STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225458	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairhaven Healthcare Center	476 Varnum Avenue Lowell, MA 01854

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all services provided for two Residents (#8 and #69), out of a total sample of 29 residents, met professional standards of quality. Specifically:1) For Resident #8 the facility failed to follow a physician-ordered hypoglycemic protocol by failing to re-check blood sugar or notify the physician when the Resident's blood sugar was less than 60 mg/dL (milligrams per deciliter).2) For Resident #69 the facility failed to follow Physician orders for offloading the Residents' heels. Findings include: 1) According to the Merk Manual Professional Version (revised October 2023) a plasma glucose (sugar) level of less than 70 mg/dL (milligrams per deciliter), in patients treated with glucose-lowering medications such as insulin, is considered hypoglycemia and should be treated to avoid a further decrease in blood glucose and consequences of hypoglycemia. Review of the facility policy, titled Hypoglycemia – Clinical Management of dated January 2025, indicated, but was not limited to, the following: -Hypoglycemia is defined as finger stick or serum glucose less than 60 mg/dL. - If a resident has a low blood sugar (hypoglycemia): - Perform glucose by finger stick: If less than 60 mg/dL recheck finger stick. If repeat finger stick remains below 60 mg/dL, institute the following unless a physician's order dictates otherwise. - If the resident is responsive and able to swallow, give 15 grams of rapidly absorbed carbohydrates. This includes four ounces of orange or apple juice, or eight ounces of skim milk or three graham crackers. - Recheck blood sugar 15 minutes after treatment. If the resident's blood sugar remains the same, has decreased or if the resident has a change in level of consciousness, administer IM (intramuscular) or SC (subcutaneous) glucagon (a hormone produced by the pancreas that plays a crucial role in regulating blood sugar levels), as ordered by the physician. Continue to check the blood sugar every 15 minutes until greater than 70 mg/dL. - Notify physician for further directions. Review of the facility policy, titled Notification to Physician for Change of Status Policy, dated March 2024, indicated, but was not limited to, the following: - - Nursing staff must notify the attending physician (or covering provider during evenings, nights, (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weekends, or holidays) immediately of: o Significant changes in a resident's medical condition. - - All notifications to the physician (or covering provider) must be documented in the Electronic Medical Record (EMAR) including: o Time and date of notification o Name of the provider contacted o Summary of the residents' condition and change in status. o Provider's response, orders received, and follow-up actions. Review of the facility's quality control log for blood glucometer readings dated August and September 2025 indicated there were no significant variances and that the facility's glucometers were accurate and functioned normally. Resident #8 was admitted to the facility in March 2018 with a diagnosis of type two diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/10/25, indicated that Resident #8 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 12 out of 15. Review of Resident #8's care plan indicated that the Resident had a nutritional problem related to a history of type two diabetes with the following intervention: - - Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness – initiated on 09/07/2023 Review of Resident #8's physician orders indicated the following active order: - - For Blood Sugar under 60, but responsive and able to swallow administer a carbohydrate snack. Recheck blood sugar every 15 minutes until blood sugar is greater than 70 (mg/dL) - Notify MD for blood sugar less than 60. No orange juice for dialysis residents - initiated 8/13/2023. Review of Resident #8's blood sugar levels indicated the following: - - On 8/7/25 at 7:21 A.M. Nurse #1 recorded a blood sugar level of 56.0 mg/dL - - On 8/28/25 at 11:21 A.M. Nurse #1 recorded a blood sugar level of 56.0 mg/dL - - On 9/1/25 at 8:00 A.M. Nurse #3 recorded a blood sugar level of 53.0 mg/dL - - On 9/11/25 at 7:55 A.M. Nurse #3 recorded a blood sugar level of 56.0 mg/dL Review of Resident #8's progress note, dated 8/7/25 and written by Nurse #1, indicated that the Resident had a blood sugar level of 56 mg/dL and that orange juice was given. Further review of the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress note failed to indicate that the blood sugar was re-checked in 15 minutes or that the physician was notified. Review of Resident #8's progress note, dated 8/28/25 and written by Nurse #1, indicated that the Resident had a blood sugar level of 56 mg/dL and that orange juice was given. Further review of the progress note failed to indicate that the blood sugar was re-checked in 15 minutes or that the physician was notified. Review of Resident #8's progress note, dated 9/1/25 and written by Nurse #3, indicated that the Resident's blood sugar was 53 mg/DL, that orange juice was given and that blood sugar was re-checked and within normal limits. Further review of the progress note failed to indicate that the physician was notified. Review of Resident #8's medical record failed to indicate that orange juice was provided, that the blood sugar was re-checked, or that the physician was notified after Nurse #3 recorded a blood sugar reading of 56 mg/dL on 9/11/25. Review of the Medication Administration Record (MAR) failed to indicate that nurses marked the following order as completed following blood sugar readings of less than 60 mg/dL on 8/7/25, 8/28/25, 9/1/25, or 9/11/25: - For Blood Sugar under 60, but responsive and able to swallow administer a carbohydrate snack. Recheck blood sugar every 15 minutes until blood sugar is greater than 70 (mg/dL) - Notify MD for blood sugar less than 60. No orange juice for dialysis residents. During an interview on 9/25/25 at 12:18 A.M. Nurse #1 said that when a Resident has a blood sugar below 60 mg/dL that nursing should administer orange juice or crackers and should notify the physician. Nurse #1 said that he provided orange juice on 8/7/25 and 8/28/25 in response to Resident #8's low blood sugar readings but did not re-check the Resident's blood sugar; Nurse #1 did not recall if he had notified the physician of the Resident's low blood sugar readings. During an interview on 9/25/25 at 11:33 A.M. Nurse #3 said that if a Resident's blood sugar fell below 70 mg/dL that nursing should provide orange juice and re-check the blood sugar in 15-30 minutes; Nurse #3 said this would be documented. Nurse #3 said she did not notify the physician or Nurse Practitioner about Resident #8's low blood sugar readings on 9/1/25 or 9/11/25. During an interview on 9/25/25 at 11:49 A.M. Unit Manager #4 said that if a Residents blood sugar was below 60 mg/dL that she would expect the nurse to provide a carbohydrate heavy snack and orange juice, notify the provider and re-check every 