M. the surveyor observed a Lantus insulin injector pen on the second-floor nursing station desk. The surveyor also observed several residents and staff in the area. During an interview on 4/28/26 at 12:20 P.M., Nurse #5 said that she had put it there because the pharmacy had delivered the wrong medication. Nurse #5 then said that she should have locked the insulin up and not left it on the nurse's desk. 2. On 4/26/26 at 7:06 A.M., the surveyor and Nurse #2 observed the fourth-floor low side medication cart: -Humalog insulin unopened and not refrigerated. Manufacture's direction is to keep unopened insulin refrigerated until ready to use. On 4/26/26 at 7:11 A.M., the surveyor and Nurse #2 observed the fourth-floor high side medication cart: -Spiriva inhaler opened and undated. -Latanoprost 0.005% eye drop opened and undated. -Spiriva Respimat 2.5 micrograms (mcg) opened and undated. During an interview on 4/26/26 at 7:22 A.M., Nurse #2 said nurses are responsible for dating medications when they are opened and refrigerate insulin until they are ready to use. During an interview on 4/28/26 at 9:40 A.M., the Director of Nursing said medications with short expiration dates should be dated when opened, and insulin should be refrigerated until ready to use. 3. On 4/26/26 at 7:15 A.M., the surveyor observed the medication storage room located on the 3rd floor unit was unlocked. The surveyor was able to gain access to the medication storage room. No staff were present at the nurse's station and residents were visible at the nurse's station and in the hall. During an interview on 4/26/26 at 7:26 A.M., Nurse #6 said he is not sure why the medication room is unlocked and said it must be locked at all times. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/28/26 at 12:51 P.M., the Director of Nursing said the medication storage room should not be unlocked and said nurses must lock the medication storage room when not in use. 4. On 4/26/26 at 7:22 A.M., the Surveyor and Nurse #6 observed the medication cart on the 3rd floor high side had the following medications that were open and undated and one medication due to expire today. On 4/26/26 at 7:22 A.M., the surveyor and Nurse #6 observed the following medication in the 3rd floor medication cart: -One Lantus (insulin glargine) Vial opened and undated. During an interview on 4/26/26 at 7:27 A.M., Nurse #6 said the opened bottle of Lantus is used and undated and said the Lantus should have been dated when opened. During an interview on 4/28/26 at 12:50 P.M., the Director of Nursing said the bottle of Lantus must be dated when opened and should not be in the medication cart without an opened date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to properly follow food storage practices in the kitchen to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Specifically, the facility failed to properly store, date and label food product to prevent the risk of foodborne illness.Findings include:During the initial kitchen walk-through on 4/26/26 at 7:15 A.M., the surveyor made the following observations:In the walk-in refrigerator:- A container of what appeared to be coleslaw was unlabeled and undated.- A container labeled Beets had a prepared date of 4/15 and a use-by date of 4/17.- A second container labeled Beets had a prepared date of 4/21 and a use-by date of 4/23.- A container of cooked rice had a prepared date of 4/22 and a use-by date of 4/24.- A container of what appeared to be grilled hamburgers had a prepared date of 4/23 and use-by date of 4/25.- A container with a peanut butter sandwich had a single date of 4/23.- A container of raw chicken breast in a container with a prepared date of 4/20/26 that was sitting in about half an inch of juice and blood.- A container of what appeared to be creamed peas with no label or date.- An opened bag of grated cheese that had no label or date.- A plastic bag of croissants that had no label or date.- A container of ginger ale that was stored directly on the floor below the rack of food products.In the walk-in freezer:- A pitcher of broccoli florets that was not covered and was open to air.- Boxes of product were stored directly on the floor.In the dry storage room:- Multiple bags of opened hamburger rolls were not covered or labeled and were open to air. The hamburger rolls were hard to the touch.During an interview on 4/28/26 at 7:19 A.M., the Foodservice Director (FSD) said ready-to-eat food including peanut butter sandwiches should be discarded after one day and all other food should be discarded after three days. The FSD then said all prepared food should be dated and labeled as to what it is.During a follow-up interview on 4/28/26 at 11:08 A.M., the surveyor shared the observations from 4/26/26, the FSD said the food should have been properly labeled, dated and discarded if past the written date. The FSD then said the raw chicken should have been discarded because it was sitting in juice and blood.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically,1. For Resident #15, the facility a. failed to ensure staff implemented contact precautions for Resident #15, with active C-diff Infection (Clostridium difficile, a spore forming toxin that can develop in the intestines after antibiotic use and causes watery diarrhea), and b. failed to follow proper infection control practices for shared medical equipment, and c. failed to ensure staff performed hand hygiene after providing care. 2. The facility failed to implement Enhanced Barrier Precautions (EBP) for two Residents (#130 and #2) out of a total of 32 Residents who required the use of EBP.Findings Include: Review of the facility policy titled Infection Control Policy and Procedure, dated 2026, indicated but was not limited to: To help prevent the development and transmission of communicable diseases and infections in the Facility and to ensure that the Facility: I. Develops and implements an ongoing infection prevention and control program (IPCP) to prevent, recognize and control the onset and spread of infection to the extent possible and B. Written standards, policies, and procedures for the IPCP, which shall include, but are not limited to:a. A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the Facility;b. When and to whom possible incidents of communicable disease or infections should be reported. c. Standard and transmission -based precautions to be followed to prevent spread of infections;d. When and how isolation should be used for a resident; including but not limited to; i. The type and duration of the isolation, depending upon the infectious agent or organism involved, and f. The hand hygiene procedures to be followed by staff involved in direct resident contact. VII. Prevention and Control of Transmission of InfectionI. Enhanced Barrier Precautions (EBP)a. Enhanced barrier precaution means an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and glove use during high