STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225481	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage Health & Rehab of New Bedford	200 Hawthorn Street New Bedford, MA 02740

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on document review and interview, the facility failed to implement their grievance process and attempt to resolve grievances in a timely manner for one Resident (#25), out of a total sample of 17 residents.Findings include: Review of the facility's policy titled Grievance Policy, dated 1/5/26, indicated but was not limited to the following: - [Corporate Name] shall ensure that residents, family members, responsible parties are provided with a mechanism to communicate concerns, conflicts, complaints, grievances or opportunities for improvement in care and services- grievance forms are available for the resident, family, responsible party to complete on first floor bulletin board, through resident council activity staff, and with social services- it is the responsibility of all staff who hear a grievance to report it to their supervisor- investigation and resolution of grievances shall be completed in a timely manner (within 5 working days of receipt of the grievance form)- the individual initiating the grievance will be notified of the findings and method of resolution by the Director of Social Services or designee- the Director of Social Services will maintain grievance forms received and resolutions developed- the Director of Social Services will use the grievance tracking log to track the grievance process Resident #25 was admitted to the facility in July 2019 and had diagnoses including Alzheimer's disease, unspecified dementia, hypertension and history of transient ischemic attack (a temporary blockage of blood flow to the brain typically caused by a blood clot). During an interview on 2/17/26 at 9:30 A.M., the healthcare proxy (HCP) for Resident #25 said she had put in grievances for repetitive bruising and other care issues and had recently put in a few more grievances on 2/9/26 and had not heard back from the facility. She said the facility does not get back to her with resolutions and when they have meetings with her, they claim she is accusatory, but she is concerned about her family member and wants to make sure they are getting the best care and not getting hurt by staff. During an initial interview on 2/17/26 at 10:46 A.M., the Administrator said he is the facility's grievance officer, and he works closely with the social worker (SW). Review of the Grievance Book indicated the following from July 2025 to February 17, 2026 for Resident #25: - 8/5/25: Nature of concern: see attached - a social service progress note was attached to the grievance which indicated the following: family verbalized they feel staff is intentionally not answering the phone from 9:00 P.M. to 10:00 P.M., on Friday, Saturday and Sunday nights. Family expressed frustration with avoiding communication; SW informed family that is not the facility practice; SW suggested the family call when the receptionist is available, family not receptive to suggestionsDepartment notified: AdministratorActions taken: SW spoke with grievant and offered coping strategies and calling when receptionist is available at center; staff will be counselled as to gravity of responding to phone calls at all times day and nightFollow up: ombudsman will be made aware; family will continue to update SWResolution issued: 8/5/25 - SW spoke with grievant The record and grievance form failed to indicate Resident #25's family received any resolution to their grievance but instead was asked to plan phone calls around the availability of the facility's receptionist. - 11/25/25: Nature of concern: see attached - letter from family indicating concerns with ongoing bruises on Resident #25 whether related to Hoyer (mechanical lift used to move residents from one surface to another) or certified nurse aides (CNA) not handling the Resident gently and using lift pads/turning sheet. Letter continues (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to reference three bruises in September, three in October, one in November (current voiced issue from 11/22/25); concern continued to indicate when they voice concerns about grievances, they are told it is due to the Resident being on aspirin and they do not address the grievance or cause of bruises.Corrective actions: see attached there is no information attachedDate decision was issued: 12/2/25 Review of the record indicated two separate progress notes by the social worker regarding this grievance as follows: 11/28/25: received envelope with grievance dated 11/25/25, writer available in facility on 11/26 and did not reach out. SW notified administrator and ombudsman. 