15 minutes and that this would be documented in the electronic medical record. Unit manager #4 said she was not aware of Resident #8's low blood sugar levels on 8/7/25, 8/28/25, 9/1/25, or 9/11/25 and did not notify the physician or nurse practitioner but would have expected the Nurse to have done so. During an interview on 9/25/25 at 11:55 A.M. Nurse Practitioner (NP) #1 said she would expect nurses to follow the physician-ordered hypoglycemic protocol. NP #1 said she is on call and available to be notified by staff of medical changes from 7 A.M. until 5 P.M. NP #1 said she was not notified about Resident #8's blood sugar readings on 8/7/25, 8/28/25, 9/1/25, or 9/11/25. NP #1 said she would have especially expected to be notified of Resident #8's low blood sugar levels as they have been happening so often and that this was a significant issue for this Resident; NP #1 said the risk of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not following the hypoglycemic protocol for a Resident with low blood sugar is that if the blood sugar was low enough and did not come back up the Resident would be at risk for coma. During interview on 9/25/25 at 2:40 P.M. and 9/26/25 at 9:29 A.M., the Physician said she would expect nurses to follow the physician-ordered hypoglycemic protocol. The physician said that NP #1 would have been the provider to be notified about the blood sugar readings on 8/7/25, 8/28/25, 9/1/25 and 9/11/25 as the Physician did not work on those days. The physician said the provider should have been called for blood sugars of less than 60 mg/dL and that this should have been documented. The Physician said if a Resident with low blood sugar did not receive the hypoglycemic protocol that the Resident could become more hypoglycemic. During an interview on 9/26/25 at 9:55 A.M. the Director of Nursing (DON) said that if a Resident had a blood sugar of less than 60 mg/dL that the nurse should provide the Resident with orange juice, notify the physician, and re-check the blood sugar level in 15 minutes. The DON said that she would expect nursing to document in the medication administration record if the hypoglycemic protocol was initiated. 2.) Resident #69 was admitted to the facility in October 2022 with diagnoses including end stage renal disease, muscle weakness and type 2 diabetes. Review of Resident #69's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 9 out of possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The MDS further indicated the Resident was at increased risk of pressure ulcer development. On 9/24/25 at 8:53 A.M., the surveyor observed the Resident lying in his/her bed with heels directly on the mattress. On 9/25/25 at 8:30 A.M., the surveyor observed the Resident lying in his/her bed with heels directly on the mattress. During an observation and interview on 9/26/25 at 11:25 A.M., the surveyor observed the Resident lying in his/her bed with heels directly on the mattress. The Resident said he/she has not been wearing the heel boots since his/her heels wounds healed. Review of the Resident's current physician orders indicated the following: -Dated 2/24/25, Off-load heels with floating booties when in bed every shift for red boggy heels. -Dated 4/21/23, Elevate left heel off mattress with heel boot while in bed every shift for prevention wear multipodus while in bed. -Dated 9/19/25, Skin prep to left heel every shift document appearance. Review of care plan date initiated 10/25/24: Resident has potential alteration in skin integrity related to comorbidities. Intervention dated 9/16/25: Apply heel booties when in bed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/25 at 11:31 A.M., Certified Nursing Assistant (CNA)#4 said he had provided morning care to the Resident. He said Resident #69 did not have heel booties and he did not see them in the room. During an interview on 9/26/25 at 11:32 A.M., Nurse #3 said the Resident has orders for heel booties while in bed and he/she should have them on. During an interview on 9/26/25 at 11:49 A.M., the Director of Nursing said the orders should be followed and nurses should ensure the heel booties are applied.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and interview the facility failed to provide a dignified dining experience for two Residents (#49 and #107) out of a total sample of 29 residents. Specifically:1. For Resident #49, the facility failed to ensure a dignified dining experience.2. For Resident #107, the facility failed to ensure a dignified dining experience and referred to the Resident as a feeder, rather than by his/her preferred name. Findings include:The facility policy titled Resident Dignity, dated June 2024, indicated:-Residents shall be treated with respect at all times. -A dignified dining experience is provided to all residents. -Staff must address residents by their preferred name and never by diagnosis, room number or care needs. 1. For Resident #49 the facility failed to ensure a dignified dining experience. Resident #49 was admitted to the facility in April 2025 and has diagnoses that include Alzheimer's disease, dementia without behavioral disturbance and osteoarthritis of the shoulders. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/25/25, indicated Resident #49 is rarely understood and was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #49 requires set-up or cleaning assistance with eating. Review of the most recent Nutrition Risk Assessment, dated 8/25/25, indicated Resident #49 eats w(with) /continual supervision, assistance as he/she allows. Review of the Activities of Daily Living care plan, dated as revised 9/2/25, indicated Resident #49 had the following interventions:-Eating: Continual supervision with assistance as resident allows;-Utilize task segmentation as indicated to help improve ADL participation.-Provide the amount of staff intervention that is needed for task completion with self-performance fluctuations Review of the most recent Quarterly Functional Abilities Assessment, dated 7/10/25, indicated Resident #49 is dependent on staff for eating. On 9/24/2025 at 8:55 A.M., Resident #49 was observed seated at a table in the unit dining room, facing the wall with his/her back to the staff in the room. Resident #49 had a breakfast plate in front of him/her and was eating scrambled eggs ands toast covered with jelly with his/her hands. Resident #49 had jelly all over his/her hands and was licking his/her fingers that were covered in eggs and jelly. There were utensils present, as well as several staff present in the dining room however staff were assisting other residents and provided no cues to use utensils and offered no assistance with the meal. On 9/24/2025 sat 12:27 P.M., Resident #49 was observed seated at a table in the unit dining room with a plate of lunch directly in front of him/her. Resident #49 had utensils available however was observed to be eating salad with his/her hands. There were 6 staff present in the dining room but none were supervising Resident #49 or providing cues to use the utensils and no assistance was offered. The surveyor continued to make the following observations:-Between 12:27 P.M., and 12:31 P.M. Resident #49's hands became covered in pizza