STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225431	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oc Reading Center LLC	1364 Main Street Reading, MA 01867

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure that Residents were provided with a dignified existence on two of two units. Specifically, the facility failed to:1. Ensure that staff members were not using their personal cellphones in Resident areas with Residents present. 2. Ensure that staff members were not speaking a foreign language to each other in front of Residents who do not speak that language.Findings include: Review of the facility policy titled Resident Rights, dated and revised January 2025, indicated the following: - All residents will be treated with kindness, respect, and dignity based on established Resident Rights. - Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness and dignity. 1. The surveyor made the following observations: On 12/29/25 at 2:08 P.M. in the second-floor dining room, a Certified Nursing Assistant (CNA) was sitting in the corner of the room using her personal cell phone with multiple Residents in the dining room within view of the CNA, the CNA was not engaging with the Residents. On 12/29/25 at 2:28 P.M., the surveyor walked past a Resident's room who was on a one-to-one observation, there were two CNA's sitting in the room with the Resident present and lying in his/her bed. One CNA was sitting with a bedside table in front of her with her personal cell phone on it. A second CNA was standing next to the sitting CNA leaning over looking at the cell phone. At 2:30 P.M., as the surveyor was walking past the room again, one of the CNA's left the room holding her cell phone and was observed putting it in her side pant pocket. During an interview on 12/30/25 at 2:07 P.M., the Director of Nursing (DON) said staff members should not be on their personal cell phones in Resident areas. The Surveyor showed the DON the photos of staff on their cell phones and she said it was unacceptable. 2. a. During an observation on 12/29/2025 at 10:22 A.M., A.M., on the third-floor unit, a housekeeper entered Resident 20's room. Resident #20 was observed to be seated in a specialized recliner with Certified Nursing Assistant #2 next to him/her. CNA #2 and the housekeeper began speaking in a language that was not English, with Resident #20 in between them as they conversed. The conversation was observed between CNA #2 and the housekeeper and not with Resident #20. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #20's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #20's preferred language as English. Further, the MDS indicated Resident #20 scored a 10 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having moderately impaired cognition. b. On 12/30/25 at 3:15 P.M., on the third-floor unit, two staff were on the opposite side of the nursing desk and could be heard speaking in a language that was not English. The staff were positioned near the entrance to a resident's room, and another resident was observed sitting in a wheelchair right next to the staff, as the staff conversed in another language. During an interview on 12/30/25 at 2:08 P.M., the Director of Nursing (DON) was made aware by the surveyor of staff speaking a language that was not English in front of and in Resident #20's room. The DON said staff should not be speaking to each other in another language around residents, unless it is their preferred language. On 12/30/25 after 3:15 P.M., the DON was made aware of staff speaking a language that was not English at the desk near the entrance to a resident room, which was occupied, and with a resident at wheelchair height right next to the staff. The DON said staff should not speaking in a language that is not English around residents.

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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 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 observations 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 stored according to manufacturer's guidelines in three of three medication carts observed. Findings include: Review of the facility policy titled, Storage of Medications, dated as revised August 2025, indicated that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the suppliers. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. I. General Guidance 8. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. II: Temperature 4. Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 F (2 C) and 46 F (8 C) with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. Controlled substances that require refrigeration are stored within a locked box within the refrigerator that is attached to the inside of the refrigerator or in accordance with state regulations and facility policy.III: Expiration Dating (Beyond-Use Dating) 1. Expiration dates (beyond-use dates) of dispensed medications shall be determined by the pharmacist at the time of dispensing.2. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date.3. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, and blood sugar testing solutions and strips require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency.5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.a. The nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating.b. If a vial or container is found without a stated date opened, the date opened will automatically default to the date dispensed and the expiration date will be calculated accordingly, unless otherwise indicated in a facility-specific 1. On 12/29/25 at 10:46 A.M., the surveyor observed the following on the second-floor front cart: - one bottle of acidophilus capsules opened, manufacturer's guidelines indicate to refrigerate once opened.- one glargine insulin vial, unopened, manufacturer's guidelines indicated to refrigerate until opened. - three insulin lispro vials, opened and undated, manufacturer's guidelines indicated good for 28 days once opened.- one tirzepatide injection pen, opened and undated, manufacturer's guidelines indicate good for 30 days once opened. - two umeclidinium inhalers, opened and undated, manufacturer's guidelines indicated good for 6 weeks once opened. - one tresiba injection pen, opened and undated, manufacturer's guidelines indicated good for 8 weeks once opened. During an interview on 12/29/25 at 10:52 A.M., Nurse #1 said nursing should label and date medications based on manufacture's guidelines. 2. On 12/29/25 at 10:53 A.M., the surveyor observed the following on the second-floor back cart: - two bottles of acidophilus capsules opened, manufacturer's guidelines indicated to refrigerate once opened. - one umeclidinium and vilanterol, opened and undated, manufacturer's guidelines indicated good for 6 weeks once opened. - one insulin glargine pen, opened and undated, manufacturer's guidelines indicated good for 28 days once opened.- one fluticasone furoate, umeclidinium and vilanterol inhaler, opened and undated, manufacturer's guidelines indicated good for 6 weeks once opened. During an interview on 12/29/25 at 10:59 A.M., Nurse #2 said nursing should label and date medications based on manufacture's guidelines. 3. On 12/29/25 at 11:01 A.M., the surveyor observed (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following on the third-floor front cart: - one bottle of acidophilus capsules opened, manufacturer's guidelines indicated to refrigerate once opened.- one glargine insulin vial, opened and undated, manufacturer's guidelines indicated good for 28 days once opened.- one insulin lispro vial, opened and undated, manufacturer's guidelines indicated good for 28 days once opened.- one glargine insulin pen, unopened, manufacturer's guidelines indicated refrigerate until opened. - two bottles of liquid lorazepam, opened and not refrigerated, manufacturer's guidelines indicated to refrigerate. During an interview on 12/29/25 at 11:08 A.M., Nurse #3 said nursing should label and date medications based on manufacture's guidelines. During an interview on 12/29/25 at 11:11 A.M., the Director of Nursing said that nursing should label and date medications according to manufacturer's recommendations. The DON said that medications should be discarded according to manufacturer's guidelines.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interviews, and record review, the facility failed to identify and assess the use of pillows tucked underneath a fitted sheet and on top of the raised edges of the perimeter mattress on both sides of the bed as a potential restraint for one Resident (#42) out of a total sample of 19 residents. Findings include:Review of the facility's policy titled, Restraint Free Environment, dated as revised March 2025, indicated:-It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints.-Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to: -Tucking in a sheet tightly so that the resident cannot get out of bed. -Using devices such as cushions that the resident cannot remove and prevents the resident from rising. -Placing a resident on a concave mattress so that the resident cannot independently get out of bed.-The resident has the right to be treated with respect and dignity, including the right to be free from any physical and chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.-Behavioral interventions should be used and exhausted prior to the application of a physical restraint or administration of medications that could be perceived as a chemical restraint.