contact resident care activities.ii. For residents who enhanced verification options are indicated enhanced barrier precautions shall be employed when performing the following high contact resident care activities: 1. Dressing2. Bathing /showering3. Transferring 4. Providing hygiene 5. Changing linens 6. Changing briefs or assisting with toileting.IX. Transmission Based PrecautionsE. When a resident is placed on transmission-based precautions the staff should implement the following:a. Clearly identify the type of precautions and the appropriate PPE to be used;c. Make PPE readily available near the entrance to the residence room; d. DON appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on transmission-based precautions (e.g., contact precautions);e. Use disposable or dedicated non-critical resident-care equipment (e.g., blood pressure cuff, bedside commode) if non critical equipment is shared between residents, it will be clean and disinfected following manufacturer's instructions with an EPA registered disinfectant after use;F. Contact Precautions are intended to prevent transmission of infections that are spread by direct (e.g., person-to-person)or indirect contact with the resident or environment and require the use of appropriate PPE including a gown and gloves upon entering (i.e., before making contact with the resident or residence environment) the room or cubicle. Prior to leaving the residence room or cubicle, the PPE is removed and hand hygiene is performed.1a. Resident #15 was admitted to the facility in October 2024 with the following diagnoses: pneumonia, primary hypertension, and osteoarthritis. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/28/26, indicated that Resident #15 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15, and required Substantial/maximal assistance with Activities of Daily Living tasks. Review of the medical record for Resident #15 indicated the Resident was discharged from the hospital in April, 2026. Discharge paperwork indicated Resident #15 tested positive for C.diff and was started on oral antibiotics. Review of the active physician orders indicated the following: Contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Precautions r/t (related to) severe C. Diff every shift. Start Date: 4/25/26.Review of Resident #15 Care Plan indicated: Resident has C. Difficile. Date Initiated: 4/25/26. Interventions include: -CONTACT Precautions: Wear gown and gloves when entering room and when in room. Place soiled linens in plastic bags. After removing gown and gloves, wash hands with soap and water. Resident stays in room.- Encourage/ assist with hand washing after being toileted and before and after meals.On 4/27/26 at 6:49 A.M., the surveyor observed a precaution bin hanging outside Resident #15's room. The precaution bin was filled with personal protection equipment (PPE) masks, gowns, and gloves. There was a contact precaution sign on the wall outside of the entrance to the room. The door to the room was open and Nurse #10 was observed taking vital signs inside the room. Nurse #10 was not wearing PPE. Nurse #10 then exited Resident #15's room, closed the door with her bare contaminated hand, and without washing her hands she proceeded to push the vital signs machine down the hall. Nurse #15 did not disinfect the vital signs machine. On 4/27/26 at 6:52 A.M., Nurse #10 was observed pushing the same contaminated vital signs machine into another resident room and began to take vital signs on another resident. Nurse #10 then exited the room and without washing her hands she proceeded to push the vital signs machine down the hall. Nurse #15 did not disinfect the vital signs machine and did not perform hand hygiene.On 4/27/26 at 6:55 A.M., the Director of Nurses (DON) was overheard telling Nurse #10 to wipe down the vital signs machine and to use hand sanitizer after she exited a resident's room.During an interview on 4/27/26 at 6:57 A.M., Nurse #10 said Resident #15 is on contact precautions for C.diff and said she should have worn PPE when entering the room because C. diff is contagious and said the vital signs machine should have been wiped down in between after each use. Nurse #10 said she should have performed hand hygiene. 1b. On 4/27/26 at 6:58 A.M., the surveyor observed Certified Nursing Assistant (CNA) #2 enter Resident #15's room without wearing any PPE. CNA #2 was observed providing care to Resident #15. CNA #2 was then observed exiting the Resident's room, and with her bare contaminated hand she closed the door and did not perform hand hygiene. During an interview on 4/27/26 at 7:02 A.M., CNA #2 said she does not know why the Resident is on precautions and said she didn't notice the sign outside of the door and said she thinks it is for the other Resident in the room but was not sure. CNA #2 said no one mentioned to her that either Resident had to be on precautions. During an interview on 4/27/26 at 7:03 A.M., Nurse #7 said Resident #15 has active C.diff and is on contact precautions and said staff must wear PPE when entering the room and must wash their hands with soap and water. During an interview on 4/27/26 at 7:05 A.M., the DON said there is a contact precaution sign and precaution bin outside Resident #15's room but she does not know why, and the DON said she would have to look into it to see why the Resident is on contact precautions. The DON said staff must follow the infection control guidelines and wear PPE whenever entering the room and must perform hand hygiene.During an interview on 4/28/26 at 7:47 A.M., the Nursing Supervisor said staff must follow contact precautions and clean equipment in-between use to prevent the spread of infections and said staff must wash their hands with soap and water especially for Resident #15 who has C.diff. On 4/27/28 at 7:50 A.M., the surveyor observed the Director of Nursing hanging up a sign next to the contact precaution sign located outside of Resident #15's room. The sign written in black marker indicated: Wash hands with soap & water before you leave the room. Must wear gown & glove before you enter room. Change gown and gloves to take care of 2nd resident.During an interview on 4/28/26 at 12:05 P.M., the Regional Nurse said staff must follow the infection control guidelines for Contact Precautions and should not enter the room without the appropriate PPE and said staff must disinfect equipment in-between use and must wash their hands with soap and water to prevent the spread of C.diff. 2a. During an observation on the Fourth Floor Unit on 4/27/26 at 7:08 A.M., the surveyor observed CNA #4 entering a resident's room and providing personal care for Resident #130. There was a sign on the Resident's doorway to indicate the need for Enhanced Barrier Precautions (EBP) for both A & B beds. CNA #4 utilized gloves only and did not use gowns when providing personal care to the Resident.During an interview on 4/28/26 at 8:00 A.M., CNA #4 said he should have used the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriate Personal Protective Equipment (PPE) when providing personal care to Resident #130 and said he was giving Resident #130 a bed bath and should have on gown and gloves for protection. 