STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225439	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odd Fellows Home of Massachusetts	104 Randolph Road Worcester, MA 01606

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to assist three Residents (#30, #62, and #88), with signed consents, out of a total sample of 19 residents, in obtaining routine dental care, increasing the Residents' risks for unidentified dental disease and deteriorating oral health.Findings include:Review of the facility's Dental Services Policy, last revised [DATE], indicated the following: -Residents and/or their responsible party are responsible for the selection of a dentist or dental service to be used by the resident for dental supervision while in the facility. -Residents are assisted in obtaining regular and emergency dental care through the dentist or the dental service indicated at the time of admission. -Each resident may have an annual oral examination by a licensed dentist, and this examination shall be recorded on the resident's record. Review of the American Dental Association (ADA) guidance titled Your Top Nine Questions About Going to the Dentist - Answered, dated 2026 and located at Common Questions About Going to the Dentist | MouthHealthy - Oral Health Information from the ADA included the following: -Regular dental visits are important because they can help spot dental health problems early . -See a dentist if you have a medical condition such as Diabetes, Cardiovascular Disease, . -Even if you don't have any symptoms, you can still have dental health problems that only a dentist can diagnose. -Regular dental visits will also help prevent problems from developing. 1. Resident #30 was admitted to the facility in [DATE] with diagnoses including Diabetes, Hypertension, and gastro-esophageal reflux disease (GERD). Review of Resident #30's Minimum Data Set (MDS) Assessment, dated [DATE], indicated: -The Resident has clear speech (distinct intelligible words). -The Resident usually makes self understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time). -The Resident usually understands others (misses some part/intent of message but comprehends (continued on next page)

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

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	most conversations). -The Resident has no facial pain, discomfort or difficulty with chewing. Review of Resident #30's Dental Consent Form, dated [DATE], indicated the Resident consented to dental care services. Review of Resident #30's Nursing Note, dated [DATE], indicated: -The Resident complained of tooth pain. -The Nurse Practitioner (NP) assessed the Resident and prescribed Amoxicillin (antibiotic medication) to be administered for seven days. -The NP placed a referral for the Resident to see a dentist. Review of Resident #30's NP Note, dated [DATE], indicated: -The Resident was assessed for tooth pain. -The Resident complained of severe pain in the molars. -The Resident's second molar was red and swollen on both sides of his/her mouth. -The Resident was diagnosed with a tooth infection and the NP ordered Amoxicillin to be administered to the Resident for seven days. Review of Resident #30's Nursing Note, dated [DATE], indicated the Resident went to the dentist that same day and the dentist did not see the Resident due to the Resident's insurance being expired. Review of an [Insurance] Note, dated [DATE], indicated . no eligibility [DATE] to [DATE]. Now elig (eligible) [DATE] to current. Review of Resident #30's clinical record did not include any evidence the facility assisted the Resident in obtaining routine dental care between the date the Resident consented to dental services ([DATE]) and when the Resident went to the dentist on [DATE] (six years). Further review of the Resident's clinical record did not include any evidence that the facility assisted the Resident in obtaining a dental appointment after the facility was notified of the Resident's eligibility for insurance on [DATE]. During an interview on [DATE] at 9:29 A.M., Resident #30 said he/she has not been seen by a dentist for oral cavity inspection and his/her teeth have not been cleaned in over a year. Resident #30 said he/she thinks he/she may have some cavities that need fillings because he/she had a toothache a while ago. Resident #30 said he/she wants to see a dentist. Resident #30 said his/her teeth do not bother him/her currently. During an observation at this time, the surveyor observed Resident #30 with areas of brown discoloration on his/her front top teeth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 5:15 P.M., Nurse Manager #1 said Resident #30 consented to dental services in 2019. Nurse Manager #1 reviewed Resident #30's clinical record and said that the Resident went to see a dentist recently due to having a toothache, and that he located no evidence the Resident had been provided routine dental care since the Resident consented to dental services in 2019. During an interview on [DATE] at 7:50 A.M., Nurse Manager #1 said Resident #30 went to the dentist on [DATE] due to experiencing a toothache. Nurse Manager #1 said the dentist did not see the Resident because the Resident's insurance had expired. Nurse Manager #1 said the Resident's insurance had been renewed but that the facility had not yet provided the Resident assistance to obtain a dental appointment. Nurse Manager #1 said it is important to obtain routine dental care services for residents to prevent dental health problems. 