sauce and salad dressing and he/she was licking the food off of his/her hands. On 9/25/2025 at 8:19 A.M., Resident #49 was observed seated at a table in the unit dining room. Staff placed a breakfast plate in front of him/her that included scrambled eggs, toast, a cinnamon bun and oatmeal. There was a spoon placed on the plate beside the eggs. The surveyor continued to make the following observations:-At 8:36 A.M., Resident #49 stuck his/her fingers into the scrambled eggs then licked them. There were several staff present in the dining room, however no one cued Resident #49 to use his/her utensil and no assistance was offered. Throughout the observation between 8:19 A.M., and 8:36 A.M., staff did not offer assistance with feeding or cueing to use utensils when he/she ate non-finger like food with his/her hands. On 9/25/2025 at 12:09 P.M., Resident #49 was observed seated at a table in the unit dining room. Staff placed a lunch plate in front of him/her that included macaroni and cheese and a chicken thigh. After placing the lunch and a fork in front if Resident #49 the staff person walked away and Resident #49 began eating the macaroni and cheese with his/her hands. The surveyor continued to make the following observations:-At 12:10 P.M., a staff person stood beside Resident #49 setting up his/her tablemate with lunch. While doing so Resident #49 ate the macaroni and cheese with his/her hands. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The staff person offered no assistance to Resident #49 and no cues to use a utensil.-At 12:14 P.M., a staff person again stood beside Resident #49 and cut up the tablemate's food. While doing so Resident #49 ate the macaroni and cheese with his/her hands. The staff person offered no assistance to Resident #49 and no cues to use a utensil.Throughout the observation between 12:09 P.M., and 12:14 P.M., staff did not offer assistance with feeding or cueing to use utensils when he/she ate non-finger like food with his/her hands. 0n 9/26/2025 at 8:24 A.M., Resident #49 was observed seated at a table in the unit dining room. Staff placed a breakfast plate in front of him/her that included toast, oatmeal and scrambled eggs. The surveyor continued to make the following observations. -Between 8:24 A.M., and 8:34 A.M., Resident #49 made no attempts to self feed. At 8:34 A.M., he/she attempted to use a spoon to eat the eggs, however as Resident #49 lifted the spoon to his/her mouth the eggs fell onto the table and Resident #49 used his/her hands to eat the eggs off of the table.-At 8:41 A.M., Resident #49 picked up a butter container and ate the butter by licking it off his/her fingers. At that time there were 8 staff present in the dining room and no cueing or assistance was provided.-At 8:43 A.M., after consuming the butter container with his/her fingers, Resident #49 picked up a jelly container and ate the jelly by licking it off his/her fingers.Throughout the observation between 8:24 A.M., and 8:43 A.M., staff did not offer assistance with feeding or cueing to use utensils when he/she ate non-finger like food with his/her hands. During an interview with the Nurse Unit Manager #3 on 9/26/2025 at 9:58 A.M., she said that it is her expectation that if a resident has variable ability to self feed and staff observe the resident struggling to eat or eat non finger foods such as eggs, or macaroni and cheese with their hands that the staff intervene and offer assistance, cue the resident to use a utensil or offer a meal that is finger food such as a sandwich. During an interview with Resident #49's Certified Nursing Assistant (CNA) #3 on 9/26/2025 at 10:17 A.M., she said that Resident #49 sometimes needs assistance with meals because he/she tires. CNA #3 said that if the staff notice Resident #49 using his/her hands while eating they try to help him/her or give him/her a spoon. CNA #3 added that Resident #49 should be receiving finger foods for meals because he/she forgets a lot and eats things with his/her hands that he/she shouldn't. During an interview with the Director of Nursing (DON) on 9/26/2025 at 1:01 P.M., she said that it is her expectation that if a resident is struggling to eat and eating non-finger food with their hands, staff should intervene as it is not a dignified dining experience. 2. For Resident #107, the facility failed to ensure a dignified dining experience and referred to the Resident as a feeder, rather than by his/her preferred name. Resident #107 was admitted to the facility in September 2024 and has diagnoses that includes Alzheimer's disease, epilepsy and weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/11/25, indicated that Resident #107 rarely is understood and is assessed by staff to have severely impaired cognition. The MDS further indicates that Resident #107 has no behavior of rejecting care and is dependent on staff for eating assistance. Review of the Functional Abilities and Goals Assessment, dated 9/23/25, indicated Resident #107 is dependent on staff for eating assistance. Review of the Activities of Daily Living care plan, dated as revised 9/23/25, indicated Resident #107 requires assist of one for eating. On 9/24/2025 at 8:32 A.M., Resident #107 was observed seated in a recliner chair in the unit dining room. There was a covered breakfast plate placed directly in front of him/her. Resident #107 was observed to lean forward and attempt to take the cover off the food, however as he/she did so, a staff person walked by, said in a little while and pushed the plate of food out of reach. The surveyor continued to make the following observations: -At 8:37 A.M. a Certified Nursing Assistant (CNA) sat beside Resident #107, facing his/her tablemate and assisted the tablemate with their meal. No assistance was offered to Resident #107 and his/her plate of food remained covered and out of reach.-At 8:39 A.M., Resident #107 looked multiple times at his/her covered plate of food and then at the staff assisting the table mate. He/she remained without any assistance. On 9/24/2025 at 12:23 P.M., Resident #107 was observed seated in a recliner chair in the unit dining room. A staff person placed a covered plate of food in front of Resident #107 and walked away without offering assistance. The surveyor continued to make the following (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observations: -At 12:29 P.M., Resident #107 leaned forward and tried to take the cover off the plate of food but was unable to do so. He/she sat back in the chair and watched a tablemate be fed their meal. On 9/25/2025 at 8:13 A.M., Resident #107 was observed seated in a recliner chair in the unit dining room with 2 tablemates. All three residents had drinks however Resident #107s were placed out of reach. The surveyor continued to make the following observations: -At 8:17 A.M., Resident #107 watched as a CNA stood beside him/her feeding a tablemate. The staff person did not offer Resident #107 any assist with the covered beverages placed in front of him/her.-At 8:27 A.M., a CNA placed a covered plate of food in front of Resident #107 and walked away without offering assistance.