2b. During an observation on the Fourth Floor Unit on 4/27/26 at 12:44 P.M., the surveyor observed CNA #4 enter a resident's room and was providing personal care for Resident #2. There was a sign on the Resident's doorway to indicate the need for Enhanced Barrier Precautions (EBP). CNA #4 utilized gloves only and did not use gowns when providing personal care to the Resident.During an interview on 4/28/26 at 8:01 A.M., CNA #4 said he should have used the appropriate Personal Protective Equipment (PPE) when providing personal care to Resident #2 and said he was washing the resident up and should have put on gown and gloves when giving him/her a bed bath. During an interview on 4/28/26 at 7:49 A.M., the Nursing Supervisor said staff must follow the guidelines for EBP and said staff should not be performing personal care without the use of appropriate PPE and said any close contact care requires the appropriate EBP protection. During an interview on 4/28/26 at 12:05 P.M., the Director of Nurses (DON) said staff must follow the infection control guidelines for EBP and wear PPE whenever providing personal care to Residents who have a sign indicating the need for EBP.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure their process for self-administration of medications was followed for two Residents (#82 and #30) out of a total sample of 32 residents. Specifically:For Resident #82, the facility failed to ensure the Resident took his/her medications timely after leaving the medications at the bedside and failed to have a physician's order to self-administer any other medications other than the inhaler.For Resident #30, the facility failed to ensure the Resident was assessed for the capacity to self-administer medications and failed to ensure the Resident took his/her medications after leaving the medications at the bedside.Findings include:Review of the facility policy titled Self Administration of Medications dated 2001 Indicated that residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Further review indicated that nursing staff reviews the self-administered medication record for each nursing shift and transfers pertinent information to the Medication administration record kept at the nursing station appropriately noting the doses that were self-administered.1. Resident #82 was admitted to the facility in July 2021 with diagnoses including history of suicidal ideations, psychoactive substance abuse disorder and depression.Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #82 is cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #82 requires supervision with activities of daily living.On 4/26/26 at 8:13 A.M., the surveyor observed a medication cup, with 6 medications in it, at the bedside. During an interview on 4/26/26 at 8:13 A.M., Resident #82 said that the medications were his/her nighttime medications. Resident #82 then said that the evening nurse leaves his/her medications with him/her to take when he/she is ready to go to sleep. Resident #82 then said that he/she didn't fall asleep until around 3 A.M., and he/she forgot to take the medications last night. Resident #82 then took the nighttime medications in front of the surveyor at 8:13 A.M. Review of the physician's orders indicated an order for Resident may self-administer Inhaler and keep locked at bedside. Further review failed to indicate that Resident #82 could self-administer any other medications. Further review indicated that the medications given at 9:00 P.M. and 10:00 P.M. consisted of the following:Docusate Sodium Capsule 100 MG (milligrams) give 200 mg by mouth at bedtime for constipation.Melatonin Tablet 5 MG give 5 mg by mouth at bedtime for Insomnia.Remeron Oral Tablet 15 MG (Mirtazapine) give 1 tablet by mouth at bedtime.Zoloft Tablet 25 MG (Sertraline HCl) give 1 tablet by mouth at bedtime for depression.Gabapentin Capsule 100 MG give 2 capsules by mouth three times a day for neuronal pain. Review of the care plan indicated a focus for the following: Resident has requested to administer his/her own inhaler medication Date Initiated: 4/15/26. Further review failed to indicate a care plan for the self-administration of any other medications or for leaving the medications at bedside. Review of the facility document titled Medication Self-Administration Screen dated 4/15/26 indicated Resident #82 is fully able to self-administer medications as ordered. However Resident #82 did not self-administer medications as ordered on 4/26/26 at 8:13 A.M., as observed by the surveyor.During an interview on 4/27/26 at 10:55 A.M., the Director of Nursing (DON) said that the Resident should be assessed for each medication for self-administration. The DON then said that medications should never be left at the bedside for the Resident to take whenever he/she chooses, and that the nurse is supposed to stay with all residents to ensure the medications have been taken. During an interview on 4/27/26 at 12:53 P.M., Nurse #1 said that medications that have been removed from their containers and placed in a medication cup, are never to be left with a resident even if they are allowed to self-administer. Nurse #1 then said that the nurse is supposed to stay with the residents to ensure the medications have been taken.2. Resident #30 was admitted to the facility in December 2021 with diagnoses including alcohol abuse, depression and type 2 diabetes.Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #30 is (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact, scoring a 15 out of 15 on the Brief interview for mental status exam. Further review indicated that Resident #30 requires supervision for activities of daily living. On 4/26/26 at 7:40 A.M., the surveyor observed pills in cup at bedside. The surveyor also observed two tubes of medication at bedside, one tube of hydrocortisone cream and one tube of Ketonzole cream and one of an anti-fungal cream. During an interview on 4/26/26 at 7:40 A.M., Resident #30 said that the nurse sometimes leaves the medication for him/her to take later. Review of the medical record failed to indicate that Resident #30 had been assessed for the safe self-administration of medications. Review of the physician orders dated April 2026 failed to indicate a physician's order for the self-administration of medications. Review of the care plan failed to indicate Resident #30 can self-administer medications. During an interview on 4/27/26 at 10:55 A.M., the Director of Nursing (DON) said that the Resident should be assessed for each medication for self-administration. The DON then said that medications should never be left at the bedside and that the nurse is supposed to stay with the residents to ensure the medications have been taken. During an interview on 4/27/26 at 12:53 P.M., Nurse #1 said that medications are never to be left with a resident. Nurse #1 then said that the nurse is supposed to stay with the residents to ensure the medications have been taken.