2. Resident #62 was admitted to the facility in February 2026 with diagnoses including Unspecified Dementia, Type 2 Diabetes Mellitus, Deficiency of other Vitamins, other Vitamin B12 Deficiency Anemias and Essential Primary Hypertension. Review of Resident #62's [DATE] Physician's Orders indicated the following:-Dental consult as needed, initiated [DATE]. Review of Resident #62's admission record dated [DATE] indicated the Resident wears both full upper and lower dentures. Review of Resident #62's Care Plan did not include any problems, goals, or interventions for dental care. Review of the Dental Services Contract indicated that Resident #62 requested dental services on [DATE]. Review of the MDS Assessment, dated [DATE], indicated Resident #62:-had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 points.-was able to make him/herself understood and understands others-had no natural teeth or tooth fragments. On [DATE] at 8:18 A.M., the surveyor observed the Resident with no teeth in his/her mouth. During an interview on [DATE] at 12:52 P.M., the Resident said that he/she had no natural teeth or dentures. The Resident said that he/she would like to see a dentist for an oral exam. The Resident said that he/she consented upon his/her admission to the facility and requested dental services but had not been given a date and or a time of an appointment. During an interview on [DATE] at 1:42 P.M., the Administrator said that ancillary physician services included a dental provider which was available to residents who reside in the facility every six months and as needed. The Administrator said that 'as needed' indicated that the facility would schedule the service and put Resident #62 on the list to be seen upon his/her request. The Administrator said that dental services were last provided in the facility on [DATE]. During an interview on [DATE] at 3:30 P.M., with the Administrator and Unit Manager (UM) #1, the Administrator said that she was unable to provide evidence that Resident #62 was currently on the (continued on next page)

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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 observations, interviews, and record review, the facility failed to implement infection control practices to prevent transmission of infections for three Residents (#64, #13, and #32), out of a total sample size of 19 residents. Specifically, the facility failed:1. For Resident #64, to implement Contact precautions (the use of protective equipment such as gowns and gloves to prevent the spread of parasites from one person to another) in accordance with Resident's plan of care plan increasing the risk to other residents, staff and visitors for contracting scabies (tiny mites that burrow under a person's skin, lay eggs and trigger an allergic reaction that causes itching). 2. For Resident #13, to implement Contact Precautions when the Resident became symptomatic and tested positive for Clostridioides difficile (C. diff: a bacterium causing severe diarrhea and colitis), which increased the risk for transmission of C. diff among residents and staff. 3. For Resident #32, to ensure that Enhanced Barrier Precautions (EBPs - the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), were appropriately utilized when providing high contact care for the Resident, to mitigate the risk of organism transmission and the spread of infection to the Resident and other residents within the facility. Findings include: 1. Review of the facility's policy titled Contact Precautions, dated 4/15/25, included but was not limited to: Contact Precautions are indicated for those residents known to be infected/colonized with an infectious organism that could be transmitted through direct contact with a resident or by direct contact with the environmental surfaces/equipment. -Diseases requiring contact precautions include: >Scabies >Clostridium Difficile (C. diff- a highly contagious bacterial infection that causes severe diarrhea) Resident #64 was admitted to the facility in January 2026. Review of Resident #64's person centered care plan indicated the following: -Problem: Residents [sic] have skin rashes, suspected Scabies, start date 2/20/26. -Goal: Staff will maintain Contact Precautions. -Approach: >Maintain Contact Precautions at all times, start date 2/20/26 Review of Resident #64's March 2026 Physician's Orders indicated the following: Permethrin (a topical medication used to treat Scabies) 5% cream, apply cream than [sic] shower after eight (8) to 12 hours. Repeat the same process in seven (7) days once a day every seven days, with a start of 2/21/26 and an end date of 3/9/26. Scabies examination once-one time, effective 3/3/26. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Scabies examination once-one time, effective 3/11/26. During an observation on 3/25/26 at 10:15 A.M., the surveyor observed signage posted to Resident #64's room that included but was not limited to: CONTACT PRECAUTIONS REPORT TO NURSE BEFORE ENTERING >Don (put on) gloves upon entry into the room. >Remove gloves before leaving patient room. >Don gown upon entry into the room. >Remove gown and preform hand hygiene before leaving the patient care environment. During an observation and interview on 3/25/26 at 10:20 A.M., the surveyor observed Housekeeping Staff #1 holding clothing in her arms and enter Resident #64's room without performing hand hygiene or donning a gown and gloves. Housekeeping Staff #1 opened the Resident's top dresser drawer, placed clothing inside, then closed the drawer. Housekeeping Staff #1 then opened the Resident's closet door, placed clothing into the Resident's closet then closed the closet door. Housekeeping Staff #1 then exited the room without performing hand hygiene. Housekeeping Staff #1 said Resident #64 was on Contact