12/2/25: family recently shared care concerns and followed up with a grievance; education provided to family related to Resident #25 taking aspirin. The information on the grievance form and in the medical record failed to indicate a corrective action or resolution was offered to the family to address their concern of ongoing bruising to their family member. The Grievance Book and February Grievance Log failed to indicate the HCP for Resident #25 had filed any grievances in the month of February 2026 During an interview on 2/18/26 at 12:07 P.M., the Director of Nurses (DON) said the family had put in multiple grievances on 2/9/26 but could not speak to why they were not available for review in the Grievance Book. She reviewed the Grievance Book and Grievance Log and said she does not know why the process of tracking the grievances was not being followed as it should be and she would have to find the grievances for the survey team to review. During an interview on 2/18/26 at 12:36 P.M., the Ombudsman said she is very aware of ongoing issues and grievances that the family had provided to the facility regarding care issues and ongoing bruising to Resident #25. She said the family felt they got no response when providing verbal grievances and she encouraged them to put them in writing and photograph their concerns and the grievance form while slipping them under the SW door to prove they had been provided to the facility. She said she felt this way the facility could not tell the family they never received them and the family would have proof they provided them in writing. She said this shouldn't be necessary and the resident and families have the right to voice grievances verbally and have them resolved quickly but that process was not working at the facility. She said she had informed the facility numerous times it is their responsibility to be honest and communicate directly with the family to find a resolution to their concerns, but that doesn't seem to be happening, and the grievances have been ongoing for about a year. She said the family of Resident #25 has been consistently reporting to her that they are not receiving any resolutions to their concerns and they feel unheard. She said the facility SW reached out and informed her that the family left three grievances around 2/9/26 and the facility felt the grievances were repeat issues that had already been resolved. The Ombudsman said she informed the facility that they need to have good communication with the family and resolve concerns and she would only be involved at the family's request as her role is to advocate and speak on the behalf of the residents and their families to ensure their rights are being followed and this issues are ongoing which would indicate that is not happening. She said the facility and family have both informed her they are attempting to coordinate a meeting for next week to discuss these current grievances and the ongoing issues the family is reporting. During an interview on 2/18/26 at 1:47 P.M., CNA #1 said if a resident or family has a concern or complaint, she notifies the nurse or supervisor on duty. She said she doesn't know anything about the grievance process or use of grievance forms. During an interview on 2/18/26 at 1:54 P.M., CNA #3 said if a resident or family has a concern or complaint she attempts to fix the issue, but if she cannot she informs a nurse or supervisor so they can handle it. She said she doesn't know anything about grievance forms and is not part of the grievance process but would complete a witness statement if asked to do so by a nurse. During an interview on 2/18/26 at 2:00 P.M., CNA #4 said if a resident or family tells her a complaint or concern, she passes it along to the supervisor or nurse on duty. She said she had nothing to do with the grievance process or grievance forms and had never offered one to anyone or assisted in completing one. She said they were trained to just report issues. During an interview on 2/18/26 at 2:06 P.M., Nurse #3 said if a family or resident voices a complaint or concern to her she notifies the supervisor on duty or on call on the weekends. She said (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she does not have anything to do with the grievance process. During an interview on 2/18/26 at 2:47 P.M., the SW provided the survey team with the three grievances from Resident #25's family written on 2/9/26. She said she would expect that if any resident or family voices a concern to the staff they should encourage or help the family in completing a grievance form and they should also alert a nurse or supervisor to the situation. She said residents and their families have the right to voice grievances verbally but no form would be completed for those. She said the only way for the facility to track if a grievance is resolved and not ongoing is to ensure the resident or their family feels heard and the process is followed and documented well. She said she is not the grievance officer for the facility, but assists the Administrator with the investigation and relaying information to the families/residents in follow up. She said the Administrator maintains all grievances in the book, ensures they are complete and logs them. She said for the grievance in August 2025 education should have been done, but it may have been done verbally without documentation and that is why