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide reasonable accommodation of needs and preferences for one Resident (#52) out of a total sample of 32 residents. Specifically, for Resident #52, the facility failed to provide an appropriate wheelchair and therapy to manage the wheelchair, to increase desired independence.Findings include:Resident #52 was admitted to the facility in January 2026 with diagnoses including bipolar disorder, depression and anxiety.Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #52 is moderately cognitively impaired, scoring a 9 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #52 is dependent on staff for activities of daily living.Review of the care plan indicated that Resident #52 is dependent on staff for activities of daily living.On 4/26/26 at 8:42 A.M. the surveyor observed Resident #52 in a reclining chair (Geri-chair) next to his/her bed.During an interview on 4/26/26 at 8:42 A.M., Resident #52 said that he/she wants a wheelchair so that he/she can be more independent. Resident #52 said that he/she was given a wheelchair in the past but the leg rests did not fit and the wheelchair has disappeared.Review of the Physical Therapy (PT) evaluation dated 1/10/26 indicated the plan of treatment included wheelchair management training with a short-term goal of patient will increase ability to safely propel self in wheelchair 25 feet with Min A (minimum assist) on level surfaces in order to decrease level of assistance from caregivers, facilitate participation with functional daily activities and increase performance skills with functional tasks. Further review indicated a long-term goal of 150 feet with modified independence. Review of the PT treatment encounter notes dated 1/10/26 through 2/8/26 indicated the following:1/10/26-pending wheelchair for out of bed. 1/23/26-patient issued a standard wheelchair for when patient is out of bed.1/27/26-wheelchair management: training in safe maneuvering through doorways, analysis of patient's body alignment and functional skills in new or existing wheelchair, assessment of current seating system for appropriate modifications and safe and efficient wheelchair mobility over various surfaces. Further review failed to indicate assessments or outcomes of above listed wheelchair training and failed to indicate if the wheelchair was assessed as appropriate for Resident #52. Review of the PT Discharge summary dated [DATE] indicated that Resident #52 is dependent on others for wheelchair propulsion. Review of the Occupational Therapy (OT) evaluation dated 1/12/26 failed to indicate goals for the use of a wheelchair. Review of the OT treatment encounter notes dated 1/12/26 through 3/16/26 indicated the following:2/10/26-patient was provided with new wheelchair.Further review failed to indicate wheelchair training was provided and failed to indicate if the newly issued wheelchair was assessed as appropriate for Resident #52. Review of the OT Discharge summary dated [DATE] failed to indicate wheelchair training was provided and failed to indicate if the newly issued wheelchair was assessed as appropriate for Resident #52. During an interview on 4/27/26 at 12:58 P.M., the Director of Rehabilitation (DOR) said that we should have provided a wheelchair that was appropriate for Resident #52 to use. The DOR then said that Resident #52 should have been assessed for what type of wheelchair was appropriate and then provided therapy to assist the Resident obtain his/her maximum functional ability. The DOR said that we dropped the ball on this one and Resident #52 was not provided the therapy needed to maximize functional mobility with a wheelchair.

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	225425	A. Building B. Wing	04/28/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record reviews and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for dependent Residents for one Resident (#73) out of a total sample of 32 Residents. Specifically, the facility failed to ensure incontinence care was provided timely and in accordance with the standards of care and the Resident care plan.Findings include:Review of the facility policy, titled, Activities of Daily Living (ADL), Supporting, dated as revised April 2025, indicated but was not limited to the following:Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.5. Appropriate care and services are provided for Residents who are unable to carry out ADL's independently, with the consent of the Resident, and in accordance with the plan of care, including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming and oral care);c. elimination (toileting)1. Resident #73 was admitted to the facility in April 2026 with the following diagnoses: vascular dementia with other behavioral disturbance, type two diabetes mellitus, acute kidney failure, and primary hypertension.Review of the most recent Minimum Data Set (MDS) assessment, dated 4/15/26, indicated that Resident #73 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15, and is dependent on staff with activities of daily living. Further review of the MDS indicated Resident #73 is incontinent of bowel and bladder.Review of Resident #73's incontinence care plan dated 4/8/26 and last revised 4/23/26, indicated the following: Resident is incontinent of urine.Interventions:-Assist to toilet as needed.-Provide incontinence care as needed-Provide preventative skin care with incontinence careReview of Resident #73's incontinence care plan dated 4/8/26 and last revised 4/23/26, indicated the following: Resident is incontinent of bowel.Interventions:-Assist to toilet as needed.-Preventative skin care with each incontinent episode.-Provide peri-care after each incontinent episode.Review of Resident #73's ADL Care Plan dated 4/8/26 and last revised 4/23/26, indicated the following: Resident has an ADL Self Care Performance Deficit r/t (related to) Bipolar, Dementia, Cerebral infarction.Interventions:-TOILET USE: The Resident is totally dependent on staff for toilet use.