-Between 8:27 A.M., and 8:32 A.M., Resident #107 watched on as the CNA assisted his/her tablemates, while he/she sat there with a covered plate of food in front of him/her. -At 8:32 A.M., a CNA sat down beside Resident #107, and using her hands tore apart piece of toast and placed it in Resident #107's oatmeal and began feeding him/her. On 9/25/2025 at 12:07 P.M., Resident #107 was observed seated in a recliner chair in the unit dining room with 3 tablemates. All 4 residents had drinks however Resident #107s chair was reclined back at a 45 degree angle and the drink was out of reach. On 9/26/25 at 8:25 A.M., Resident #107 was observed seated in a recliner chair in the unit dining room waiting for breakfast. -At 8:27 A.M., a CNA placed a covered bowl of oatmeal in front of Resident #107 and walked away.-At 8:30 A.M., a CNA sat down to assist Resident #107's tablemate with breakfast. Resident #107 say with a covered bowl of oatmeal in front of him/her watching. -At 8:31 A.M., a CNA placed plate of scrambled eggs and toast on the table in front of Resident #107 but out of reach and walked away. Resident #107 looked at the plate of food then watched on as his/her tablemate was fed. -At 8:34 A.M., a CNA placed a cover on top of Resident #107's plate of food and walked away.-At 8:39 A.M., a CNA sat down beside Resident #107, and while laughing and talking to another staff person at table, placed a spoonful of oatmeal in Resident #107's mouth. During an interview with the Nurse Unit Manager #3 on 9/26/2025 at 9:55 A.M., she said that Resident #107 is dependent on staff for all care, including feeding. Nurse Unit Manager #3 said that is is her expectation that residents that require feeding assist not have their food placed in front of them until the staff are ready to sit down and provide the assistance. Nurse Unit Manager #1 said that she prefers that resident's who require feeding assistance be seated together and be fed at the same time because the residents should not have to watch tablemates be fed while they wait for assistance. During an interview with Resident #107's CNA #2 on 9/26/2025 at 10:05 A.M., she said that Resident #107 is dependent on staff for all aspects of care, including meals. CNA #2 said that Resident #107 is a feeder we try to put all the feeders at the same table because we should not serve them until they are ready to eat. CNA #2 said that she remembers being told at one time she should not to refer to residents as feeders, but by their name. During a follow-up interview with the Nurse Unit Manager #3 on 9/26/2025 10:17 A.M., she said that staff should mot be referring to residents as feeders but by their name. Nurse Unit Manager said that she has a lot of new staff that still need education. During an interview with the Director of Nursing (DON) on 9/26/2025 at 1:01 P.M., she said that it is her expectation that staff should serve food when they are ready to provide feeding assistance and that dependent residents should not have to sit at the table watching others eat while waiting with food in front of them. As well, the DON said that staff should refer to residents by their name, not by their care need.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interviews, the facility failed to ensure one Resident, (#77) was free from unnecessary psychotropic medication, out of a total sample of 29 residents. Findings include:Review of the facility policy titled PRN use of Psychotropic Medication , dated June 2025, indicated the following:-PRN psychotropic medications may only be given if prescribed by a licensed physician or authorized prescriber and with appropriate consents signed by the appropriate person.-Each PRN order must specify indication, dosage, frequency, and duration.-The attending physician will be notified of repeated or ineffective use, and the order will be reviewed routinely or as scheduled by authorized provider. Resident #77 was admitted to the facility in July 2023 with diagnoses including alcoholic cirrhosis of the liver, psychosis, and anxiety. Review of Resident #77's most recent Minimum Data Set (MDS) assessment, dated 6/19/25, indicated the Resident scored a 5 out of a 15 on the Brief Interview for Mental Status exam, indicating that Resident #77 had severe cognitive impairment. Review of Resident #77's physician orders indicated the following order with a start date of 11/6/24.-Lorazepam (an antianxiety medication) Oral Concentrate 2mg/ml (milligrams/milliliter). Give 0.5 mg by mouth every 8 hours as needed for anxiety related to anxiety disorder.Review of Resident #77's physician orders indicated the following with a start date of 12/9/24.-Lorazepam (an antianxiety medication) Oral Concentrate 2mg/ml (milligrams/milliliter). Give 1 mg by mouth every 8 hours as needed for anxiety related to anxiety disorder. The medical record failed to indicate a 14 day stop date had been initiated for the PRN lorazepam. Review of the Medication Administration Record, dated November 2024 through September 2025, indicated the Resident received Ativan five times in November, five times in December, one time in January, one time in February, one time in March, five times in April, five times in May, four times in July, six times in August, and four times in September. Review of Resident #77's Behavioral Health Group recommendations, dated 11/5/24, indicated:-Lorazepam, liquid, (2mg/ml) give 0.5mg by mouth every 8 hours for anxiety prn for 30 days then reassess.Review of Behavioral Health Group recommendation, dated 12/3/24, indicated:-Lorazepam, 2mg/ml. Increase to 1mg/0.5ml every 8 hours for anxiety. Review of Resident #77's consultant pharmacist recommendation to prescriber, dated 7/19/25, indicated:-Resident is receiving the following PRN psychotropic medication- Ativan (Lorazepam). Please note PRN psychotropic medications are required to be re-evaluated after the initial 14 days of therapy and at the prescriber's discretion thereafter.-If therapy is to continue, beyond 14 days, please note medical justification for continued use in progress note and specify number of days the PRN order is to continue. Review of Resident #77's physician progress note, dated 7/25/25, indicated:-Patient followed by psych and recommendation to increase lorazepam to 1mg every 8 hours as need for anxiety. No concerns since that. Will continue to get as he/she needs it occasionally per staff. During an interview on 9/25/25 at 11:56 A.M., Nurse #1 said a PRN psychotropic should be ordered for one to two weeks and then reassessed by physician. During an interview on 9/25/25 at 12:01 P.M., Unit Manager #1 said a PRN psychotropic medication should be reevaluated by the physician in about one week and that should be part of the order. During an interview on 9/25/25 at 12:31 P.M., the Director of Nursing said a PRN psychotropic should have a 14 day stop date unless the physician documents a reason to extend the medication use.