-Before a resident is physically restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints, and determine: a. How the use of the restraints would treat the medical symptom. b. The length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released. c. The type of direct monitoring and supervision that will be provided during use of the restraint. d. How the resident will request staff assistance and how his/her needs will be met while the restraint is in place. e. How to assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. Resident #42 was admitted to the facility in July 2025 with diagnoses including Parkinson's Disease, diabetes, and malnutrition.Review of the Minimum Data Set (MDS) assessment, dated 9/30/25, indicated the staff assessment of the Brief Interview for Mental Status (BIMS) indicated Resident #42 as having severe cognitive impairment. Further the MDS indicated Resident #42 was dependent on staff for mobility and did not utilize a restraint.On 12/29/25 at 7:30 A.M., the surveyor observed Resident #42 lying in bed on a perimeter mattress (a mattress with raised edges, acting as a barrier to prevent residents from rolling or falling out of bed). There were two pillows tucked under the fitted sheet and on top of the edges of the perimeter mattress on his/her left side and one pillow tucked under the fitted sheet and on top of the edges of the perimeter mattress on his/her right side. There were fall mats on each side of the bed.On 12/29/25 at 11:54 A.M., the surveyor observed Resident #42 lying in bed on a perimeter mattress. There were two pillows under the fitted sheet and on top of the edges of the perimeter mattress on his/her left side from knee to shoulder area and one pillow under the fitted sheet and on top of the edge of the perimeter mattress on his/her right side in the knee area.On 12/29/25 at 4:28 P.M., the surveyor observed Resident #42 in bed with pillows tucked under both sides of the fitted sheet on top of the perimeter mattress.On 12/30/25 at 6:29 A.M., the surveyor observed Resident #42 lying sideways in bed, with his/her legs over the right side of the bed, with pillows under both sides of fitted sheet on top of the edges of the perimeter mattress. CNA #3 came into the room and repositioned the Resident in bed and did not remove the pillows. CNA #3 said Resident #42 has raised sides on the mattress to prevent him/her from falling out of bed, and that the pillows under the sheet are to keep him/her in bed as he/she falls out of bed no matter what they (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do.On 12/30/25 at 7:57 A.M., the surveyor observed Resident #42 lying sideways in bed with pillows under the fitted sheet on both sides of the bed. Unit Manager #2 came into room and repositioned Resident in bed and did not remove the pillows.On 12/30/25 8:03 A.M., the surveyor observed Resident #42 lying in bed with a pillow under the fitted sheet on left side of the bed.Review of the plan of care related to falls, dated as initiated 7/10/25 and revised 12/30/25, indicated:-Perimeter mattress, keep resident in center.Further review of Resident #42's clinical record including the active care plans, paper chart, the electronic medical record, completed assessments and physician's orders failed to include any documentation to support the use of pillows tucked under Resident #42's fitted sheet.During an interview on 12/30/25 at 1:52 P.M., Unit Manager #2 said Resident #42 is a fall risk and has a scoop mattress, floor mats, and his/her bed in a low position. Unit Manager #2 said she has seen pillows tucked under the fitted sheets. Unit Manager #2 said the pillows should not be used as they are a restraint.During an interview on 12/31/25 at 7:50 A.M., the Director of Nursing said if nursing is putting pillows under a fitted sheet, it should be assessed for a restraint and care planned, but it should not be used as it is a restraint.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement an effective baseline person-centered care plan within 48 hours from admission to the facility for one Resident (#76) out of a total sample of 19 residents. Specifically, Resident #76 was admitted to the facility due to a fall, Resident #76 sustained a fall four days after admission, and a falls care plan was not developed or implemented until four days after admissionFindings include: Review of the facility policy titled Care Plans - Baseline, dated and revised 2017, indicated the following:- A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.- To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. The baseline care plan must include the minimum healthcare information necessary to properly care for a resident including, but not limited to - Initial goals based on admission ordersResident #76 was admitted to the facility in December 2025 with diagnoses including myocardial infarction, repeated falls and unsteadiness on feet.Review of Resident #76's admission Brief Interview for Mental Status exam dated 12/24/25 indicated that the Resident scored a 0 out of 15 indicating he/she as having severe cognitive impairment.Review of Resident #76's in-progress Minimum Data Set assessment dated [DATE] under Section V: Care Area Assessment indicated that Falls were triggered for the Resident.Review of Resident #76's admission Fall Risk assessment dated [DATE] indicated that the Resident's last known fall was documented as during current stay/within past month.Review of Resident #76's nursing note dated 12/24/25 at 10:45 P.M., indicated the following: Resident #76 was brought to acute care hospital after he/she had experienced a fall with LOC (loss of conscious). Patient has a PMH (prior medical history) of Obesity, Chronic Afib (Atrial