Precautions for a rash. Housekeeping Staff #1 said that because she did not touch the Resident, she did not need to wear a gown and gloves or clean her hands in the Resident's room. Housekeeping Staff #1 then continued to deliver clothing to other resident rooms on the unit. During an observation and interview on 3/25/26 at 10:22 A.M., the surveyor observed Certified Nurse Aide (CNA) #1 enter Resident #64's room without performing hand hygiene or donning a gown and gloves. CNA #1 then pushed the Resident's privacy curtain at the center of the room back to the wall and turned off the Resident's call light. The privacy curtain was observed to make contact with CNA #1's right and left hands as well as her shirt. CNA #1 then pulled the Resident's bed linens up to the head of the bed while making contact with the Resident's bed against her legs, exited the room and did not perform hand hygiene. CNA #1 said that she was not giving care to the Resident, so she did not need to put on a gown and gloves. CNA #1 said that the Resident had Contact Precautions for scabies but did not have scabies any longer. During an interview on 3/25/26 at 10:24 A.M., the Infection Preventionist (IP) said Resident #64 had been started on Contact Precautions and treated with Permethrin for suspected scabies starting on 2/21/26. The IP said that Resident #64 still had a rash remaining to the thighs, so Contact Precautions needed to continue until the Resident was seen by Dermatology to be cleared of the suspected scabies infection. The IP said that all staff should don a gown and gloves before entering Resident #64's room. The IP said that when staff failed to follow Contact Precautions scabies could be spread to other residents, staff, and visitors in the facility. 2. Resident #13 was admitted to the facility in October 2025 with diagnoses including Toxic Gastroenteritis and Colitis, and Clostridioides difficile (C. diff: a bacterium causing severe diarrhea and colitis). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Disease Control and Prevention (CDC) guidance titled C. diff. Facts for Clinicians, dated 3/5/24, indicated the following: -C. diff is spore-forming. -C. diff sheds in feces. -Any surface, device or material that becomes contaminated with feces could serve as a reservoir for C. diff spores. -C. diff spores can transfer to patients by the hands of healthcare personnel who have touched a contaminated surface or item. -Gloves are important because hand sanitizer doesn't kill C. diff. Review of the CDC guidance titled Transmission-Based Precautions (TBPs), dated 4/3/24, indicated the following: -TBPs are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. -Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. -Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. -Donning PPE (personal protective equipment) upon room entry and properly discarding before exiting the patient room is done to contain pathogens. Review of the CDC Infection Control guidance under Appendix A for Preventing Transmission of Infectious Agents in Healthcare Settings: Type and Duration of Precautions Recommended for Selected Infections and Conditions, last reviewed 2/7/25, indicated the following for C. diff: -Contact Precautions plus Standard Precautions for duration of illness. Review of Resident #13's Nursing Note, dated 1/30/26, indicated: -The Resident was having diarrhea. -The physician ordered for a stool C. diff test. Review of Resident #13's Nursing Note, dated 2/2/26, indicated: -Lab results (C. diff) came back and were reviewed by the physician. -An order to start Vancomycin 125 milligrams (mg) QID (four times a day) was given to start on 2/3/26. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's Nursing Progress Note, dated 2/3/26, indicated the Resident was taking Vancomycin for C. diff. Review of Resident #13's clinical record indicated the following Physician's Orders: -Enhanced Barrier Precautions (EBP) for wound every shift (10/29/25 and no end date). -Vancomycin Capsule; 125 mg, one tab, give one tablet 4 (four) times a day (2/3/26-2/16/26). -Vancomycin recon (reconstituted) soln (solution); 50 mg/milliliter (mL); amt (amount): 2.5 mL oral. Give 2.5 mL TID (three times a day) x 2 (two) weeks (2/26/26-3/12/26) -Vancomycin recon soln; 50 mg/mL; amt: 2.5 mL oral. Give 2.5 mL (125 mg) BID (twice a day) x 2 weeks (3/12/26-3/26/26). -Vancomycin recon soln; 50 mg/mL; amt: 2.5 mL oral. Give 2.5 mL QD (daily) x 2 weeks (3/26/26-4/9/26). The physician's orders failed to indicate Contact Precautions for active treatment of C.diff. Review of Resident #13's March Bowel Log indicated the Resident was incontinent of stool and that the Resident's stool was loose and fatty (last recorded on 3/25/26). On 3/24/26 at 10:45 A.M., the surveyor observed the following posted outside of Resident #13's door: -Enhanced Barrier Precautions (EBP). -Everyone must: -Clean hands, including before and when leaving the room (picture on sign indicated use of alcohol-based hand rub [ABHR]). -Providers and staff must also: -Wear gloves and gown for the following high contact care activities: Dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, . wound care. -No signage for Contact Precautions was posted. On 3/25/26 at 8:12 A.M., the surveyor observed the same EBP signage posted outside of Resident #13's door. No signage for Contact precautions was posted. During an interview on 3/25/26 at 4:40 P.M., the IP said Resident #13 was being treated and was symptomatic for C. diff. The IP said Resident #13 required Contact Precautions. At this time, the IP and surveyor reviewed the EBP sign posted outside of the Resident's door. The IP said the