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview the facility failed to ensure one Resident (#28) out of a total sample of 29 residents was provided with the correct physician ordered adaptive equipment with meals. Specifically, Resident #28 was not provided with a double handed mug for 5 of 5 observed meals. Findings include:The facility policy titled Adaptive Equipment and Assistive Devices, dated January 2025, indicated the following:Purpose: To ensure residents have safe and appropriate access to adaptive equipment that promotes independence, mobility, and quality of life, while minimizing risks of accidents or misuse. -The facility provides and supervises the use of adaptive equipment such as mobility aids (wheelchairs, walkers, canes), bathroom safety devices (grab bars, toilet risers, commodes) and specialized dining utensils. -Equipment needs are identified through the comprehensive assessment and documented in the resident's care plan. -Consideration include strength, range of motion, balance, cognition and personal fit. Resident #28 was admitted to the facility in April 2024 and has diagnoses that include dementia without behavioral disturbance and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/11/25, indicated Resident #28 is rarely/never understood and was assessed by staff to have moderately impaired cognition. The MDS further indicated Resident #28 has no behaviors and is dependent on staff for eating. Review of Resident #28's active physician's orders include the following order, with a start date of 1/30/25:-Use double-handled mug with red straw lid for all beverages, with all meals Review of Resident #28's Activities of Daily Living (ADLs) care plan, with a revision date of 9/23/25, indicated the following interventions:-EATING: requires assist from staff to dependent. Need for assist d/t (due to) cognitive loss, would not eat without staff assist, dx (diagnosis) dysphagia. Use cup with lid for all beverages, start date 11/26/24. Review of Resident #28's Nutrition care plan, dated as revised 8/22/25, indicated the following interventions-Adaptive equipment as ordered: lip plate, mug with lid & straw, start date 10/10/24. Review of Resident #28's most recent Nutritional Risk Assessment, dated 8/11/25, indicated:-Resident #28 attempts to self-feed w/supervision at times and will otherwise be assisted at meals. On 9/24/2025 at 8:31 A.M., Resident #28 was observed seated in the unit dining room waiting for breakfast. There were two mugs, with one handle each, and a straw in each, placed directly in front of him/her. The surveyor continued to make the following observation:-At 8:39 A.M., staff sat down beside Resident #28 to provide feeding assist with the meal, however they did not provide the physician ordered double-handled mug with a red straw lid. On 9/24/2025 at 12:14 P.M., Resident #28 was observed seated in the unit dining room waiting for lunch. There were two mugs, with one handle each, and a straw in each, placed directly in front of him/her. On 9/25/2025 at 8:12 A.M., Resident #28 was observed seated in the unit dining room waiting for breakfast. There were two mugs, with one handle each, and a straw in each, placed directly in front of him/her. The surveyor continued to make the following observation:-At 8:24 A.M., Resident #28 used his/her thumb to push one of the straws toward his/her mouth then without attempting to lift the mug with one handle, leaned forward and drank from the straw. -At 8:26 A.M., staff delivered breakfast to Resident #28 however did not replace the mugs present with the correct physician ordered mugs. On 9/25/2025 at 12:06 P.M., Resident #28 was observed seated in the unit dining room waiting for lunch. There were two mugs, with one handle each, and a straw in each, placed directly in front of him/her. The surveyor continued to make the following observation:- Resident #28 was observed to attempt but was unable to pick up one of the mugs, and rather he/she leaned forward to drink from the straw. On 9/26/2025 at 8:22 A.M., Resident #28 was observed seated in the unit dining room waiting for breakfast. There were two mugs, with one handle each, and a straw in each, placed directly in front of him/her. The surveyor continued to make the following observation:-At 8:27 A.M., a Certified Nursing Assistant (CNA) placed a bowl of oatmeal in front of the Resident however did not replace the mugs present with the correct physician (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered mugs. During an interview with Resident #28's CNA #1 on 9/26/2025 at 9:49 A.M., she she said that Resident #28 requires total assistance with care, including feeding. CNA #1 was not sure what type of mug Resident #28 is supposed to use with beverages. During an interview with Nurse Unit Manager #3 on 9/26/2025 9:51 A.M., she said that she was not aware that Resident #28 had a physician's order for mugs with double handles and that she would have to follow-up. During an interview with the Director of Nursing (DON) on 9/26/2025 at 1:01 P.M., she said that if their is a physician's order for Resident #28 to have double handed mugs with his/her meals, then they should be provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to review and revise the care plan for one Resident (#102), following the completion of one comprehensive assessment.Specifically, facility staff failed to review and revise the care plan when Resident #102 started hospice and a comprehensive assessment for significant change in status (SCSA) was completed. Findings include:Review of the facility policy titled, Updating Care Plans Following Significant Changes in Resident Condition, dated April 2025, indicated the following:-A significant change in condition may include, but is not limited to: -Substantial decline in physical, mental, or psychosocial status. -New physician orders impacting care.-The Interdisciplinary Team (IDT) will immediately review the residents' condition and revise the care plan to reflect updated goals, interventions, and outcomes. Updates must be completed with the regulatory timeframe (generally within 7 days of identification of change) or sooner if clinically indicated. Resident #102 was admitted to the facility in October 2024 with diagnoses that include dysphagia, protein calorie malnutrition, and gastrostomy tube (G tube). Review of Resident #102's Minimum Data Set, dated [DATE], revealed that Resident #102 had a Brief Interview for Mental Status score of 7 out of a possible 15 which indicated that he/she has severe cognitive impairment. The MDS also indicated that Resident #102 had a G tube, was NPO (nothing by mouth), and was receiving hospice services. According to census, dated 8/20/25, Resident #102 was admitted to hospice. Review of Resident #102's social service progress note, dated 8/18/25, indicated health care proxy agreed to hospice sign on. Resident be seen by hospice team to sign on. Review of Resident #102's social service progress note, dated 8/26/25, indicated that Resident was admitted to hospice. Review of Resident #102's social service progress note, dated 9/3/25, indicated significant change noted, Resident signed on with hospice. Review of Resident #102's current plan of care failed to include any care related to hospice. During an interview on 9/25/25 at 9:30 A.M., Unit Manager #1 said that care plans are updated by nursing with significant changes in status. During an interview on 9/25/25 at 12:31 P.M., the Director of Nursing said that she would expect nursing to update care plan when a resident starts on hospice.