Fibrillation) not on AC (anti-coagulants) due to recurrent falls.Review of Resident #76's nursing progress note dated 12/26/25 at 6:43 A.M., indicated the following: Resident is here due to s/p (status post) fall.Resident #76's falls care plan with person-centered interventions was not implemented until 12/28/25.Review of Resident #76's Nursing Progress note dated 12/28/25 at 11:21 P.M., indicated the following: Resident s/p (status post) fall on 12/28/25 @ (at) 4:52 P.M.Review of Resident #76's care plan dated 12/28/25 indicated the following:I am at risk or have the potential to fall r/t (related to) poor safety awareness, confusion, behaviors, impaired mobility h/o (history of) falls. Review of the Falls care plan interventions are all dated 12/28/25.Review of Resident #76's Social Service Progress Note dated 12/30/25 at 7:32 A.M., indicated the following: 48HR (48 hour) meeting yesterday 12/29 as family requested. Resident admitted STR (short-term rehab) from [NAME] Hospital after having lightheadedness and s/p fall at home.Review of Resident #76's Nursing Progress Note dated 12/31/25 at 6:53 A.M., indicated the following: The resident had an unwitnessed fall on 12/28 at 4:52. Neuros was [sic] taken and recorded. The resident is now on Ativan 2x a day. When the resident wakes up, he/she starts yelling and he/she does get wild and he/she will lash out.During an interview on 12/30/25 at 10:02 A.M., Unit Manager #1 said baseline care plans should be made within 48 hours of admission and they are typically done by the MDS nurse. Unit Manager #1 said baseline care plans should be created for anything relevant to a Resident's admission diagnoses including history of falls.During an interview on 12/30/25 at 10:15 A.M., MDS Nurse #1 said baseline care plans should be created within 48 hours of admission, and anything flagged on the nursing admission assessment would result in a baseline care plan being created. MDS Nurse #1 said Resident #76 had a fall at home and he/she should have had a falls care plan created within 48 hours of admission. MDS Nurse #1 said a falls baseline care plan with interventions could have alerted staff of his/her falls history to help prevent further falls.During an interview on 12/30/25 at 10:36 A.M., MDS Nurse #2 said she put in Resident #76's falls care plan on 12/28/25 because she knew the Resident was at risk of (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falls and it was coincidental he/she had a fall the same day. MDS Nurse #2 said Resident #76 should have had a falls baseline care plan developed within 48 hours since he/she was admitted due to a fall.During an interview on 12/30/25 at 2:07 P.M., the Director of Nursing (DON) said Resident #76 should have had a baseline care plan developed upon admission since the Resident was admitted due to a fall.

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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. Based on observation, interviews, and record review, the facility failed to ensure a resident with pressure ulcers receives the necessary care and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for one Resident (#2) out of a total sample of 19 residents. Specifically, the facility failed to:Ensure weekly skin checks were being completed for Resident #2 who has a stage 2 pressure ulcer 2. Ensure assessment of a pressure ulcer was being completed. Findings include:Review of the facility policy titled Pressure Ulcers/Skin Breakdown, dated as revised March 2014, indicated:-The nursing staff will assess and document an individual's significant risk factors for developing pressure sores.-The nurse shall describe and document/report the following:a. Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue. Resident #2 was admitted to the facility in April 2025 with diagnoses including peripheral vascular disease (a circulation disorder), history of cerebral infarction (type of stroke), and vascular dementia.Review of the Minimum Data Set (MDS) assessment dated , 11/26/25, indicated that Resident #2 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. This MDS also indicated that Resident #2 had a pressure ulcer that was not present on admission. 1.Review of Resident #2's active physician's orders include the following:-Weekly skin checks on Thursdays. Complete weekly skin check UDA (user-defined assessment).-May admit to Hospice as of 8/14/25.Review of Resident #2's plan of care related to falls, dated as initiated on 4/15/25, indicated:-Monitor skin during care and weekly during skin assessments.Review of Resident #2's Norton Scale for prediction risk of pressure ulcer, dated 5/20/25, indicated Resident was a moderate risk for pressure ulcer development as evidenced by a score of 11.Review of Resident #2's skin checks from May 2025 until December 2025 indicated skin checks were performed on:5/4/25,5/6/25, 8/4/25,9/11/25, 9/13,25, 9/15/25, 9/22/25, 10/2/25, 10/16/25,10/24/25, and 12/28/25. Resident #2 had 11 weekly skin checks completed, out of 35 weekly skin checks documented from May 2025 until December 2025. 