requirements indicated on the EBP sign were not the same as the requirements for Contact Precautions and that staff were required to wash their hands with soap and water when exiting the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities. According to the CDC, more than 50 percent (%) of residents may be colonized with an MDRO in skilled nursing facilities so enhanced infection control may help reduce the transmission of these organisms. EBP may be used when contact precautions do not otherwise apply. Unlike contact precautions, when placed on EBP residents are not restricted to their rooms, do not require placement in a private room, and may participate in group activities. -The facility will implement EBP during high contact resident care activities for those residents who are colonized with an MDRO unless otherwise ordered by healthcare provider.-Examples of high contact resident care activities:>dressing>bathing/showering>transferring>changing linens>changing briefs or assisting with toileting>device care or use- central line, urinary catheter, feeding tube, tracheostomy/ventilator>wound care- any skin opening requiring a dressing-The facility may choose to implement enhanced barrier precautions to include any resident with an indwelling medical device or wound, regardless of MDRO colonization or infection status.-The Infection Preventionist (IP)/Designee will provide staff, residents and/or resident representatives with education regarding the purpose of EBP. -Staff will perform hand hygiene and don PPE before entering the resident's room.-Staff will remove PPE and perform hand hygiene before exiting resident's room. Resident #32 was admitted to the facility in July 2017 with diagnoses including Neuromuscular Dysfunction of Bladder, Hypertensive Chronic Kidney Disease with Stage 1 through Stage 4 Chronic Kidney Disease, and Stage 3 Pressure Ulcer on Right Heel. Review of the Minimum Data Set (MDS) Assessment, dated 2/19/26, indicated Resident #32:-had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 0 out of a possible 15 points.-had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body).-had stage 3 pressure ulcer (a full thickness skin injury extending through the dermis into the subcutaneous fat tissue). Review of Resident #32's March 2026 Physician's Orders indicated: -EBP every shift with high contact care. Bathing, dressing, transferring, wound care, device management. Hand hygiene pre- and post-high contact care. Special instructions: Foley. Every shift: Day 7:00 A.M.-3:00 P.M., Eve (Evening) 3:00 P.M.-11:00 P.M., Night 11:00 P.M.-7:00 A.M., initiated 11/20/24.-Change Foley catheter 18 French (Fr)/10 milliliters (ML) monthly on the 23rd 3-11; once a day on the 23rd of the month; eve 3:00P.M. -11:00 P.M., initiated 10/30/25.-Cleanse stage 3 on right heel with normal saline, pat dry apply cal alg (calcium alginate- highly absorptive, non-woven, and non-adhesive primary dressings made from natural brown seaweed fibers)/Santyl (medicine used for debriding chronic dermal ulcers) then cover with border dressing and wrap with kerlix daily, once a day; day, initiated 2/14/26. On 3/24/26 at 3:20 P.M., the surveyor observed a sign posted outside of Resident #32's door. The signage indicated the following:-ENHANCED BARRIER PRECAUTIONS >EVERYONE MUST: -clean their hands including before entering and when leaving the room. > providers and staff must also:-wear gloves and a gown for the following high contact resident care activities: -dressing-bathing/showering-transferring-changing linens-providing hygiene-changing brief or assisting with toileting-device care or use: central line, urinary catheter, feeding tube, tracheostomy -wound care: any skin opening requiring a dressing On 3/26/26 from 9:28 A.M. to 9:31 A.M., the surveyor observed the following:-CNA #4 exited Resident #32's room with a hydraulic lift, no hand hygiene or PPE was observed.-CNA #3 was next to Resident #32's bed covering the Resident with a blanket. -CNA #3 was wearing gloves while handling the Resident's linens. No gown was observed. -CNA #3 exited the room and was observed to doff gloves and perform hand hygiene. -CNA #3 re-entered the room, pulled and repositioned the Resident's (continued on next page)

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	225439	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odd Fellows Home of Massachusetts	104 Randolph Road Worcester, MA 01606

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blanket. CNA #3 was not observed to perform hand hygiene or don (put on) any PPE when re-entering the room and handling the bed linens and blanket. During an interview on 3/26/26 at 9:34 A.M., CNA #3 said that she and CNA #4 transferred Resident #32 to bed. CNA #3 said that the Resident has a wound and a catheter and required a gown during bathing. CNA #3 and the surveyor reviewed the EBP signage posted outside the Resident room door together. CNA #3 said that she should have put on a gown when transferring Resident #32 to bed and when handling the Resident's linens, but she did not. CNA #3 said that it was important for her to wear a gown to prevent the transfer of germs from herself to Resident #32 and from the Resident to her and other residents. During an interview on 3/26/26 at 10:09 A.M., CNA #4 said that he had worn gloves when he and CNA #3 transferred Resident #32 back to bed. CNA #4 and the surveyor reviewed the EBP signage posted outside Resident #32's door together. CNA #4 said that he should have worn a gown when transferring Resident #32 to bed to prevent the spread of infection to the Resident and other residents. CNA #4 said he was aware that Resident #32 has a catheter and he should have worn a gown. During an interview on 3/26/26 at 1:15 P.M., the IP said that all nursing staff have been educated and trained on EBP upon hire and annually. The IP said that each time a resident is placed on any type of precaution, all staff are educated on the proper use of gown and gloves during high contact care to prevent the spread of infection. The IP said that nursing staff should have worn a gown when transferring Resident #32 to prevent the spread of infection.