- PERSONAL HYGIENE/ORAL CARE: The Resident requires total staff participation with personal hygiene and oral care.On 4/28/26 the surveyor made the following observations on the fourth-floor nursing unit:At 7:50 A.M., Resident #73 was observed sitting in a chair in the hall across from the nurse's station. The Resident was wearing a nursing gown and had socks on. Staff and other Residents walked past the Resident on the nursing unit.At 7:54 A.M., the surveyor observed a large puddle located under Resident #73's chair that went from under the chair to halfway across the floor in the hallway. The Resident did not have any beverages and there were no observed spills within the area of the observations. One staff member was observed walking past Resident #73 and one staff member was observed standing at the nurses station directly across from Resident #73.At 8:07 A.M., the Nursing Supervisor noticed Resident #73 was wet and a puddle was on the floor coming from the Residents chair. The Nursing Supervisor told another staff member to contact housekeeping to clean up urine and said another staff member would come over to change Resident #73 who had an incontinent episode in the hall. The Nursing supervisor and Nurse #9 placed a blanket on the floor to cover the urine puddle.At 8:17 A.M., Nurse #9 walked over to Resident #73 and told the surveyor that Resident #73 is incontinent of urine and that he/she needed to be changed as she walked Resident #73 back to his room that was located right next to where the Resident was sitting. Nurse #9 was observed walking Resident #73 into his/her room and assisting him/her to sit on the edge of the bed. Nurse #9 said I will be right back with your breakfast, as she exited the room and began checking the meal truck in the hall. Nurse #9 did not provide incontinence care.At 8:22 A.M., a staff member walked into Resident #73's room and delivered a breakfast tray and placed it on the overbed table and walked out of the room. Resident #73 was visible from the hall.At 8:37 A.M., the surveyor observed Resident #73 walking out of his/her room and into the hall. The Resident was reaching down between his/her (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	legs and appeared to be lifting the incontinence brief up in the front over his/her gown.At 8:40 A.M., the Surveyor observed a staff member approach Resident #73 and said, come on let's go back to your room, CNA #3 then walked Resident #73 into his/her room and sat the Resident on his/her bed and partially shut the bedroom door. The Resident was visible from the hallway. CNA #3 did not provide incontinence care.At 8:47 A.M., CNA #3 walked into Resident #73's room, stood Resident #73 up and then sat the Resident in a chair located near the window and exited the room. CNA #3 said I am going to go back and change Resident #73 and wash him/her. CNA #3 did not provide incontinence care. At 8:50 A.M., the surveyor observed Resident #73 walk out of his/her room and into the hall. The Resident lifted his/her gown up and was wearing an incontinent brief that appeared to be full of dark colored urine and was sagging down. Resident #73 was struggling to pull up the brief with one hand. The Residents incontinence brief appeared to be leaking. One staff member walked past Resident #73 as he/she was exposing the leaking incontinent brief. Another Resident was sitting in the hall and said What are you doing? You need a new one on.At 8:52 A.M., the Nursing Supervisor was observed walking over to Resident #73 and said, What are you doing?, as she walked Resident #73 back into his/her room and said CNA #3 will be coming in and will help you get ready for the day. The Resident was observed sitting on the edge of his/her bed. The Nursing Supervisor then exited the room.At 8:54 A.M., CNA #3 was observed entering the Residents room to provide ADL care.During an interview on 4/28/26 at 11:50 A.M., CNA #3 said she was late coming into work and did not provide incontinent care when she first arrived this morning and said the first time, she changed Resident #73 was after breakfast. CNA #3 said the Resident needed to be changed because the incontinence brief was full of urine and he/she was wet. CNA #3 said she was not aware of the Resident having an incontinent episode in the hall before breakfast and said he/she should have been changed before and after breakfast to keep his/her skin clean because he/she is incontinent and needs help During an interview on 4/28/26 at 11:51 A.M., Nurse #8 said he observed Resident #73 sitting in the chair in the hall and saw staff cleaning up the urine that was on the chair and on the floor while he was in the middle of a medication pass down the hall. Nurse #8 said he would expect staff who found the Resident to provide incontinent care because he/she was wet with urine and needed to be changed.During an interview on 4/28/26 at 11:57 A.M., the Nursing Supervisor said Resident #73 should have been changed this morning when the Nurse walked him/her back into the room because Resident #73 was visibly wet and his/her incontinent brief was full of urine. The Nursing Supervisor said it was concerning that he/she was not changed and said the nurse should have changed him/her and not placed the Resident back in bed sitting in a wet incontinence pad.During an interview on 4/28/26 at 12:40 P.M., the Director of Nursing said Resident #73 should have been provided incontinence care when the staff first observed him/her sitting in the hall in a puddle of urine and said Resident #73 is dependent on staff and should not have had to sit in a wet incontinence brief for an hour during the breakfast meal.During an interview on 4/28/26 at 12:44 P.M., the Regional Nurse said it is her expectation that staff provide incontinence care timely and said the staff should have washed Resident #73 and provided a new brief when they first observed him/her in the hall leaking urine.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure a safe smoking environment for the residents of the facility. Specifically, 1.The facility failed to provide adequate supervision for Resident #69 during smoking, resulting in a burn. 2.The facility failed to provide adequate supervision for other residents, while smoking. Findings include: Review of the facility policy titled ?Smoking Policy-Residents', dated October 2023, indicated the following but not limited to: -This facility has established and maintains safe resident smoking practice. Review of the Resident Smoking Agreement, dated 11/19/25 indicated the following: -Residents may not provide other residents with cigarettes or other smoking paraphernalia and may not light a cigarette for another resident. 