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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. Based on observation, record review and interview the facility failed to ensure assistance with Activities of Daily Ling (ADLs) was provided for one Resident (#49) out of a total sample of 29 residents. Specifically, for Resident #49 the facility failed to ensure assistance was provide with meals. Findings include:Review of the facility policy titled Activities of Daily Living (ADL), dated April 2024 indicated:-Residents who cannot perform ADLs independently will receive appropriate services to support nutrition, grooming, personal and oral hygiene, mobility, toileting, dining and communication. Resident #49 was admitted to the facility in April 2025 and has diagnoses that include Alzheimer's disease, dementia without behavioral disturbance and osteoarthritis of the shoulders. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/25/25, indicated Resident #49 is rarely understood and was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #49 requires set-up or cleaning assistance with eating. Review of the most recent Nutrition Risk Assessment, dated 8/25/25, indicated Resident #49 eats w/continual supervision, assistance as he/she allows. Review of the Activities of Daily Living care plan, dated as revised 9/2/25, indicated Resident #49 had the following interventions:-Eating: Continual supervision with assistance as resident allows.-Utilize task segmentation as indicated to help improve ADL participation.-Provide privacy and promote dignity, converse with resident while providing care.-Provide the amount of staff intervention that is needed for task completion with self-performance fluctuations Review of the most recent Quarterly Functional Abilities Assessment, dated 7/10/25, indicated Resident #49 is dependent on staff for eating. On 9/24/2025 at 8:55 A.M., Resident #49 was observed seated at a table in the unit dining room, facing the wall with his/her back to the staff in the room. Resident #49 had a breakfast plate in front of him/her and was eating scrambled eggs ands toast covered with jelly with his/her hands. Resident #49 had jelly all over his/her hands and was licking his/her fingers that were covered in eggs and jelly. There were utensils present, as well as several staff present in the dining room however staff were assisting other residents and provided no cues to use utensils and offered no assistance with the meal. On 9/24/2025 sat 12:27 P.M., Resident #49 was observed seated at a table in the unit dining room with a plate of lunch directly in front of him/her. Resident #49 had utensils available however was observed to be eating salad with his/her hands. There were 6 staff present in the dining room but none were supervising Resident #49 or providing cues to use the utensils and no assistance was offered. The surveyor continued to make the following observations:-Between 12:27 P.M., and 12:31 P.M. Resident #49's hands became covered in pizza sauce and salad dressing and he/she was licking the food off of his/her hands. On 9/25/2025 at 8:19 A.M., Resident #49 was observed seated at a table in the unit dining room. Staff placed a breakfast plate in front of him/her that included scrambled eggs, toast, a cinnamon bun and oatmeal. There was a spoon placed on the plate beside the eggs. The surveyor continued to make the following observations:-At 8:36 A.M., Resident #49 stuck his/her fingers into the scrambled eggs then licked them. There were several staff present in the dining room, however no one cued Resident #49 to use his/her utensil and no assistance was offered. Throughout the observation between 8:19 A.M., and 8:36 A.M., staff did not offer assistance with feeding or cueing to use utensils when he/she ate non-finger like food with his/her hands. On 9/25/2025 at 12:09 P.M., Resident #49 was observed seated at a table in the unit dining room. Staff placed a lunch plate in front of him/her that included macaroni and cheese and a chicken thigh. After placing the lunch and a fork in front if Resident #49 the staff person walked away and Resident #49 began eating the macaroni and cheese with his/her hands. The surveyor continued to make the following observations:-At 12:10 P.M., a staff person stood beside Resident #49 setting up his/her tablemate with lunch. While doing so Resident #49 ate the macaroni and cheese with his/her hands. The staff person offered no assistance to Resident #49 and no cues to use a utensil.-At 12:14 P.M., a staff person again stood beside Resident #49 and cut up the tablemate's food. While doing so Resident #49 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ate the macaroni and cheese with his/her hands. The staff person offered no assistance to Resident #49 and no cues to use a utensil.Throughout the observation between 12:09 P.M., and 12:14 P.M., staff did not offer assistance with feeding or cueing to use utensils when he/she ate non-finger like food with his/her hands. 0n 9/26/2025 at 8:24 A.M., Resident #49 was observed seated at a table in the unit dining room. Staff placed a breakfast plate in front of him/her that included served toast, oatmeal and scrambled eggs. The surveyor continued to make the following observations. -Between 8:24 A.M., and 8:34 A.M., Resident #49 made no attempts to self feed. At 8:34 A.M., he/she attempted to use a spoon to eat the eggs, however as Resident #49 left the spoon to his/her mouth the eggs fell onto the table and Resident #49 used his/her hands to eat the eggs off of the table.-At 8:41 A.M., Resident #49 picked up a butter container and ate the butter by licking it off his/her fingers. At that time there were 8 staff present in the dining room and no cueing or assistance was provided.-At 8:43 A.M., after consuming the butter container with his/her fingers, Resident #49 picked up a jelly container and ate the jelly by licking it off his/her fingers.Throughout the observation between 8:24 A.M., and 8:43 A.M., staff did not offer assistance with feeding or cueing to use utensils when he/she ate non-finger like food with his/her hands. During an interview with the Nurse Unit Manager #3 on 09/26/2025 at 9:58 A.M., she said that Resident #49 has variable ability to self feed, therefore staff should observe the resident with meals and offer assistance as needed. During an interview with Resident #49's Certified Nursing Assistant (CNA) #3 on 9/26/2025 at 10:17 A.M., she said that Resident #49 sometimes needs assistance with meals because he/she tires. CNA #3 said that staff monitor the Resident with meals and if the staff notice Resident #49 using his/her hands while eating they try to help him/her or give him/her a spoon. During an interview with the Director of Nursing (DON) on 9/26/2025 at 1:01 P.M., she said that it is her expectation that staff provide assistance with meals as needed. The DON said that if a resident is struggling to eat, and eating non-finger food with their hands, staff should intervene and offer assistance.