no proof is attached to the grievance itself. She said for the November grievance the staff explained the Resident is on medication that causes bruises and the family isn't understanding, but the facility informed the Ombudsman, so they are aware of the family issues. The SW reviewed the 2/9/26 grievances. She said they are not resolved and the information had not been discussed or provided to the family even though she signed the forms saying that the grievance was resolved and decision was provided on 2/9/26 for all three issues. She said the first issue of having other people's laundry in Resident #25's closet and concerns with inaccurate medical record documentation were new and reported to the Ombudsman as a resolution. She said that information wasn't shared with the family but looking at it now she can see that is not a real resolution. She said the splint being dirty was a new grievance, and the facility will put the splint on a cleaning schedule but that information hasn't been shared with the family yet. She said the grievance for the two welts on Resident #25's skin was also not resolved, but the team completed the form and signed it without relaying their findings or resolution to the family yet. She said they also found a skin check, dated 1/26/26, that indicated the skin issue wasn't there even though the family said they saw it on 1/22/26, (the family provided photographs of the areas that were dated 1/22/26). She said the corrective action indicated the Resident crosses her legs and is in the biggest brief the facility has (green). On review, she said she does not know how that resolution would prevent another issue of the same type and the information had not yet been shared with the family. She said she was asked to sign all three grievance forms as completed on 2/9/26 but they are not complete since the information hasn't been shared with the family and the family has requested a meeting to discuss ongoing issues. She said in retrospect ongoing issues of the same type would indicate they were not resolved. During an interview on 2/18/26 at 3:34 P.M., the Administrator said his expectation is that if any staff member receives a complaint or concern from a resident or family member that they try to correct the immediate issue, then notify the supervisors and either provide the resident/family member with a grievance form or complete one to ensure all concerns are documented and followed through in accordance with the facility policy. He said from there he expects that nursing or social service document the resolution. He said all issues need to be documented on a grievance form since it is the only way for the facility to track if issues are a pattern, ongoing, or unresolved. He said residents and their families have the right to formulate grievances both verbally and in writing. He said Resident #25's family had a threatening way about them and they see the same issues coming up over and over again after they address them and have reported this to the Ombudsman. He said he doesn't know if the facility had ever really resolved any of Resident #25's family's concerns. He reviewed the August 2025, November 2025 and February 9, 2026 grievance forms. He said looking at the area that documents corrective actions and resolutions does not seem to be providing resolutions to the issues, but instead defenses and excuses, which is probably why the issues were ongoing. He said really looking at the situation from a different perspective he can see that the facility had repeatedly provided defense and excuses and did not address the underlying issues in the grievances to resolve any of the concerns brought forward and (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	can understand why the family is so frustrated. He said he realized that in allowing these grievances to go unaddressed with a proper resolution made him part of the problem and he planned on attending the meeting the family had requested. He said the grievance process was not in place as it was intended and Resident #25's grievances had not been resolved. During a follow up telephone interview on 2/20/26 at 11:21 A.M., the HCP for Resident #25 said the facility had not provided her any information to help resolve her grievances that she placed on 2/9/26, but had requested a meeting to discuss the ongoing concerns that have gone unresolved and she's hoping to get some information next week to resolve her concerns.