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, record review, and interviews, the facility failed to maintain a clean and homelike environment for two Residents (#52 and #70), out of a total sample of 19 residents, on one unit (Second Floor-South) out of five units observed. ˆ Specifically, the facility staff failed to ensure that: -Resident #52's bedroom floor was maintained in a clean and sanitary manner. -Resident #70's bed frame, bed rail, mattress, floor mat and bedroom floor were maintained in a clean and sanitary manner. Findings include: Review of the facility's Resident Handbook, last revised 3/24/26, indicated: >Environment- The Healthcare Center must provide a safe, clean, comfortable and home-like environment, allowing each resident the opportunity to use his/her personal belongings to the greatest extent, provide housekeeping and maintenance services, and assuring clean bath and bed linens that are in good repair. ˆ A. Resident #52 was admitted to the facility in December 2025 with diagnoses including benign prostatic hyperplasia and obstructive and reflux uropathy. Review of the Minimum Data Set (MDS) Assessment, dated 12/16/25, indicated Resident #52: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. -required substantial/maximal assistance from staff for toileting.ˆ -had an indwelling catheter.ˆ Review of Resident #52's progress notes indicated: -On 2/24/26, the Resident's Foley catheter was changed due to leakage, and the urine was clear orange colored due to Pyridium (a pain medication used to treat urinary urgency, pain and discomfort. A common side effect is orange-red colored urine). -On 1/28/26, the Resident's Foley catheter was changed due to leakage. -On 1/22/26, the Resident's Foley catheter was changed due to leakage. On 3/24/26 at 9:11 A.M., the surveyor observed three large, dried, bright yellow/orange-colored stains on the Resident's floor.ˆ On 3/24/26 at 3:53 P.M., the surveyor observed three large, dried, bright yellow/orange-colored stains on the Resident's floor.ˆ On 3/25/26 at 9:57 A.M., the surveyor observed the three bright yellow/orange-colored large stains on the Resident's bedroom floor. During an interview at this time, Resident #52 said that his/her catheter frequently leaks and that the stains on his/her floor have been there for weeks. On 3/25/26 at 2:06 P.M., the surveyor and the Administrator observed the stains on Resident #52's floor. During an interview at this time, the Administrator said that the Resident's bedroom environment was not home-like. B. Resident #70 was admitted to the facility in October 2021 with diagnoses including dementia, lack of coordination, and unsteadiness on feet. Review of the MDS Assessment, dated 2/26/26, indicated Resident #70: -was severely cognitively impaired as evidenced by a BIMS score of 0 out of 15. -was dependent on staff for Activities of Daily Living (ADLs).ˆ -was always incontinent of urine and bowel.ˆ On 3/24/26 at 9:39 A.M., the surveyor observed Resident #70's room to have a strong odor of feces.ˆ There were dried, dark brown colored stains on the left side of the Resident's bed frame, on the left bed rail, the right side of the mattress, on the tile floor to the right of the bed, and on the floor mat. On 3/24/26 at 3:38 P.M., the surveyor observed Resident #70's room, and there were dried, dark brown colored stains on the left side of the Resident's bed frame, on the left bed rail, the right side of the mattress, on the tile floor to the right of the bed, and on the floor mat. On 3/25/26 at 9:56 A.M., the surveyor observed Resident #70's room, and there were dried, dark brown colored stains on the left side of the Resident's bed frame, on the left bed rail, the right side of the mattress, on the tile floor to the right of the bed, and on the floor mat. On 3/25/26 at 2:10 P.M., the surveyor and the Administrator observed the stains that remained in Resident #70's room on the bed frame, the bed rail, the mattress, the tile floor, and the floor mat. During an interview at this time, the Administrator said that the stains were an infection control concern and that the Resident's room was not a home-like environment.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to coordinate vision care services for one Resident (#62), out of a total sample of 19 residents, increasing the Resident's risk for further deterioration of vision when the Resident, who was diagnosed with diabetes and hypertension, had bilateral cataracts and left eye blindness. Specifically, for Resident #62, the facility failed to schedule vision care appointments and ensure that the Resident was seen and received appropriate treatment to maintain vision abilities, when the Resident consented to and requested vision care services. Findings include:Review of the facility's policy titled Ancillary Physician Services, revised 4/2024, included but was not limited to:-Routine and emergency Optometry services are available to meet the resident's health services by the resident's assessment and plan of care.-Routine and emergency Optometry services are provided to our residents through:>A contract agreement with a licensed optometrist that comes to the facility routinely.