2. Review of Resident #2's physician orders, dated 10/24/25, indicated:-To area on right heel, cleanse with wound cleanser, pat dry, apply Calcium alginate (a treatment used in highly absorbent, gel-forming wound dressings for moderate to heavy exudate (wound drainage) , promoting moist healing, controlling bleeding, and filling deep wounds), cover with ABD (a large highly absorbent gauze dressing used for heavy-draining wounds) and wrap with Kling (absorbent bandage) daily and as needed.Review of Resident #2's plan of care related to stage 2 pressure ulcer, dated as initiated 10/27/25, indicated:-Administer treatments as ordered and monitor for effectiveness.-Assess/record/monitor wound healing. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician.Review of Resident #2's wound assessment reports indicated the last report was completed on 10/23/25. The report indicated Resident #2 had a stage 2 pressure ulcer to his/her right heel that measured length=2.50 centimeters (cm) x width=2.50 cm and had no depth. The wound was described as having moderate serosanguineous (mix of blood and fluid from a wound) drainage.Review of Resident #2's wound care specialist's progress note, dated 10/23/25, indicated that the right heel scab had been mechanically debrided (removed tissue from a wound) to better assess the underlying tissue. The wound bed revealed non-granulating tissue (lacks healthy tissue) with areas of purple discoloration, suggestive of early ischemic (lack of blood flow) changes or persistent deep tissue involvement.Review of Resident #2's wound-weekly observation tool, dated 10/23/25, indicated the stage 2 pressure ulcer was worsening and had slough and necrotic (dead tissues) tissue present.Review of Resident #2's medical record failed to indicate any further documentation to describe the stage 2 pressure ulcer to Resident's right heel.During an interview on 12/30/25 at 1:41 P.M., Unit Manager #2 said that Resident #2 was no longer being seen by the wound care specialists as he/she was now on Hospice. Unit Manager #2 said since Resident #2 was on (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospice she had been doing wound rounds with Unit Manager #1. Unit Manager #2 said they were not aware that they were supposed to document in the weekly observation tool. Unit Manager #2 said she was not aware that skin checks had not been completed for Resident #2, and they should be.During an interview on 12/31/25 at 8:00 A.M., the Director of Nursing (DON) said that weekly skin checks should be completed so that staff are aware if a Resident is developing any new open areas. The DON said that residents with wounds should also have a weekly wound assessment completed and documented so that staff is monitoring if the wound is improving or getting worse.

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	225431	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oc Reading Center LLC	1364 Main Street Reading, MA 01867

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure professional standards for nutrition were implemented for one Resident (#54), out of a total sample of 19 residents. Specifically, for Resident #54, the facility failed to address a significant weight loss in a timely manner resulting in Resident #54 continuing to lose weight resulting in a severe total loss of body weight of 11.97% in approximately 2 months. Findings include:Review of the facility's policy titled, Weight Assessment and Intervention, revision date March 2022, indicated Resident's weights are monitored for undesirable or unintended weight loss.Weight AssessmentResidents are weighed upon admission and at intervals established by the interdisciplinary team.Weights are recorded in each unit's weight record chart and the individual's medical record.Any weight change of 5% (percent) or more since the last weight assessment is retaken the next day for confirmation. A If the weight is verified, nursing will immediately notify the dietician in writing. Unless notified of significant weight change, the dietician will review the weight record monthly to follow individual weight trends over time.The threshold for significant weight unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss+ (usual weight-actual weight/ (usual weight) x 100):1 month- 5% weight loss is significant; greater than 5% is severe.3 months- 7.5% weight loss is significant; greater than7.5% is severe.6 months- 10% weight loss is significant; greater than 10% is severe. Resident #54 was admitted to the facility in May 2025 and has diagnoses that include but are not limited to pain in left hip, difficulty walking, other symptoms and signs involving cognitive functions and awareness, muscle weakness and history of falling.Review of Resident #54's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #54 scored 12 out of 15 on the Brief Interview for Mental Status exam indicating he/she has moderately impaired cognition. Further, the MDS indicated Resident #54 required set up or clean up assistance for eating, is 70 inches in height, weighed 195 pounds and had a weight