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on document review and interview, the facility failed to implement their abuse policy for injuries of unknown origin for one Resident (#25), out of a total sample of 17 residents. Findings include: Review of the facility's policy titled Abuse, Neglect and Exploitation, undated, indicated but was not limited to the following: - It is the responsibility of our employees, agency staff, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incidents or suspected incidents of neglect or resident abuse, including injuries of unknown source to facility management- The abuse coordinator in the facility is the Director of Nurses (DON)- To help with recognition of incidents of abuse the following definitions of abuse are provided: injury of unknown source is defined as an injury that meets both of the following conditions: 1. the source of the injury was not observed by any person or the source of the injury could not be explained by the resident AND 2. the injury is suspicious because of the extent of the injury; location of the injury; number of injuries observed at one particular point in time or the incidence of injuries over time. Resident #25 was admitted to the facility in July 2019 and had diagnoses including Alzheimer's disease, unspecified dementia, hypertension, and history of transient ischemic attack (TIA) (a temporary blockage of blood flow to the brain typically caused by a blood clot). Review of the Minimum Data Set (MDS) assessment, dated 11/20/25, indicated the Resident was dependent for all activities of daily living, including transferring in and out of the bed, used a wheelchair for dependent mobility and had limitations on one side of his/her upper body, was not on any anticoagulant medications (blood thinner medication that decreases the bloods' ability to clot, preventing the formation and growth of harmful blood clots), and did not have any physical behaviors or rejection of care behaviors. Review of the Brief Interview for Mental Status (BIMS) indicated the Resident is rarely or never understood and had severely impaired cognitive skills. Review of the medical record indicated the Resident's Healthcare proxy (HCP) was activated on 8/19/24. Review of the current Physician's Orders indicated but was not limited to:- Aspirin 325 milligrams(mg) one daily for TIA (3/22/25) During an interview on 2/17/26 at 9:30 A.M., the HCP for Resident #25 said the Resident is dependent on the staff for care and required two staff members for care. She said the Resident frequently suffers from bruises on their arms, legs, and thighs and the facility does not provide them with a source or cause of the bruising but instead uses the excuse that the Resident is on aspirin and therefore will bruise easier. She said they never have a reason of how the bruises occurred and she is concerned and has shared those concerns with the facility. During an interview on 2/18/26 at 11:21 A.M., the DON said she had provided the surveyor with six completed incident report (type: Bruise) and investigations for bruising found on Resident #25 on 5/6/25, 7/7/25, 7/17/25, 9/29/25, 10/15/25 and 2/9/26. She said she did not have any other investigations for the Resident and those provided were completed investigations. Review of the facility provided incident reports/investigations indicated the following: - 5/6/25: Description: at 8:00 P.M. on 5/5/25 the nurse was notified that the patient had a faint bruise to his/her left upper thigh during activities of daily living (ADLs); the area was assessed to be less than pink and miniscule; reassessed on 5/6/25 and the area became more prominent with purple discoloration 0.4 by (x) 0.4 centimeters (cm); skin prep to heels; all other skin to be within normal limits. Predisposing factors left blank. Two witness statements none indicate a source or cause of area. Change in condition assessment indicated bruise on left thigh and otherwise left blank. - 7/7/25: Description: During shower a penny sized bruise was observed on the left inner ankle. Predisposing factors indicate confusion and ambulating without assist (resident was non-ambulatory); one witness statement dated 7/3/25 indicating bruise found on the right leg during shower and reported to nurse. Change in condition form blank. No source or cause of bruise identified.- 7/17/25: Description: During routine A.M. shower a 2.5cm x 2.5cm deep purple-greenish discoloration on patients left lower ankle; no other bruises or injuries; no recent reports of injury were noted. Predisposing factors indicate confused, impaired memory and other (dependent for ADLs and mechanical lift (Hoyer)); no witness (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	statements or change of condition. No source or cause of bruise identified.- 9/29/25: A source of injury was indicated on this incident report/investigation- 10/15/25: Description: HCP notified staff of discoloration to left forearm laterally; greenish-yellow dime sized discoloration observed; geri-sleeves were placed. Predisposing factors blank. Change in condition indicated Aspirin 325mg daily, Resident is currently a Hoyer for transfers and noted a yellow and greenish discoloration to the LLE [sic] (left lower extremity). No cause or source identified.