>Referral to the resident's personal optometrist.>Referral to community Optometrist or>Referral to health care organizations that provide Optometry services.-The Residents have the right to select an Optometrist of their choice when services are needed.-Selected Optometrist will be available to provide follow-up care per resident's request.-Social services or nursing representatives will assist residents with appointments, transportation arrangements, and for reimbursement of an Optometrist's services under the state plan, if eligible.-All services provided are recorded in the resident's medical records. A copy of the resident's record is provided to any facility to which the resident transferred. Resident #62 was admitted to the facility in February 2026 with diagnoses including Type 2 Diabetes Mellitus, Age-Related Nuclear Cataract Bilateral, Essential Primary Hypertension, and Blindness Left Eye Category 4. Review of Resident #62's current March 2026 Physician's Orders indicated the following: -Atropine drops (drops used to treat eye conditions by blocking the chemical acetylcholine, which relaxes the ciliary muscle of the eye and causes the pupil to dilate) 1 percent (%); amount (amt) 1 drop into Left (L) eye, ophthalmic (eye) twice a Day, 8:00 A.M., 8:00 P.M., initiated 2/2/26.-Brimonidine drops 0.2% (eye drops used to lower high eye pressure associated with open angle glaucoma or ocular hypertension, preventing potential vision loss), amt 1 drop into Right (R) eye, ophthalmic (eye) twice a day, 8:00 A.M., 8:00 P.M., initiated 2/2/26.-Prednisolone Acetate (eye drops used to lower high eye pressure associated with open angle glaucoma or ocular hypertension, preventing potential vision loss) drops suspension 1% amt 1 drop into (L) eye, ophthalmic (eye) four times a day, 8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M., initiated 2/2/26. -Timolol drops (associated with open angle glaucoma or ocular hypertension, preventing potential vision loss) 0.5%; amt: 1 drop into (R) eye; ophthalmic (eye) twice a day, 8:00 A.M., 8:00 P.M., initiated 2/2/26.-Optometrists consult as needed, initiated 2/2/26. Review of the Resident's clinical record included a Request for Service for Eye Care Services signed by the Resident dated 2/2/26.Further review of Nursing admission Record, dated 2/2/26, indicated Resident #62's left pupil was unreactive, due to left eye problem. Review of the Minimum Data Set (MDS) Assessment, dated 2/9/26, indicated Resident #62:-was able to make him/herself understood and understood others. -had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 points.-had severely impaired vision and used corrective lenses.On 3/24/26 at 8:18 A.M., the surveyor observed Resident #62 seated in a stationary chair in his/her bedroom wearing eyeglasses. The Resident said that he/she would like to see the eye doctor for an exam and was blind in his/her left eye. Resident #62 said it was difficult to see with his/her left eye, and he/she required the use of eyeglasses. The Resident said he/she needs an eye examination to get his/her eyeglasses replaced with a different prescription strength to accommodate his/her visual needs. During an interview on 3/25/26 at 12:52 P.M., the Resident said that he/she consented for vision services and treatment upon his/her admission to the facility due to his/her left eye blindness and cataracts in his/her bilateral eyes and had not been provided with an appointment to be seen and he/she is still waiting to see the eye doctor to be evaluated for an (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eyeglasses replacement. During an interview on 3/25/26 at 1:42 P.M., the Administrator said that the facility provides vision services through an outside vendor every four months and as needed. The Administrator said ?as needed' indicated the facility would schedule the service for residents if the resident had consented for the services and has medical conditions that required the resident to be seen and examined earlier than the scheduled routine vision services timeframes. The Administrator further said the vendor for vision services was last in the facility on 10/21/25 and Resident #62 should be on the next scheduled list, but Resident #62 was not.During an interview on 3/25/26 at 3:30 P.M., with the Administrator and the Unit Manager (UM), the Administrator provided a consent form for vision services signed by Resident #62 upon his/her admission to the facility. The Administrator said Resident #62 was not currently on the list for routine vision care services and should have been put on the list for vision service when the Resident consented for vision care. During an interview on 3/26/26 at 8:48 A.M., the Director of Nursing (DON) said nursing staff were responsible for ensuring Resident #62 was added to vision services vendor's list to be seen for the next visit if the Resident had consented for the services. The DON also said that if the residents had their own provider outside the facility, nursing staff would arrange transportation for residents to see the outside provider. The DON said Resident #62 was recently admitted to the facility and he/she should have been put on the vision services vendor list to be seen for the next scheduled visit. The DON said she was unable to provide evidence that Resident #62 was put on the next scheduled vision services list.