loss of 5% or more in the last month or 10% or more in the last 6 months and is not on a physician-prescribed weight loss regimen.On 12/29/25 Resident #54 was observed sitting up in a chair in his/her room. Resident #54 had an ensure supplement drink (a nutrition supplement) in front of him/her. When asked about his/her weight he/she said I do not know about my weight. Review of Resident #54's clinical record indicated the following:-A physician's order dated 5/15/25 and discontinued order dated 10/23/25: Regular diet, regular texture, thin liquids consistency. -a [NAME]-Nutritional Assessment Comprehensive dated 5/16/25 type: Admission, which indicated Resident #54's most recent weight dated 5/15/25 as 232.2 with a BMI of 33.3. Goal/Intervention, 1. maintain weight free from significant changes, 2. PO (by mouth) intake to meet daily nutrition and hydration needs, 3. tolerate diet textures as ordered 4. nutritional related labs WNL (within normal limits)Review of Resident #54's documented weights under the results tab in the electronic medical record indicated the following:5/15/25: 232.2 lbs. (pounds)(standing)5/15/25: 232.2 duplicate Lbs. (standing)6/4/25: 215.6 Lbs. (standing)7/14/25: 204.4 Lbs. (standing)7/29/25: 198.8 Lbs. (standing)8/5/25: 198.2 Lbs. (standing)Review of the documented weight dated 5/15/25 of 233.2 Lbs., and the next documented weight dated 6/4/25 of 215.6 Lbs., indicated Resident #54 lost 16.6 pounds, equaling a total loss of body weight of 7.15% in 20 days.Review of the documented weight dated 6/4/25 of 215.6 Lbs., and the next documented weight dated 7/14/25 of 204.4 Lbs., indicated Resident #54 lost 27.8 pounds equaling a total loss of body weight of 11.97% in 60 days, which meets the criteria of severe weight loss.Review of the medical record indicated the next recorded weight on 7/29/25 of 198.8 Lbs. indicated Resident #54 continued to lose weight equaling a total body weight loss of 14.35% since Resident #54's admission to the facility.Review of Resident #54's care plan, date initiated 5/16/25 and revised on 9/23/25 indicated the Resident is at risk for malnutrition related risk d/t (due to) elevated BMI (body mass index) and PMH (past medical history) TBI (traumatic brain injury), falls, OA (osteoarthritis), BPH (benign (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prostatic hyperplasia), and Asperger's syndrome, Goal: maintain a weight free from significant changes. Interventions include weigh a/o (as ordered), provide diet texture a/o and record % intake-regular with regular texture and thin liquids, PBJ and ice cream [NAME]/DI (lunch and dinner) The interventions were revised dated 9/23/25 which was over 4 months after Resident #54's admission to the facility and over 3 months after the significant weight loss occurred and documented on 6/4/25.The medical record failed to indicate a reweigh was obtained after the 6/4/25 documented weight loss or that a reweigh was documented after further weight loss documented on 7/14/25. Review of the progress notes in Resident #54's medical record from 5/15/25 through 7/13/25 failed to indicate any documentation of the Resident's weight loss, nor did the progress notes indicate the registered dietitian or medical provider were notified of Resident #54's weight loss documented on 6/4/25. A progress note dated 7/14/25 indicated the NP (nurse practitioner) was made aware of weight loss NNO (no new orders) at this time. This note was documented 41 days after Resident #54 experienced a significant total loss of body weight of 7.15% documented on 6/4/25.Review of Resident #54's active and discontinued physician's orders failed to indicate an order to weigh Resident #54 after admission to the facility until 7/21/25, when weekly weights were ordered and after the Resident experienced severe weight loss. Further review of the orders indicated Resident did not have interventions to prevent further weight loss until after 41 days of the significant weight loss documented on 6/4/25.Further review of the medical record failed to indicate Resident #54 was assessed by a registered dietitian until 9/23/25.During an interview on 12/30/25 at 11:43 A.M., Certified Nursing Assistant #2 said the nurses tell them how often to weigh a resident. CNA #2 said some residents are weighed monthly, some weekly and a few daily. CNA #2 said if a resident has a weight loss it is reported to the nurse and a reweight may be taken.During an interview on 12/30/25 at 3:35 P.M., with Unit Manager (UM) #2, who was the nurse who entered the 6/4/25 weight of 215.6 into the medical record, said residents are weighed each month unless they are on hospice. UM #2 said if there is a weight difference of a three-pound loss or gain then a re-weigh is obtained to verify the weight. UM #2 said the medical record will also flag if there is a weight change/loss/gain. UM #2 said the nurse practitioner is informed and an order to be seen by the dietitian would be entered, and they (Registered Dietitian (RD)) will take it from there to assess when a resident is identified for weight