STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225461	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Gardens	130 Chestnut Street Franklin, MA 02038

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a [NAME] Treatment Plan (court approved treatment plan for the administration of antipsychotic medications) was active and current for administration of an antipsychotic medication for one Resident (#10), out of a total sample of 14 residents. Findings include: Review of the facility's policy titled Psychoactive Medication Policy, dated [DATE], indicated but was not limited to the following: -Residents who have guardians need to have a [NAME] in order for the facility to administer antipsychotic medication Resident #10 was admitted to the facility in [DATE] with diagnoses which included schizophrenia and dementia. Review of the medical record indicated Resident #10 was found to be incapable of taking care of himself/herself by reason of mental illness and Guardianship was appointed on [DATE] by the Commonwealth of Massachusetts Probate and Family Court. Subsequent review of the medical record indicated the court issued an expansion of the Guardianship on [DATE] and authorized administration of antipsychotic medication via a [NAME] Treatment Plan, which expired on [DATE] at 4:00 P.M. Review of the Physician's Orders, dated [DATE], indicated: -Clozapine (antipsychotic) 100 milligrams (mg) by mouth twice a day, start date, [DATE], discontinued [DATE]. -Clozapine 50 mg by mouth at bedtime, start date [DATE], discontinued [DATE]. -Clozapine 100 mg by mouth twice a day, start date, [DATE] Review of the Medication Administration Records (MAR), dated [DATE] through [DATE], indicated Resident #10 was administered Clozapine 100 mg by mouth twice a day as ordered by the physician without an active [NAME] Treatment Plan in place. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:22 A.M., the Administrator said the facility does not have a social worker at this time and he will need to go through documents left in the prior social worker's office to see if the active treatment plan can be located. During a subsequent interview on [DATE] at 11:13 A.M., the Administrator said Resident #10 has a permanent legal guardian in place and there is no updated court approved [NAME] Treatment plan. He said he contacted the facility's attorney used for guardianship and they do not have anything that is up to date. The Administrator said the most recent treatment plan is expired, and the facility will need to submit a new request to the court.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR- Preadmission screening for residents with a mental disorder or intellectual disability) was accurately completed prior to the admission of one Resident (#4), in a total sample of 14 residents. Findings include: Review of the Nursing Facility Bulletin 169: Updates to Nursing Facility Regulations: PASRR for Intellectual Disability (ID), Developmental Disability (DD), and Serious Mental Illness (SMI), dated October 2021, indicated the following: A Level I Screening identifies whether an applicant for admission to a nursing facility has, or may have, ID, DD, and/or SMI (i.e. a positive Level I Screening). Effective October 29, 2021, a Level I Screening must be conducted using the revised Preadmission Screening and Resident Review (PASRR) Level I Screening Form, PASRR-L1 (10/21). If the individual has a positive Level I Screening, the screener must refer the individual to the appropriate PASRR authority for a Level II Evaluation or Abbreviated Level II Evaluation, as applicable, unless the individual satisfies all of the criteria for an Exempted Hospital Discharge. Resident #4 was admitted to the facility in December 2023 with a diagnosis of schizoaffective disorder following a seven-week hospitalization on a psychiatric unit. Review of the medical record included a PASRR, dated 12/1/23, with the following information: -current location: psychiatric hospital -Section B: -Question 4A: does the applicant have any of the following documented diagnoses of mental illness or disorder; answer: no (the box to indicate a diagnosis of schizoaffective disorder was not checked) -Question 5A: within the past two years has the applicant required one of the treatments listed below; answer: no (the box to indicate an inpatient psychiatric hospitalization was not checked) -SMI Screening Results: If you answered YES to questions 5A, 5B, or 6 check positive SMI screen; answer: negative SMI screen (Level II PASRR Evaluation not indicated). -Section E: -Question 14: Has the application screened positive for SMI only, and does the applicant possibly qualify for a categorical determination: No responses were checked in this section. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/25 at 11:50 A.M., the Administrator said there was no additional information in the PASRR electronic portal system or with the PASRR office regarding if they received the Level I screen for Resident #4 and there was no indication Resident #4 had a Level II PASRR evaluation. He said the facility Social Workers were responsible for the oversight of the PASRR process but there currently was not a Social Worker.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on document review and interview, the facility failed to ensure that monthly medication regimen reviews (MRR) were communicated to the physician and addressed in a timely manner for one Resident (#1), out of a total sample of 14 residents. Specifically, the facility failed to ensure recommendations from August and September 2024 by the pharmacy consultant to evaluate continued use of as needed Geri-tussin (cough syrup) and menthol lozenge was reviewed and responded to by the provider in a timely manner. Findings include: Review of the facility's policy titled Medication Reconciliation Policy, revised January 2025, indicated but was not limited to the following: -This facility reconciles medication to ensure that the resident is free of any significant medication errors -Monthly Processes: Provide pharmacy consultant access to all medication areas and records for completion of pharmacy services activities -Respond to any medication irregularities reported by pharmacy consultant within relevant time frames. Review of the facility's policy titled Consultant Pharmacist Services Provider Requirements, dated 8-2020, indicated but was not limited to the following: -The facility will ensure regular and reliable consultant pharmacist services are provided to residents. -Reviewing the medication regimen (medication regimen review) of each resident at least monthly. -Documenting the review and findings in the resident's medical record or a readily retrievable format. -A