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record reviews and interviews, the facility failed to provide treatment and services related to an indwelling urinary catheter (a thin flexible tube inserted into the bladder to drain urine outside the body), for two Residents (#3 and #92) out of a total sample of 29 residents. Specifically,1.For Resident #3, the facility failed to implement the physician's orders related to the correct indwelling catheter balloon and size.2.For Resident #92, the facility failed to implement the physician's orders related to the correct indwelling catheter balloon and size and empty the urinary drainage bag as ordered.Findings include:Review of the facility policy titled ?Urinary catheter Care' dated April 2024, indicated the following:-Empty the drainage bag at least every 8 hours and as needed.1.) Resident #3 was admitted to the facility in June 2021 with diagnoses including benign hyperplasia with lower urinary tract symptoms and neuromuscular dysfunction of bladder. Review of Resident #3's Minimum Data Set (MDS) assessment, dated 8/1/25, indicated the Resident scored an 8 out of a total possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderately impaired cognition, the MDS further indicated the Resident required indwelling catheter. On 9/25/25 at 9:10 A.M., the surveyor and Nurse #2 observed Resident #3's indwelling urinary catheter as size 16 French (fr) with a 5 milliliter (ML) balloon. Review of Resident #3's physician's order dated 6/24/23 indicated: -Insert foley catheter 16 fr with 10ml balloon every night shift starting on the 17th and ending on the 17th every month related to neuromuscular dysfunction of bladder. Review of Resident #3's care plan date initiated 9/10/25: Resident has a foley catheter because of BPH, urinary retention, bilateral hydronephrosis and acute focal pyelonephritis 14Fr 10cc. -Interventions: Change foley and bag per MD order. Review of Resident #3's Treatment Administration Record (TAR), dated 9/17/25 indicated the indwelling catheter was changed. During an interview on 9/25/25 at 12:26 P.M., Nurse #2 said nurses should follow orders with correct size of indwelling urinary catheter. During an interview on 9/25/25 at 1:35 P.M., Unit Manager #2 said when changing the foley catheter the nurses should check order to ensure they have the correct catheter size. If there is no same catheter size, they would then notify the Nurse Practitioner (NP) to have orders for a substitution catheter that they have on hand. 2.) Resident #92 was admitted to the facility in March 2023 with diagnoses including retention of urine, urinary tract infection, neuromuscular dysfunction of bladder. Review of Resident #92's Minimum Data Set (MDS) assessment, dated 8/6/25, indicated the Resident scored a 10 out of a total possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderately impaired cognition. The MDS further indicated the Resident required indwelling catheter. On 9/24/25 at 2:35 P.M., the surveyor observed Resident #92's foley catheter bag with 1400 milliliters (ML) of urine. During an observation and interview on 9/24/25 at 4:56 P.M. Nurse #5 said that she worked on this unit regularly and that she was Resident #92's nurse. Nurse #5 said she had not emptied Resident #92's foley catheter bag yet this shift and observed that Resident #92's foley catheter bag currently contained 1,600 mL of urine. Nurse #5 said certified nursing assistants (CNA's) were supposed to change the Resident's foley catheter bag at the beginning and end of their shift and that if they had emptied the bag at the beginning of the shift it would not be that full. On 9/25/25 at 9:10 A.M., the surveyor and Nurse #2 observed Resident #3's indwelling urinary catheter as size 18 French with a 10 milliliter (ML) balloon. Review of Resident #3's physician's order indicated:-Empty foley bag two times a shift for prevention of irritation/urine backflow related to retention of urine. Dated 6/12/25-Foley catheter care every shift. Dated 3/12/25-Insert a foley catheter 20 French (fr) 10 milliliter (ML) balloon. -Cipro (antibiotic used for treating infections) oral tablet 500 milligram (MG) give one tablet via gastrostomy tube two times a day for UTI (urinary tract infection) for 10 days. Dated 9/15/25 Review of Resident #92's care plan date initiated 4/12/25: Resident has a foley catheter 14 fr 10 ml balloon because of urinal retention This places the resident at risk for Infection Urinary retention. -Intervention: Catheter care every shift and as needed. During an interview on (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/25/25 at 12:26 P.M., Nurse #2 said nurses should follow orders with correct size of indwelling urinary catheter and the Resident's catheter is emptied twice per shift as his/her bag fills up quickly. During an interview on 9/25/25 at 1:35 P.M., Unit Manager (UM) #2 said when changing the foley catheter the nurses should check the order to ensure they have the correct catheter size. If there is no same catheter size, they would then notify the Nurse Practitioner (NP) to have orders for a substitution catheter that they have on hand. The UM said the Resident's catheter is emptied twice a shift because he/she has a large output due to receiving fluids every 4 hours.During an interview on 9/26/25 at 11:46 A.M., the Director of Nursing said nurses should follow physician order for correct catheter size to prevent causing bladder irritation. She also said foley catheters are emptied every shift and as needed and for Resident #92's foley catheter it is emptied twice a shift as the Resident has high urine output.

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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. **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 for one Resident (#2) who required 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 29 residents. Specifically, the facility failed to ensure clamps and pressure dressings were kept with the Resident in case of emergency related to a tunneled hemodialysis catheter (a plastic tube used for exchanging blood between a patient and a hemodialysis machine). Findings includeReview of the facility policy titled 'Emergency Care of Dialysis Patients' dated April 2025, indicated the following but not limited to:-Staff will monitor and respond to common dialysis emergencies, including but not limited to: -Excessive bleeding from access site. -Apply direct pressure to control bleeding at vascular access site. Resident #2 was admitted to the facility in August 2025 with diagnoses including End stage renal disease, dependent on dialysis. Review of Resident #2's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored 5 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had severe cognitive impairment. The MDS further indicated the Resident was dependent on dialysis. Review of Resident #2's current physician orders indicated the following:-Non serrated clamps to be kept at bedside and on person. Review of Resident #2's current plan of care related to hemodialysis indicated the following:-If bleeding occurs apply pressure dressing and call 911.-Non serrated clamp will be kept at bedside and in dialysis bag and on wheelchair to clamp chest port catheter in the event of bleeding. On 9/25/25 at 8:25 A.M., Resident #2 was observed sitting on edge of bed. The surveyor did not observe emergency clamps or pressure dressings in the Resident's room. On 9/25/25 at 10:30 A.M. Resident #2 was observed walking around his/her room. The surveyor did not observe emergency clamps or pressure dressings in the Resident's room. During an observation and interview on 9/25/25 at 10:52 A.M., the surveyor and Nurse #1 did not observe emergency clamp and pressure dressing in the Residents room. Nurse #1 said emergency clamp and pressure dressings should be in the Resident's room. During an interview on 9/25/25 at 12:01 P.M., Unit Manager #1 said emergency clamp should be in the Resident's room, next to bed. During an interview on 9/25/25 at 12:31 P.M., the Director of Nursing said residents with tunneled dialysis catheters should have emergency clamps and pressure dressing at the bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225458	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairhaven Healthcare Center	476 Varnum Avenue Lowell, MA 01854