loss. UM #2 reviewed Resident #54's weights in the medical record and said at the time she was not the Unit Manager and the Resident was not her primary patient. UM #2 said she entered the weight and did not provide any further follow up.During an interview on 12/30/25 at 4:31 P.M., the Registered Dietitian said she just started at the facility about one month ago. She said generally, the practice for the RD is to assess a resident when they are admitted determining risk factors and develop the plan of care. The RD said some facilities will weigh a resident weekly for 4 weeks then determine a further weight order. The RD said there are many factors that can contribute to changes in a resident's weight. The RD said if a weight loss occurred, she would ask for a re-weigh to verify the weight loss. The RD said if a significant weight loss is identified an assessment should be conducted to dive into the causes, review the care plan and determine interventions. The RD said it would be concerning if a resident continued to trend down in weight loss. The RD said she did not know Resident #54 and that it was her understanding that there was an RD covering at the time.During an interview on 12/30/25 at 4:52 P.M., and 5:41 P.M., the Director of Nursing said she is recently new to the facility and that typically residents are weighed on admission and weekly for the first 4 weeks. The DON said previous weights should be reviewed for any losses or gains and any changes addressed timely. The DON said the weights documented for Resident #54 indicated a significant weight loss. The DON said it was an unexpected weight loss and it should have been addressed when documented on 6/4/25. The DON said Resident #54's weight loss should have been assessed by a registered dietitian, and the medical provider should have been made aware sooner. The DON said the Resident continued to lose weight and could have plateaued earlier with interventions and assessment.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for 1 Resident (#17), out of three applicable residents who require renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 19 residents. Specifically, the facility failed to ensure for Resident #17 who had a tunneled femoral hemodialysis line (type of vascular access used for hemodialysis, allowing access to the bloodstream for blood filtration in the thigh area), the facility failed to ensure nursing implemented storage of a clamp at bedside in case of emergency in accordance with the physician's order. Findings include: Review of the facility policy titled, End-Stage Renal Disease, Care of a Resident with, dated as revised September 2025, indicated residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis. Resident #17 admitted to the facility in April 2023 with diagnosis including end stage renal disease, dependence on renal dialysis, diabetes, and atrial fibrillation. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/10/25, indicated that Resident #17 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #17 was independent with activities of daily living and he/she required dialysis. Review of Resident #17's plan of care related to dialysis, dated 9/25/23, indicated:- Observe access site for bleeding every shift.- Assess dialysis access site location/skin integrity every shift. Notify physician of any signs and symptoms of site infection. Review of Resident #17's physician's orders included:- Pressure dressing and clamp at bedside, dated 6/20/24.- Dialysis Catheter Site: a right tunneled femoral hemodialysis line. Monitor every shift for signs and symptoms of bleeding/infection every shift for prevention. Notify physician of abnormal findings, dated 4/10/23.On 12/29/25 at 8:07 A.M., 12/29/25 at 4:14 P.M., and 12/30/25 at 10:13 A.M., the surveyor observed Resident #17 in his/her bed. Resident #17 had a right tunneled femoral hemodialysis line. There was a bag with gauze above Resident #17's bed but there was no clamp inside the bag.During an interview on 12/30/25 at 10:15 A.M., Unit Manager #1 said that Resident #17 has a right tunneled femoral hemodialysis line. Unit Manager #1 said that Resident #17 should have an emergency kit at the bedside including a clamp incase Resident #17's hemodialysis line breaks. Unit Manager #1 said that if hemodialysis line breaks it is a medical emergency and Resident #17 could bleed out (excessive bleeding) and Unit Manager #1 said that if bleeding occurred nursing would need to immediately clamp the hemodialysis line and apply pressure until emergency medical service (EMS) arrives.On 12/30/25 at 10:19 A.M., the surveyor and Unit Manager #1 were unable to locate the clamp in Resident #17's room. Resident #17 said he/she would allow the clamp to be stored in his/her room in the event of an emergency.During an interview on 12/30/25 at 2:12 PM Director of Nursing said that nursing should have ensured that there was a clamp in Resident #17's bedside according to the physician's order. The DON said that the clamp is used in an emergent situation in case the catheter line begins to bleed.