1. Resident #69 was admitted to the facility in November 2025 with diagnoses including muscle wasting and atrophy, multiple sclerosis and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #69: -Was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a total possible score of 15. -Uses Tobacco. During an interview on 4/27/26 at 8:16 A.M., Resident #69 said that he/she has a wound on his/her right ankle from a cigarette burn that had happened a while back. The Resident said he/she got burned when he/she went to light his/her cigarette using another resident's cigarette and the other resident's cigarette ash fell off and fell into Resident #69's boot. The Resident said there was a staff member outside with them, but he/she did not alert the staff to what had happened. The Resident said he/she removed his/her boot and took out the ashes. Resident #69 said she/he never made anyone from the facility aware until a week after when the area had formed a blister. Review of a progress note dated 4/5/26 indicated the following: -At approximately 3:50 PM, the resident requested a bandage for an open blister on his/her right ankle. The nurse on duty responded promptly and performed an assessment, asking the resident about the cause. The resident reported that the injury occurred approximately one week ago while smoking outside, when a cigarette butt fell into his/her shoe, resulting in a blister that has since opened. -The nurse and supervisor assessed the area and observed an open wound on the right ankle measuring approximately 0.5 cm (centimeters) in circumference and 0.3 cm in depth, with serous drainage noted. No redness or signs of infection were observed in the surrounding tissue. First aid was initiated, and the wound was cleansed and covered with bordered gauze. The Resident's footwear was assessed and noticed that was wide open no lace in place, and a smoking safety reassessment was completed. --Education was provided to both nursing staff and activity staff responsible for supervising smoking to reinforce safety measures and prevent recurrence. Resident were educated on wearing different shoes that are not wide open. Different shoes were offered. Resident HCP (name redacted) made a call and waiting for call back. NP (Nurse Practitioner) on call (name redacted) updated and order obtained foe TX (treatment). [sic] Review of Resident #69's Plan of Care for smoking dated 11/19/25, indicated the following: - The resident is at risk of injury related to smoking-Supervised smoking.Review of the smoking agreement and assessment indicated the following: -Smoking evaluation done 11/19/25 indicated Resident required supervision with smoking. -Resident smoking agreement done 11/19/25 - smoker requiring supervision. During an interview on 4/27/26 at 9:29 A.M., the Director of Nursing (DON) said supervision of residents during smoking includes not letting the residents light cigarettes using each other cigarettes. She said the staff supervising the smoking group should be lighting the residents' cigarettes as this could cause accidents like burns. During an interview on 4/27/26 at 11:22 A.M., the DON said she does not know if hot ashes from a cigarette could cause a burn since she has never smoked and would have to google that. During an interview on 4/27/26 at 11:26 A.M., Activity Staff #2 said they should always have two staff supervising smoking but don't always. She said on 4/5/26 she was the only person providing supervision and so the residents were not always provided with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continuous supervision and so this could have caused an unsafe situation for Resident #69 and other residents too. Activity Staff (#2) said she was not aware that Resident #69 got burned while smoking.2. During an observation of the smoking group on 4/27/26 at 9:18 A.M., the surveyor observed multiple residents outside the building at the designated smoking area. The area was littered with cigarette butts on the ground. Only one staff member was outside responsible for the supervision of smoking activities. The surveyor observed multiple residents lighting their cigarettes from each other's cigarettes. The Director of Nursing (DON) came outside to the designated smoking area and together with the surveyor observed the residents lighting each other's cigarettes with their own cigarettes. At 9:29 A.M., the surveyor and the DON observed the staff supervising the residents borrowing another resident's cigarette and lit another resident's cigarette. During an interview on 4/27/26 at 9:30 A.M., the Activities Director said the staff supervising the smoking group should be lighting the residents' cigarettes and they should be supervising safety during the smoking session. During an interview on 4/27/26 at 9:32 A.M., the Administrator said the staff that is outside supervising the residents should have a lighter and light the residents' cigarettes. The staff should be supervising for safe smoking. He further said the ground should be free of cigarette litter. During an interview on 4/27/26 at 9:37 A.M., Activity Staff #1 said residents should not be lighting each other's cigarettes to prevent accidents like burning. She said the staff supervising the residents should be lighting their cigarettes.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop a care plan for one Resident #46 out of a sample of 32 residents. Specifically, the facility failed to develop a person centered Post Traumatic Stress Disorder (PTSD) care plan with the Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the Resident.Findings include: A review of the facility policy titled ?Trauma-Informed Care and Culturally Competent Care' revised August 2022 indicated the following:-To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice.-To address the needs of trauma survivors by minimizing triggers and/or re-traumatization.-Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.-Trauma informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.-Trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening.-Triggers are highly individualized.-Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate.Resident #46 was admitted to the facility in March 2026 with diagnoses including PTSD.A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated Resident #46 has a diagnosis of PTSD.A review of the trauma questionnaire dated 3/13/26 indicated Resident #46 answered Yes to the following questions:-Have you ever been in a serious car accident, or a serious accident at work or somewhere else?-Have you ever been in a major natural or technological disaster, such as fire, tornado, hurricane, flood, earthquake, or chemical spill?-Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed?Review of Resident #46's care plan failed to indicate a PTSD care plan.During an interview and record review on 4/27/26 at 8:10 A.M., Social Worker #2 reviewed the medical record and said that the Resident has a diagnosis of PTSD and a person-centered PTSD care plan with triggers was not in place and should be in place. Social Worker #2 said the process for ensuring a person-centered PTSD care plan is in place is to identify the trauma at intake by completing a trauma assessment then creating a person-centered care plan from that information.During an interview on 4/27/26 at 10:48 A.M., the Director of Nurses said residents with a PTSD diagnosis should have a person-centered PTSD care plan with personalized triggers to minimize retraumatization.