written or electronic report of findings and recommendations resulting from the activities described above is given to the Attending Physician, Director of Nursing at least monthly. -The facility has a process to ensure the findings are acted upon. Resident #1 was admitted to the facility in April 2019 with diagnoses which included hypotension and dysphagia (difficulty swallowing). Review of the Physician's Orders indicated Resident #1 was prescribed the following medications: -Geri-tussin syrup 100 milligrams (mg) / 5 milliliters (ml), give 10 ml as needed (PRN), discontinued 11/4/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Menthol lozenge 1 lozenge PRN, discontinued 11/4/24. Review of the progress notes indicated the following: -Pharmacy Consultant made recommendations on 8/16/24 to review the unused PRN menthol lozenge and geri-tussin. -Pharmacy Consultant made recommendations on 9/11/24 to review the unused PRN menthol lozenge and geri-tussin. Review of the medical record failed to include the pharmacy consultant recommendation report made in August and September 2024. Further review failed to indicate the physician was made aware of the recommendations until 11/4/24, 80 days after the initial recommendation was made. During an interview on 6/17/25 at 1:20 P.M., the Director of Nursing (DON) said the pharmacy consultant reviews all resident medical records monthly. She said they submit a report to the physician to review and sign, and it is placed in the resident's medical record. The DON said all recommendations should be completed prior to the next monthly review. She said she is unable to locate Resident #1's August and September 2024 pharmacy recommendation report; the reports are not in Resident #1's medical record. The DON said the physician did not address the recommendations timely as they should have been.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to electronically submit direct care staffing data to Centers for Medicare and Medicaid Services (CMS) for the entire reporting period, Fiscal Year (FY) Quarter 2 2025 (January 1 -March 31) in accordance with the schedule specified by CMS. Findings include: Review of the facility's policy titled Payroll Based Journal, dated as revised January 2025, indicated but was not limited to: -It is the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS -The facility will submit direct care staffing information in the uniform format specified by CMS -The facility will submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly Review of the PBJ Staffing Report, CASPER Report 1705D, FY Quarter 2 2025 (January 1 - March 31), indicated the facility triggered for: -Failed to Submit Data for the Quarter (No Data Submitted for Quarter) -One Star Staffing Rating (Staff Staffing Rating Equals 1) -Excessively Low Weekend Staffing (Submitted Weekend Staffing data is excessively low) -No RN (Registered Nurse) Hours (Four or More Days Within the Quarter with no RN Hours) -Failed to have LN (Licensed Nurse) coverage 24 hours per day (Four or More Days Within the Quarter with <24 hours/day Licenses Nursing Coverage) During an interview on 6/16/25 at 8:35 A.M., the Administrator said PBJ Data was reported and he would find evidence of submission for the surveyor. During an interview on 6/16/25 at 11:03 A.M., the Director of Operations said the facility does submit the PBJ staffing data but there was an issue in all their buildings, and he had a call out to CMS. During an interview on 6/16/25 at 2:55 P.M., the Regional Clinical Nurse said the Director of Operations was still working on it, but the person responsible for submitting PBJ data was let go about a month ago and the company was under the impression the PBJ data had been submitted, and they were working with CMS to submit it now. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/17/25 at 11:29 A.M., the Administrator said corporate was responsible for submitting the PBJ data, but he did not think it happened for FY Quarter 2 2025 and could not provide evidence of submission.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, document review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment for one Resident (#207), of 14 sampled residents. Specifically, the facility failed to ensure his/her indwelling Foley catheter (tube inserted into the bladder to drain urine into a collection bag outside the body) was maintained in a sanitary manner. Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance titled Summary of Recommendations, Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated March 2024, indicated but was not limited to: -Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Review of the facility's policy titled Urinary Catheter Care, undated, indicated but was not limited to: -Infection Control: be sure the catheter tubing and drainage bag are kept off the floor. Resident #207 was admitted to the facility in June 2025 with diagnoses which included retention of urine and neuromuscular dysfunction of bladder (a urinary dysfunction in which the bladder does not empty properly, depending on the type of neurological disorder causing the problem, the bladder may empty spontaneously or may not empty at all). Review of Resident #207's Minimum Data Set assessment, dated 6/11/25, indicated he/she had an indwelling urinary catheter. Review of Resident #207's Physician's Orders indicated but was not limited to: -Foley catheter to drainage bag for urinary retention, dated 6/5/25 -Provide catheter care every shift and as needed, dated 6/5/25 Review of Resident #207's care plans indicated but was not limited to: -Resident #207 has an indwelling Foley catheter for diagnosis of urine retention and neurogenic bladder, dated 6/5/2025 On the following dates of the survey, the surveyor observed Resident #207 lying in bed with his/her indwelling Foley catheter not attached to the bed and lying directly on the floor with no protective barrier: -6/12/25 at 9:15 A.M., and -6/16/25 at 7:36 A.M. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/16/25 at 12:44 P.M., Certified Nursing Assistant (CNA) #1 said urinary (Foley) catheter bags should be hanging from the bed and should not be touching the floor. During an interview on 6/17/25 at 1:47 P.M., CNA #6 said indwelling urinary (Foley) catheters should never be sitting directly on the floor and should be hanging from the bed. During an interview on 6/17/25 at 1:35 P.M., Nurse #2 said urinary (Foley) catheters should be hanging from the bed and should not be touching the ground to prevent contamination. During an interview on 6/17/25 at 3:25 P.M., the Director of Nurses said urinary (Foley) catheter bags should be hanging from the bed or wheelchair and should not be resting on the floor.