STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225452	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Village	18 Dana Hill Road Sterling, MA 01564

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for indwelling urinary catheters for three Residents (#15, #157 and #114), of six applicable residents, out of a total sample of 28 residents, increasing the Residents risk for indwelling urinary catheter complications.Specifically, the facility failed to:1. for Resident #15, replace the Resident's indwelling urinary catheter with the correct sized catheter as ordered by the Physician during the scheduled monthly catheter change, and secure the urinary drainage bag away from contaminated surfaces. 2. for Resident #157, maintain/secure the urinary drainage bag away from contaminated surfaces.3. for Resident #114, replace the Resident's indwelling urinary catheter with the correct sized balloon during the Resident's Physician ordered monthly indwelling urinary catheter change, increasing the Resident's risk for indwelling urinary catheter complications. Findings include:Review of the facility's policy titled Indwelling Urinary Catheter, revised 10/1/15, indicated the following: -A physician's order must be obtained for insertion of an indwelling (urinary) catheter. -The order must include the catheter size, balloon size, and frequency of change. Review of the facility's policy titled, Urinary Catheters, revised 10/1/25, indicated: -preventative measures for controlling common infections are a critical component of the overall plan of care for residents with a urinary catheter. -do not allow the catheter tubing, bag, or spigot to touch the floor. 1. Resident #15 was admitted to the facility in March 2020 with diagnoses including obstructive and reflux uropathy. Review of Resident #15's December 2025 Physician's orders indicated an order for: -Suprapubic catheter 18 FR (French: size) 10 cc (cubic centimeters measurement) balloon (inflatable device used to anchor the indwelling urinary catheter in the bladder). Change suprapubic tubing every 30 days and as needed for blockage, leakage or ill findings that require new tubing, every night shift every 30 days as needed for catheter care, dated 4/22/25. Review of Resident #15's Care Plans, last revised 6/18/25, indicated: -the Resident will remain free of catheter related trauma through review date. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-16 FR, 10 cc changed monthly. -treatment as ordered. Review of the Minimum Data Set (MDS) Assessment, dated 11/13/25, indicated Resident #15: -was unable to complete the Brief Interview of Mental Status (BIMS) examination and had severely impaired cognitive skills for daily decision making. -was dependent for toileting. -had an indwelling urinary catheter. Review of Resident #15's December 2025 Treatment Administration Record (TAR) indicated the Resident's indwelling urinary catheter was changed on 12/7/25, to an 18 FR 10 cc [NAME]. Further review of the December 2025 TAR failed to indicate that the Resident's indwelling urinary catheter had been changed again any time after 12/7/25. On 12/18/25 at 8:06 A.M., the surveyor and Unit Manager (UM) #2 observed Resident #15 resting in bed which was in the low position with the urinary catheter drainage bag laying on the floor. The surveyor and UM #2 observed the Resident's current urinary catheter size to be 14 FR 10 cc balloon. During an interview at the time, UM #2 said that the Resident's catheter drainage bag should not be on the floor as it can lead to infection control issues. UM #2 also said that the Resident's catheter size should be an 18 Fr 10cc balloon as documented in the Physician's orders, and it was not, and the 14 Fr tube could potentially leak. UM #2 said that the Resident's catheter had been changed in the facility and not at Urology. 2. Resident #157 was admitted to the facility in December 2025 with diagnoses including obstructive and reflux uropathy. Review of Resident #157's Physician's orders for December 2025 indicated: -urinary catheter drainage bag, ensure Foley privacy bag is in place, start date 12/12/25. -change suprapubic catheter 24 FR 10 cc bulb (balloon) every 8 hours as needed for occlusion or leakage as needed, start date 12/12/25. Review of Resident #157's Care Plan for suprapubic catheter, initiated 12/16/25 indicated that the Resident will show no signs or symptoms of urinary infection through review date. On 12/17/25 at 9:14 A.M., the surveyor observed Resident #157 resting in bed with the urinary catheter bag that was touching the floor. On 12/18/25 at 7:56 A.M., the surveyor and UM #2 observed Resident #157 resting in bed with the urinary catheter drainage bag secured to the opposite side of the bed and laying on the Resident's floor mat. During an interview at the time, UM #2 said that the urinary drainage bag should not be laying on the mat due to potential for infection control concerns. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/25 at 10:39 A.M., the Director of Nursing (DON) said that the urinary drainage bags should not have been on the floor as it could potentially lead to an infection control issue. The DON also said that a smaller sized catheter than ordered by the Physician could lead to a potential in increased changes with the Resident's care, occlusion and leakage. 