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for one Resident (#88), out a total sample of 19 residents. Specifically, for Resident #88, the facility failed to obtain a physician's order for a baseline oxygen flow rate, oxygen titration liter flow range, and portable oxygen flow rate when the Resident was diagnosed with chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen use placing the Resident at risk for respiratory complications related to oxygen use.Findings include:Review of the facility's policy titled Oxygen and Nebulizer Setup/Tubing Infection Control Policy & Plan, undated, included the following:*To provide guidelines to prevent the spread of health care acquired infections associated with respiratory therapy equipment and to prevent transmission of infections to residents and staff.-Oxygen Administration>A practitioner's order is required to initiate oxygen therapy, except in an emergency situation.>A practitioner's order should include:-Oxygen (O2) flow rate or fraction of inspired oxygen (FiO2), and, a titration of the oxygen flow rate in order to achieve an acceptable range of peripheral oxygen saturation (SpO2) values, i.e. 88-92 percent (%). In most cases, pulse oximetry is the preferred method of measuring blood oxygen values. -A practitioner is to be contacted as soon as possible after initiation of oxygen therapy in emergency situations for verification and documentation of the necessity for oxygen therapy and to obtain any further orders. Resident #88 was admitted to the facility in June 2025 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Dependence on Supplemental Oxygen, and Unspecified Diastolic Congestive Heart Failure. Review of Resident #88's current Physician's Orders indicated the following:-Oxygen (O2) via Nasal Cannula (NC); maintain O2 above 90 percent (%) PRN (as needed); PRN 1; PRN 2; PRN 3, initiated 9/7/25.-No prescribed baseline oxygen flow rate relative to the use of oxygen and portable oxygen use. Review of the Minimum Data Set (MDS) Assessment, dated 3/5/26, indicated Resident #88:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 points. -received oxygen therapy.Review of the February and March 2026 Medication and Treatment Administration Records (MAR/TAR) failed to indicate documentation of the oxygen flow rate being administered to the Resident. Review of Resident #88's Nursing Progress Notes for February and March 2026, indicated the Resident was administered Oxygen at 2 liters per minute (LPM) via NC. Review of Resident #88's Nursing Admission/readmission Assessment, dated 2/20/26, indicated a respiratory status as Oxygen at 2 liters. Review of Resident #88's Comprehensive Person-Centered Care Plan, initiated 6/12/25, and last revised dated 3/24/26, indicated the following:-May use O2 via NC/Mask to maintain O2 Sat above 90% as needed.-Monitor lung sounds as needed.-Monitor/document respiratory status as needed.On 3/24/26 at 9:00 A.M., the surveyor observed Resident #88 seated in a wheelchair in the common area with Oxygen being administered to the Resident via NC with the oxygen tubing hanging on the side of the wheelchair and not connected to the portable oxygen concentrator. During an interview at this time, the Resident said that he/she does not feel that he/she was receiving Oxygen through the NC. Unit Manager (UM) #1 was present and got Nurse #3. During an interview at the time, Nurse #3 said that Resident #88 was ordered 1.5 LPM of Oxygen as needed. Nurse #3 checked the status of the Resident's oxygen tubing and said that the Resident's portable oxygen concentrator was in use as ordered. The surveyor requested that Nurse #3 review Resident #88's portable oxygen concentrator positioned behind the Resident's wheelchair with the oxygen tubing hanging on the right side of the Resident's wheelchair, not connected to the portable oxygen concentrator. At that time, Nurse #3 connected the oxygen tubing to the portable oxygen concentrator. Nurse #3 said that Resident #88 was at risk for low blood oxygen levels leading to shortness of breath if his/her oxygen tubing was not properly connected to the concentrator. UM #1 said at that time that Resident #88's Oxygen was scheduled as PRN and not as continuous.On 3/24/26 at 3:46 P.M., the surveyor observed Resident #88 seated in a wheelchair in the day room participating in activities with (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	O2 via NC set to 2 LPM. On 3/25/26 at 12:29 P.M., the surveyor observed Resident #88 seated in the dining room in a wheelchair with his/her O2 on via NC and tubing connected to the portable concentrator with the O2 rate set to 2 LPM. The Resident said the O2 was flowing through his/her nose with no concerns. During an interview on 3/25/26 at 12:25 P.M., the Director of Nursing (DON) said Resident #88's oxygen administration orders added should include the flow rate and the tubing connected to the portable concentrator to ensure that the Resident was being administered the Oxygen as ordered. The DON said that nursing staff should document a respiratory assessment when oxygen was being administered to Resident #88. The DON said Resident #88 was at risk for low blood oxygen levels leading to shortness of breath if he/she did not receive Oxygen at the rate ordered by the Physician or if the tubing was not properly connected. On 3/26/26 at 9:20 A.M., the surveyor observed Resident #88 seated in a wheelchair in the common area with his/her portable oxygen concentrator running at 2LPM via the NC. During an interview on 3/26/26 at 9:25 A.M., Certified Nurse Aide (CNA) #5 said Resident #88 uses his/her portable oxygen concentrator and a bedside concentrator every day and continuously during the night hours. During an interview on 3/26/26 at 10:25 A.M., Nurse #3 said she assessed Resident #88's oxygen saturation level prior to the start of her shift and had a reading of 88 to 90% that morning. Nurse #3 said that she