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on records reviewed and interviews the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS) assessment (a test used monitor for adverse consequences of antipsychotic medication) was completed for one Resident (#13), who was receiving antipsychotic medications, out of a total sample of 29 residents. Findings include:Review of facility policy titled Psychotropic Medication Management, dated October 2023, indicated the following, but not limited to:*Perform a baseline Abnormal Involuntary Movement Scale (AIMS) assessment upon initiation of any antipsychotic medication and every six months thereafter. Resident #13 was admitted to the facility in November 2024 with diagnoses including dementia with psychotic disturbance. Review of Resident #13's Minimum Data Set (MDS) assessment, dated 7/31/25, indicated the Resident scored a 4 out of a possible 15 on the Brief Interview for Mental Status, indicating he/she had severe cognitive impairment. The MDS further indicated that the Resident was receiving an antipsychotic. Review of Resident #13's physician's order, dated 11/6/24, indicated:-Quetiapine fumarate ER oral tablet extended release 24-hour 300 mg(milligram). Give 600 mg by mouth at bedtime.Review of Resident #13's physician's order, dated 9/24/25, indicated:-Risperdal oral tablet 0.5mg. Give one tablet by mouth two times a day. Review of Consultant Pharmacy Recommendation dated 4/1/25 through 4/12/25, indicated:-Resident is receiving the following antipsychotic medication, Risperdal. AIMS assessment is required every 6 months.Review of Consultant Pharmacy Recommendations dated 9/9/25, indicated: Resident is receiving Seroquel XR 600 mg at bedtime and Risperdal 1mg daily. Dose evaluation is recommended periodically to help determine the lowest effective dose. If no change is indicated please note medical necessity and potential risk of side effects versus therapeutic benefit of current therapy in progress note. Review of Resident #13's medical record failed to indicate that staff completed an Abnormal Involuntary Movement Scale (AIMS) assessment as required. During an interview on 9/25/25 at 11:56 A.M., Nurse #1 said she was not aware who completed the AIMS assessment or how often it needed to be completed. During an interview on 9/25/25 at 12:01 P.M., Unit Manager #1 said that the Assistant Director of Nursing completes the AIMS assessment. During an interview on 9/25/25 at 12:31 P.M., the Director of Nursing said an AIMS should be completed upon admission and every six months for residents who receive antipsychotic medications. She said there was no system in place to complete AIMS assessments for those residents who were not being seen by psych services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review for one Resident (#62) out of three residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. One out of three nurses observed made two errors out of 26 opportunities resulting in a medication error rate of 7.69%. Specifically, Nurse #4 administered the incorrect type of multivitamin and the incorrect type of eye drops. Findings include:Review of the facility policy titled Medication Administration - Oral, dated June 2025, indicated:-Verify Medication order on MAR (medication administration record). Check against physician order.-Compare the medication label to the resident's/patient's MAR. Resident #62 was admitted to the facility in June 2021 with diagnoses including bilateral cataracts (cloudy areas that form on the lens of the eye) and anemia. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/8/25, indicated Resident #62 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 9/26/25 at 9:34 A.M., the surveyor observed Nurse #4 administer the following medications to Resident #62:-One multivitamin with minerals tablet.-One drop of refresh eye drops into bilateral eyes. Review of Resident #62's physician's orders, initiated 3/26/22, indicated:-Multivitamin tab, give 1 tablet orally one time a day.-Systane 0.3%-0.4% drops, instill one drop in both eyes four times a day. During a follow-up interview on 9/26/25 at 1:14 P.M., Nurse #4 said she was unaware there was another multivitamin available. Nurse #4 said she was unsure if refresh eye drops were the same as systane eye drops. During an interview on 9/26/25 at 10:10 A.M., Unit Manager #1 said the facility multivitamin with minerals should only be given if the physician ordered the multivitamin with minerals. Unit Manager #1 said the facility has a multivitamin, without minerals, available and that should be given if the order indicates to administer multivitamin. During an interview on 9/26/25 at 12:56 P.M., the Director of Nursing (DON) said multivitamin with minerals should only be given if the physician ordered the multivitamin with minerals. The DON said the facility has a multivitamin, without minerals, available and that should be given if the order indicates to administer multivitamin. The DON said refresh eye drops are a different medication than systane eye drops, and Resident #62 should have received the systane eye drops, not refresh eye drops.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 all drugs and biologicals in accordance with accepted professional standards of practice. Specifically, the facility failed to ensure two bottles of lorazepam (a Schedule IV controlled substance) was maintained in a separately locked compartment. Findings include:Review of the facility policy titled Medication Storage Policy, dated March 2024, indicated:-Controlled Substances: Controlled medications are stored in a separately locked compartment within the medication cart or storage room. On 9/26/25 at 9:02 A.M., the surveyor observed an unlocked compartment in Pawtucket medication room containing two bottles of lorazepam oral concentrate 2 mg (milligrams)/ml (milliliters). There was a lock on this compartment, however it was not engaged, and the door was able to be opened without any key. During an interview on 9/26/25 at 9:03 A.M., Nurse #2 said the compartment should have been locked because it contained controlled substances. Nurse #2 said controlled substances must be locked separately from other medications. Nurse #2 said he should have locked the compartment containing lorazepam in the Pawtucket medication room but did not. During an interview on 9/26/25 at 12:56 P.M., the Director of Nursing (DON) said controlled medications, such as lorazepam) must be stored in a separately locked compartment within the medication cart or storage room. The DON said Nurse #2 should have locked the compartment containing lorazepam in the Pawtucket medication room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to ensure proper food handling on 1 of 4 resident units. Specifically, on the Pawtucketville unit, 2 different staff handled resident's toast with their bare hands. Findings include:The facility policy titled Food Handling and Safety, dated April 2024, indicated the following:-All staff handling food must wash hands thoroughly before and after handling food, wearing gloves when appropriate.-Staff will receive ongoing education on food safety ad infection control practices. On 9/25/2025 at 8:32 A.M., while observing breakfast on the Pawtucketville unit, the surveyor observed a Certified Nursing Assistant (CNA) sit down beside a resident in the unit dining room. The CNA then picked up the resident's toast with her bare hands, tore the piece of toast into pieces and placed it in the residents oatmeal. On 9/26/2025 at 8:40 A.M., while observing breakfast on the Pawtucketville unit, the surveyor observed a CNA sit down beside a resident in the unit dining room to assist with breakfast. The CNA picked up the resident's toast with his bare hands and moved it to a different part of the plate to cover it with jelly. During an interview with CNA #2 on 9/26/2025 at 10:05 A.M., she said that staff should always wear gloves when handling food items such as a resident's toast. During an interview with the Nurse Unit Manager #3 on 9/26/2025 at 10:17 A.M., she said that staff should not be handling resident's food with their bare hands because it is an infection control issue. The surveyor shared the observations of two different staff handling toast with their bare hands and Nurse Unit Manager #3 said that she has a lot of new staff that still need education. During an interview with the Director of Nursing (DON) on 9/26/2025 at 1:01 P.M., she said that staff should not be handling resident's food with their bare hands.