3. Resident #114 was admitted to the facility in May 2025 with diagnoses including neuromuscular dysfunction of the bladder. Review of Resident #114's active Physician Orders indicated the following: -Urinary catheter care every shift 16 FR 10 cc balloon, dated 5/6/25. -Catheter change monthly and as needed for accidental dislodgement, blockage, or leakage, in the evening, starting on the eleventh and ending on the eleventh every month, dated 8/11/25. Review of Resident #114's Indwelling Urinary Catheter Care Plan, initiated 5/9/25 and revised 12/4/25, indicated the following: -The Resident required the use of an indwelling urinary catheter due to urinary retention. -The Resident's catheter was a size 16 FR with a 10 cc balloon. Review of Resident #114's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -The Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15 total possible points. -The Resident required substantial/maximal assistance for lower body bathing and toileting. -The Resident had an indwelling urinary catheter. Review of Resident #114's December 2025 Treatment Administration Record (TAR) indicated the Resident's indwelling urinary catheter was changed on 12/11/25. Further review of the December 2025 TAR failed to indicate the Resident's indwelling urinary catheter had been changed again any time after 12/11/25. On 12/17/25 at 9:30 A.M., the surveyor observed Resident #114 was sitting in a wheelchair, facing his/her bed, and his/her legs were extended with his/her feet on the bed. The surveyor observed the Resident was wearing shorts, and a urinary catheter drainage tube was extended from under the Resident's shorts to a drainage collection bag that was positioned under the Resident's wheelchair. During an interview at the time, the Resident said that he/she required the use of an indwelling urinary catheter and that facility staff were supposed to change his/her indwelling urinary catheter monthly. On 12/19/25 at 3:35 P.M., the surveyor observed Resident #114's room lying uncovered on his/her bed, dressed in a t-shirt and shorts. The surveyor observed a urinary catheter drainage tube extending out from under the Resident's shorts to a drainage collection bag that was attached to the Resident's (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedframe. At this time, Nurse #1 asked the Resident if she could observe his/her catheter size and the Resident agreed. During an interview at the time, Nurse #1 said that the Resident's indwelling urinary catheter size was 16 Fr with a 5 cc balloon. Nurse #1 said that the Resident's indwelling urinary catheter balloon was the wrong size. Nurse #1 said the [NAME] size should have been a 10 cc balloon, not a 5 cc balloon. Nurse #1 further said that the catheter balloon size was important because a catheter balloon size that was too small could cause the urinary catheter to move out of place and could result in blockage of urine. The surveyor and Nurse #1 reviewed the facility's Central Supply Closet immediately following the interview and observed that there were six 16 Fr indwelling urinary catheters with 10 cc ballons. At this time, Nurse #1 said all Nurses had access to the facility's Central Supply Closet. During an interview on 12/18/25 at 4:45 P.M., the DON said that the facility did not have a shortage of indwelling urinary catheter supplies. The DON said the Nurse should have obtained the proper size indwelling urinary catheter and balloon to replace Resident #114's indwelling urinary catheter on 12/11/25.

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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, and interviews, the facility failed to maintain a clean and homelike environment for two Residents (#10 and #59) out of a total sample of 27 residents, and on one unit (Aspen Unit) out of three units observed.Specifically, the facility staff failed to ensure:-for Resident #10, that the Resident's enteral tube feeding (nutritional supplement provided through a tube to the stomach) equipment was maintained in a clean and sanitary manner.-for Resident #59, that the Resident's enteral tube feeding equipment pump and pole, and the Resident's upper left side bed rail located next to the feeding equipment was maintained in a clean manner. Findings includeReview of the facility policy titled Maintaining a Clean Environment, dated 9/1/04, indicated:-Items that collect dust or secretions may harbor microorganisms that can colonize and infect susceptible residents or be inhaled by employees performing cleaning tasks.-In certain areas, housekeeping will not be responsible for the care of specific fixtures and furnishings. These items may be the responsibility of Nursing Services, Dietary or Physical Therapy employees.-Establish a routine cleaning schedule for cleaning walls, floors, window frames, fixtures and furniture. Note: Clean obviously soiled items/areas between scheduled times. -Wash bed frames and mattresses using a disinfectant solution. -Clean furniture from top to bottom. Remove loose dirt and debris before washing or mopping. On 12/17/25 at 7:58 A.M., the surveyor observed multiple splattered, dried brown material on Resident #10's feeding tube pump. On 12/17/25 at 8:12 A.M., the surveyor observed multiple splattered, dried brown material on Resident #59's feeding tube pump and pole and the Resident's upper left side bed rail. On 12/18/25 at 7:27 A.M., the surveyor observed multiple splattered, dried brown, material on Resident #10's feeding tube pump. On 12/18/25 at 7:46 A.M., the surveyor observed multiple splattered, dried brown, material on Resident #59's feeding tube pump and pole and upper left side bed rail. On 12/22/25 at 7:31 A.M., the surveyor and Unit Manager (UM) #1 observed both Resident #10's tube feeding pump and Resident #59 feeding pump and pole and upper left side bed rail. The surveyor observed that both Resident's feeding tube equipment remained the same as previously observed with multiple areas of dried brown splattered material. During an interview at the time, UM #1 said that nursing staff were responsible for cleaning up all drips and spills on any Resident's medical equipment. UM #1 said if nursing staff were unable to get spills/stains off the equipment, then the nursing staff should notify housekeeping staff for assistance. UM #1 also said that the equipment for Resident #10 and Resident #59 had not been cleaned and should have been. During an interview on 12/22/25 at 7:59 A.M., the Director of Nursing (DON) said that all Resident equipment should be cleaned when the items become visibly soiled.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide Activity of Daily Living (ADL - basic care tasks that an individual requires on a day-to-day basis such as grooming, eating, bathing, and dressing) care to one Resident (#127), of three applicable residents, out a total sample of 27 residents. Specifically, for Resident #127, the facility failed to provide grooming services for facial hair removal when the Resident's preference was daily facial hair removal and he/she was dependent on staff for assistance, causing a decrease in the Resident's quality of life. Findings include: Review of the facility policy titled Residents Rights, dated 9/1/04 included but was not limited to the following: Purpose: to promote the safety, comfort and well-being of all residents in the facility: >As a nursing home/rest home resident you have the right to be treated with dignity. Review of the facility policy titled A.M. Care, dated 9/1/04 included but was not limited to: Purpose: To facilitate resident's overall comfort, cleanliness, grooming >Encourage or assist the resident to be as independent as possible. Resident #127 was admitted to the facility in July 2021 with diagnoses including muscle weakness and Hemiplegia (paralysis of one side of the body)/Hemiparesis (weakness of one side of the body) Affecting Dominant Right Side. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #127: -had severe cognitive impairment as indicated by a Brief Interview for Mental Status (BIMS) score of six out of a total possible score of 15 points. -was understood by others and could understand others. -had functional limitation in range of motion to one side of the upper extremity and one side of the lower extremity. -had not demonstrated rejection of care. -was dependent for personal hygiene. Review of Resident #127's ADL Person-Centered Care Plan, revised 11/4/25 included but was not limited to the following: -The Resident had self-care deficit related to right sided hemiparesis and weakness. -The Resident needed substantial/maximal assistance to dependence for personal hygiene. -The Resident's level of assistance required for ADL care may vary depending upon fatigue levels. On 12/17/25 at 8:54 A.M., the surveyor observed Resident #127 seated at the bedside in a wheelchair, dressed in a shirt, pants, socks and shoes. The surveyor also observed the Resident's face presented with short stubble hairs to the upper lip and chin. During an interview at the time, the Resident said he/she would like the hairs to be shaved but was unable to do it him/herself. On 12/18/25 at 3:46 P.M., the surveyor observed Resident #127 seated at the bedside, dressed for the day. The surveyor observed hair remaining to his/her upper lip, chin and also present at the bilateral jawline. During an interview at the time, Resident #127 said that he/she had not been offered or assisted with facial hair removal and would like to be shaved. On 12/22/25 at 8:36 A.M., the surveyor observed Resident #127 dressed for the day, seated at the bedside in a wheelchair and eating breakfast. The surveyor observed Resident #127 to have longer hair growth present to the upper lip, bilateral jaw lines and chin compared to the last observation on 12/18/25. During an interview at the time Resident #127 said that he/she had not been offered to have the facial hair removed. Resident #127 said that he/she did not like the scruff on his/her face and wanted all the facial hair to be shaved. During an interview on 12/22/25 at 8:56 A.M., Certified Nurse Aide (CNA) #1 said she was the CNA assigned to Resident #127 and that Resident #127 was assisted out of bed at 6:00 A.M. each day with help from the night shift (11:00 P.M.-7:00 A.M.) nursing staff. CNA #1 said the night shift staff were responsible to get the Resident washed, dressed, provide hygiene, and out of bed to his/her wheelchair. CNA #1 said Resident #127 was dependent for hygiene including shaving. The surveyor and CNA #1 observed Resident #127's face which remained with facial hair to the upper lip, chin and bilateral jaw lines. CNA #1 said that the Resident's facial hair appeared to have gone several days without being shaved. CNA #1 said that shaving of facial hair should be offered to the Resident daily. During an interview on 12/22/25 at 9:11 A.M., the Director of Nursing (DON) said removal of facial hair should be offered daily with morning care. The DON said not providing shaving to Resident #127, who wants to be shaved, would be a dignity concern.