administered Oxygen to Resident #88 at 2LPM PRN and should have documented a respiratory assessment for the Resident, but she did not. Nurse #3 and the surveyor reviewed Resident #88's physician's orders and Nurse #3 said that the physician's orders did not include the oxygen flow rate, and it should. Nurse #3 said that she administered Oxygen at 2LPM for Resident #88 and the Resident required the use of Oxygen during both day and night to maintain his/her oxygen saturation rate above 90%. Nurse #3 further said that documentation of respiratory assessment for Resident #88 helps to identify if the oxygen treatment was effective. During an interview on 3/26/26 at 10:35 A.M., the DON said that Resident #88 should have his/her oxygen flow rate included with the physician's orders and a respiratory assessment should be documented on the TAR as administered.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer pneumococcal immunization to one Resident (#119), out of five applicable residents reviewed for pneumococcal immunization in a total sample size of 19 residents. Specifically, the facility staff failed to offer pneumococcal immunization to Resident #119 who was at high risk for pneumococcal infection complications due to a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), had no evidence of prior pneumococcal immunizations in his/her medical record, and pneumococcal immunization had not been identified as medically contraindicated. Findings include: Review of the facility's policy titled Pneumococcal Vaccinations, undated, included but was not limited to the following: -All residents are provided the opportunity and encouraged to receive the pneumococcal vaccinations. -Pneumococcal vaccine will be administered according to the latest guidelines from the Massachusetts Department of Public Health issued each year. -The program coordinator .will be responsible to research the medical record and history to determine if the pneumococcal vaccinations have ever been given. -The program coordinator maintains a file of current residents showing status of vaccination. >after determining the resident has no history of receiving the pneumococcal vaccine, the nursing staff will obtain an order for the vaccine from the resident's Physician. >for residents previously vaccinated, record date in resident's comprehensive assessment. Resident #119 was admitted to the facility in November 2018 with diagnoses including COPD and Dependance on Supplemental Oxygen.Review of Resident #119's Minimum Data Set (MDS) Assessment, dated 1/2/26 included but was not limited to the following: -the Resident's Pneumococcal vaccination was not up to date and pneumococcal vaccination had not been offered to the Resident. Review of Resident #119's March 2026 Physician's Orders indicated: -the Resident had an invoked Health Care Proxy (HCP- an appointed person to make health care decisions for someone when they cannot do so for themselves), with a start date of 7/22/22. Review of the Resident's medical record failed to indicate that pneumococcal vaccination had been offered, declined, or contraindicated. During an interview on 3/25/26 at 2:54 P.M., the Infection Preventionist (IP) said that she was responsible to oversee the vaccination status for Resident #119. The IP said Resident #119 did not have evidence in the medical record that pneumococcal vaccination had been offered, declined or contraindicated. The IP said Resident #119's HCP should have been contacted for pneumococcal immunization consent so the vaccine could be administered. The IP said Resident #119 was at high risk for pneumonia complications due to the diagnosis of COPD.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to offer COVID-19 immunization to one Resident (#119), out of five applicable residents reviewed for COVID-19 vaccination in a total sample size of 19 residents. Specifically, the facility staff failed to offer COVID-19 immunization to Resident #119 who was at high risk for COVID-19 infection complications due to a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), had no evidence of prior 2025-2026 COVID-19 variant immunizations in his/her medical record, and COVID-19 vaccinations had not been identified as being medically contraindicated. Findings include: Resident #119 was admitted to the facility in November 2018 with diagnoses including COPD and Dependance on Supplemental Oxygen.Review of Resident #119's Minimum Data Set (MDS) Assessment, dated 1/2/26, included but was not limited to the following: -the Resident's COVID-19 vaccination was not up to date. Review of Resident #119's March 2026 Physician's Orders indicated: -the Resident had an invoked Health Care Proxy (HCP- an appointed person to make health care decisions for someone when they cannot do so for themselves), with a start date of 7/22/22. Review of the Resident's medical record indicated the following: -Resident #119 had last received COVID-19 immunization on 3/2/23. Further review of the Resident's medical record failed to include that COVID-19 Spikevax immunization had been offered, declined, or contraindicated. During an interview on 3/25/26 at 2:54 P.M., the Infection Preventionist (IP) said that she was responsible to oversee the vaccination status for Resident #119. The IP said Resident #119 did not have evidence in the medical record that COVOID-19 vaccination had been offered, declined, or contraindicated for the 2025-2026 Spikevax variant. The IP said Resident #119's HCP should have been contacted for COVID-19 immunization consent so the vaccine could be administered. The IP said Resident #119 was at high risk for COVID-19 complications due to the diagnosis of COPD.