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide or obtain from an outside resource, routine and emergency dental services to meet the needs of one Resident (#52) out of a total sample of 32 residents. Specifically for Resident #52, the facility failed to obtain a dental consult for broken carious teeth and mouth pain resulting in the development of an abscess in the left jaw.Findings include: Review of the facility policy titled dental services policy and procedure dated 2026 indicated that the facility will assist residents in obtaining routine and 24-hour emergency dental care to meet the needs of each resident.Resident #52 was admitted to the facility in January 2026 with diagnoses including bipolar disorder, depression and anxiety.Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #52 is moderately cognitively impaired, scoring a 9 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #52 is dependent on staff for activities of daily living.Review of Resident #52's care plan indicated a focus of the Resident having oral/dental health problems, Date Initiated: 01/10/2026. Further review indicated the following:Goal-The resident will be free of infection, pain or bleeding in the oral cavity by/through reviewdate. Date Initiated: 01/10/2026. Interventions-* Coordinate arrangements for dental care, transportation as needed/as ordered.Date Initiated: 01/10/2026. Provide mouth care as per ADL personal hygiene.Further review of the care plan indicated that Resident #52 is dependent on staff for activities of daily living.Review of the facility document titled Activation of Health Care Proxy/Durable Power of Attorney for Health Care indicated that on 1/13/26 Resident #52's Health Care Proxy (HCP) was activated.During an interview on 4/26/26 at 8:42 A.M., Resident #52 said that he/she has had mouth pain that had been going on for a long time. Resident #52 said that he/she had just started an antibiotic for a mouth abscess and was taking medicine for the pain.On 4/26/26 at 8:42 A.M., the surveyor observed Resident #52's left side of the face to be swollen. The surveyor then observed Resident #52's bottom teeth to be broken, jagged and black. The surveyor then observed the gums to be red and swollen along the bottom jaw line.Review of the facility document titled Nursing Evaluation with [NAME] (Admit, Readmit, Quarterly, COC) - V 5, SECTION 7. Oral Evaluation/Nutritional Screening, dated 1/9/26, indicated that on admission to the facility Resident #52 had broken/carious teeth and mouth pain.Review of the medical record indicated a dental consult activation form was blank. Further review failed to indicate that Resident #52 had been evaluated by a dentist since admission to the facility.Review of the physician orders dated April 2026 indicated an order dated 1/10/26, for dental consultation as needed. Further review indicated an order dated 2/11/26 for oxycodone HCl Oral Tablet 5 MG (milligrams) give 1 tablet by mouth every 4 hours as needed for pain. Further review indicated an order dated 4/25/26 for Clindamycin HCL 300 mg give 1 capsule by mouth every 8 hours for tooth abscess for 7 Days.Review of the Medication Administration Record (MAR) dated April 2026 indicated that Resident #52 received seven doses of oxycodone for pain on April 1st, 4th, 5th, 9th, 10th, 18th and 23rd.Review of the progress note dated 4/10/26 indicated that Resident #52 received oxycodone for mouth pain. Further review failed to indicate a Nurse Practitioner (NP) note for 4/25/26. During an interview on 4/28/26 at 11:50 A.M., Unit Secretary #1 said that she had not been informed to obtain a dental consultation until 4/26/26, and as of this time she had not been able to obtain a dental consultation. Unit Secretary #1 said that Resident #52 was not signed up for the facility's regular dental service that see the residents in the facility. Unit Secretary #1 said that she could not obtain a dental consultation outside of the facility as Resident #52 was not able to transfer independently from a wheelchair to the dental chair.Review of the medical record failed to indicate that the Healthcare Proxy (HCP) was presented with the opportunity to sign up for the dental services that can be provided within the facility.During an interview on 4/28/26 at 12:38 P.M., HCP #1 said that she was aware that Resident #52's teeth were in bad repair and had been for years. HCP #1 said that she was not presented with the opportunity to (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sign up for dental services upon admission and had she known that dental services were available at the facility she would have done so. During an interview on 4/28/26 at 11:51 A.M., Nurse #1 said that if the Resident had complained of mouth pain on admission he/she should have been seen by a dentist.During an interview on 4/28/26 at 12:11 P.M. Nurse Practitioner (NP) #1 said that she was not made aware of the condition of Resident #52's teeth or of him/her experiencing mouth pain until 4/25/26. NP #1 said that she would want to know immediately if a resident was taking oxycodone for mouth pain and if she had known she would have done an oral assessment immediately. NP #1 said that on 4/25/26 she completed an oral assessment of Resident #52's mouth and observed the teeth to be black and broken on the lower jaw. NP #1 also said that the gums were red and inflamed. NP #1 also said that Resident #52's face was significantly swollen, and the Resident was complaining of mouth pain. NP #1 said that Resident #52 had developed an abscess in the lower left jaw. NP #1 said that mouth pain is an indicator of an underlying infection and if left untreated could develop into an abscess as it did.During an interview on 4/28/26 at 12:50 P.M., the Director of Nursing (DON) said that a dental consultation should be obtained for any resident admitted to the facility with broken carious teeth and/or mouth pain. The DON then said that HCP #1 should have been given the option to sign up for the dental services that could be provided in the facility but that the dental consult activation form in the medical record indicated that it was not presented as the form was blank. During an interview on 4/28/26 at 1:45 P.M. Nurse Practitioner #2 said that she was in the facility on 4/10/26, but was not informed that the Resident was experiencing mouth pain or taking oxycodone for mouth pain. NP #2 said that if she had been informed, she would have immediately assessed the Resident's oral status. NP #2 said that oxycodone is a very strong medication and if the Resident is needing oxycodone for mouth pain that would indicate a potentially serious problem like infection.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview the facility failed to accurately document in the medical record for two Residents (#82 and #30) out of a total sample of 32 residents. Specifically: For Residents #82 and #30 the facility failed to accurately document the time the Residents took their medications on the Medication Administration Record.Findings include: Review of the facility policy titled Self Administration of Medications dated 2001 Indicated that residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Further review indicated that nursing staff reviews the self-administered medication record for each nursing shift and transfers pertinent information to the Medication administration record kept at the nursing station appropriately noting the doses that were self-administered.1. Resident #82 was admitted to the facility in July 2021 with diagnoses including history of suicidal ideations, psychoactive substance abuse disorder and depression.Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #82 is cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #82 requires supervision with activities of daily living.On 4/26/26 at 8:13 A.M., the surveyor observed a medication cup, with 6 medications in it, at the bedside. During an interview on 4/26/26 at 8:13 A.M., Resident #82 said that the medications were his/her nighttime medications. Resident #82 then said that the evening nurse leaves his/her medications with him/her to take when he/she is ready to go to sleep. Resident #82 then said that he/she didn't fall asleep until around 3 A.M., and he/she forgot to take the medications last night. Resident #82 then took the nighttime medications in front of the surveyor at 8:13 A.M. Review of the physician's orders indicated an order for Resident may self-administer Inhaler and keep locked at bedside. Further review failed to indicate that Resident #82 could self-administer any other medications. Further review indicated that the medications given at 9:00 P.M. and 10:00 P.M. consisted of the following:Docusate Sodium Capsule 100 MG (milligrams) give 200 mg by mouth at bedtime for constipation.Melatonin Tablet 5 MG give 5 mg by mouth at bedtime for Insomnia.Remeron Oral Tablet 15 MG (Mirtazapine) give 1 tablet by mouth at bedtime.Zoloft Tablet 25 MG (Sertraline HCl) give 1 tablet by mouth at bedtime for depression.Gabapentin Capsule 100 MG give 2 capsules by mouth three times a day for neuronal pain.Review of the Medication Administration Record (MAR) dated 4/25/26 at 9:00 P.M. and 10:00 P.M. indicated, in error, that Resident #82 took his/her medications at the prescribed time.During an interview on 4/27/26 at 10:55 A.M., the Director of Nursing (DON) said that the nurse should document accurately in the MAR what time the Resident took his/her medications. The DON then said that medications should never be left at the bedside for the Resident to take whenever he/she chooses. During an interview on 4/27/26 at 12:53 P.M., Nurse #1 said that medications that have been removed from their containers and placed in a medication cup, are never to be left with a resident even if they are allowed to self-administer. Nurse #1 then said that the nurse is supposed to stay with the residents to ensure the medications have been taken and document accurately in the MAR what time those medications were taken.2. Resident #30 was admitted to the facility in December 2021 with diagnoses including alcohol abuse, depression and type 2 diabetes.Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #30 is cognitively intact, scoring a 15 out of 15 on the Brief interview for mental status exam. Further review indicated that Resident #30 requires supervision for activities of daily living. On 4/26/26 at 7:40 A.M., the surveyor observed pills in cup at bedside. The surveyor also observed two tubes of medication at bedside, one tube of hydrocortisone cream and one tube of Ketonzole cream and one of an anti-fungal cream. During an interview on 4/26/26 at 7:40 A.M., Resident #30 said that the nurse sometimes leaves the pills and creams for him/her to take later.Review of the physician orders dated April 2026 failed to indicate pills scheduled (continued on next page)

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	04/28/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be administered within the two-hour window before and after 7:40 A.M. Review of the Medication Administration Record dated 4/26/26 indicated, in error, that Resident #30 took his/her medications at the scheduled time of 9:00 A.M. During an interview on 4/27/26 at 10:55 A.M., the Director of Nursing (DON) said that medications should never be left at the bedside. The DON also said that the nurses is supposed to administer and document the administration of medications accurately in the medical record. During an interview on 4/27/26 at 12:53 P.M., Nurse #1 said that medications are never to be left with a resident. Nurse #1 then said that the nurse is supposed to stay with the residents to ensure the medications have been taken and document accurately in the MAR what time those medications were taken.

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interviews, the facility failed to maintain a functioning call system for one Resident (#61) out of a total sample of 32 residents. Findings include:Review of the facility policy titled ?Answering the Call Light' date revised September 2022, indicated the following but not limited to:-Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.-Report all defective call lights to the nurse supervisor promptly.-Be sure that the call light is plugged in and functioning at all times. Resident #52 was admitted to the facility in April 2026 with diagnoses including paranoid schizophrenia and schizoaffective disorder. Review of Resident #61's Minimum Data Set (MDS) assessment dated , 4/14/26, indicated the Resident scored a 14 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated that the Resident required set-up assistance for activities of daily living. On 4/26/26 at 8:14 A.M., the surveyor observed the Resident in his/her bed, the Resident did not have access to a call light as there was no call light cord to pull. When asked how the Resident would call for help he/she said he/she would yell out for help. On 4/26/26 at 2:16 P.M., the surveyor observed the Resident lying in his/her bed with no access to a call light. On 4/27/26 at 6:45 A.M., the surveyor observed the Resident lying in his/her bed, the Resident did not have access to a call light. During an interview on 4/27/26 at 6:54 A.M., the surveyor and Certified Nursing Assistant (CNA) #1 observed Resident #61 lying in his/her bed. The Resident did not have access to a call light. CNA #1 said she did not realize that the Resident did not have a call light, she said all residents should have a call light. During an interview on 4/27/26 at 6:58 A.M., Nurse #2 said all residents should have access to a call light. During an interview on 4/27/26 at 8:56 A.M., the Maintenance Director said staff would write on the clip board at the nurse's station if anything needed to be fixed or put into TELS (a system of notifying maintenance needs). He said he was not aware that Resident #61 did not have a call light and that all residents should have access to a call light. During an interview on 4/28/26 at 11:50 A.M., the Administrator said he expects all residents to have access to a call light.