- 2/9/26: Description: Nurse was notified that the Resident obtained what appears to be a bruise to the right upper arm, noted ecchymosis on mid anterior-forearm 3cm x 2cm yellow-brown-to purple consistent with resolving bruise. No additional markings. Predisposing factors blank. Change in condition indicated skin wound. Three witness statements none identify a source or cause of the wound. Five of six of the incident reports failed to indicate a source or cause of the injury to Resident #25. Review of the progress notes for Resident #25 from May 2025 through February 18, 2026, indicated, but were not limited to the following: 5/6/25 - deep purple area to left upper thigh - the note failed to indicate a potential source of injury5/30/25 - deep purple bruise looks self-inflicted - the note failed to indicate location of the bruise or why they believed it was self-inflicted7/7/25 - two small bruises right lower extremity (RLE) at inner shin - the note failed to indicate a potential source of injury7/17/25 - purple-blue bruise to left lower ankle - the note failed to indicate a potential source of the injury 10/8/25 - bruise to right shin - could possibly be because Resident crosses their legs - the note failed to indicate a cause/source that was verified or investigated10/14/25 - left forearm green-yellowish discoloration was positional and transfers - the note failed to indicate a cause/source of the bruise but provided factors that may lead to a source 2/9/26 - bruise to right forearm lines up with splint which is likely source of injury Review of the progress notes indicated seven incidents of bruising to the Resident from May 2025 to February 18, 2026. Six of the seven incidents failed to identify an investigated source or cause of injury, and six of eight incidents had incident reports initiated. Review of the Healthcare Facility Reporting System (HCFRS) from May 2025 to February 18, 2026, failed to indicate the injuries of unknown source had been reported to the Department of Public Health (DPH) in accordance with their abuse policy and guidance. During an interview on 2/19/26 at 2:35 P.M., the DON reviewed the surveyor's findings and said all the incidents without a known cause or source of how the bruise or discoloration may have occurred should have been reported to DPH in accordance with the facility abuse policy for investigation and to rule out potential abuse. She could not explain why the two documented incidents of bruising/discoloration on 5/30/25 and 10/8/25 had been unknown to her and therefore not investigated or reported. She said the Resident could not have self-inflicted injuries as he/she had no history of self-inflicting injuries, is not resistive to care, and had very limited mobility. She said she did not have any information on the 5/30/25 and 10/8/25 incidents and she had not reported any of the incidents of injury of unknown source in accordance with the facility abuse policy; the policy was not followed as it should have been. During an interview on 2/19/26 at 3:30 P.M., the Administrator said his expectation is that bruises or any injury of unknown origin/cause or source is reported and investigated as potential abuse in accordance with the facility policy and if that did not occur in these circumstances the policy was not implemented as it was supposed to be.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on document review and interview, the facility failed to report injuries of unknown origin for one Resident #25, out of a total sample of 17 residents.Findings include: Review of the facility's policy titled Abuse, Neglect, and Exploitation, undated, indicated but was not limited to the following: - It is the responsibility of our employees, agency staff, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incidents or suspected incidents of neglect or resident abuse, including injuries of unknown source to facility management- The abuse coordinator in the facility is the Director of Nurses (DON)- To help with recognition of incidents of abuse the following definitions of abuse are provided: injury of unknown source is defined as an injury that meets both of the following conditions: 1. the source of the injury was not observed by any person or the source of the injury could not be explained by the resident AND 2. the injury is suspicious because of the extent of the injury; location of the injury; number of injuries observed at one particular point in time or the incidence of injuries over time. - Employees, facility consultants and/or attending physicians must immediately report any suspected abuse or incidents of abuse to the DON. In the absence of the DON such reports can be made to the supervisor on duty. Review of the facility's policy titled Residents Right to Freedom from Abuse, Neglect, Exploitation, dated 2024, indicated but was not limited to the following: - When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately.- Reporting the alleged violation within required timeframes pursuant to federal and state statues and regulations. - In response to allegations of abuse, neglect, exploitation or mistreatment the facility shall: ensure all alleged violations including injuries of unknown source are reported in the proper time frame and report the results of all investigations to the administrator and to other officials in accordance with state law, including the state surveying agency within five working days of the incident Resident #25 was admitted to the facility in July 2019 and had diagnoses including Alzheimer's disease, unspecified dementia, hypertension, and history of transient ischemic attack (TIA) (a temporary blockage of blood flow to the brain typically caused by a blood clot). Review of the Minimum Data Set (MDS) assessment, dated 11/20/25, indicated the Resident was dependent for all activities of daily living, including transferring in and out of the bed, used a wheelchair for dependent mobility and had limitations on one side of his/her upper body, was not on any anticoagulant medications (blood thinner medication that decreases the bloods' ability to clot, preventing the formation and growth of harmful blood clots), and did not have any physical behaviors or rejection of care behaviors. Review of the Brief Interview for Mental Status (BIMS) indicated the Resident is rarely or never understood and had severely impaired cognitive skills. Review of the medical record indicated the Resident's Healthcare proxy (HCP) was activated on 8/19/24. Review of the current Physician's Orders indicated but was not limited to:- Aspirin 325 milligrams(mg) one daily for TIA (3/22/25) During an interview on 2/17/26 at 9:30 A.M., the HCP for Resident #25 said the Resident is dependent on the staff for care and required two staff members for care. She said the Resident frequently suffers from bruises on their arms, legs, and thighs and the facility does not provide them with a source or cause of the bruising but instead uses the excuse that the Resident is on aspirin and therefore will bruise easier. She said they never have a reason of how the bruises occurred and she is concerned and has shared those concerns with the facility. Review of the facility provided incident reports/investigations indicated the following: - 5/6/25: Description: at 8:00 P.M. on 5/5/25 the nurse was notified that the patient had a faint bruise to his/her left upper thigh during activities of daily living (ADLs); the area was assessed to be less than pink and miniscule; reassessed on 5/6/25 and the area became more prominent with purple discoloration 0.4 by (x) 0.4 centimeters (cm); skin prep to heels; all other skin to be within normal limits. Predisposing factors left blank. Two witness statements none indicate a source or cause of area. Change in condition assessment indicated bruise (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on left thigh and otherwise left blank. - 7/7/25: Description: During shower a penny sized bruise was observed on the left inner ankle. Predisposing factors indicate confusion and ambulating without assist (resident was non-ambulatory); one witness statement dated 7/3/25 indicating bruise found on the right leg during shower and reported to nurse. Change in condition form blank. No source or cause of bruise identified.- 7/17/25: Description: During routine A.M. shower a 2.5cm x 2.5cm deep purple-greenish discoloration on patients left lower ankle; no other bruises or injuries; no recent reports of injury were noted. Predisposing factors indicate confused, impaired memory and other (dependent for ADLs and mechanical lift (Hoyer)); no witness statements or change of condition. No source or cause of bruise identified.- 9/29/25: A source of injury was indicated on this incident report/investigation- 10/15/25: Description: HCP notified staff of discoloration to left forearm laterally; greenish-yellow dime sized discoloration observed; geri-sleeves were placed. Predisposing factors blank. Change in condition indicated Aspirin 325mg daily, Resident is currently a Hoyer for transfers and noted a yellow and greenish discoloration to the LLE [sic] (left lower extremity). No cause or source identified.- 2/9/26: Description: Nurse was notified that the Resident obtained what appears to be a bruise to the right upper arm, noted ecchymosis on mid anterior-forearm 3cm x 2cm yellow-brown-to purple consistent with resolving bruise. No additional markings. Predisposing factors blank. Change in condition indicated skin wound. Three witness statements none identify a source or cause of the wound. Review of the progress notes for Resident #25 from May 2025 through February 18, 2026, indicated, but were not limited to the following: 5/6/25 - deep purple area to left upper thigh 5/30/25 - deep purple bruise looks self-inflicted7/7/25 - two small bruises right lower extremity (RLE) at inner shin 7/17/25 - purple-blue bruise to left lower ankle10/8/25 - bruise to right shin - could possibly be because Resident crosses their legs 10/14/25 - left forearm green-yellowish discoloration was positional and transfers 2/9/26 - bruise to right forearm lines up with splint which is likely source of injury Review of the progress notes indicated seven incidents of bruising to the Resident from May 2025 to February 18, 2026. Six of the eight incidents failed to identify an investigated source or cause of injury, and six of eight incidents had incident reports initiated. Review of the Healthcare facility reporting system from May 2025 to February 18, 2026, failed to indicate the injuries of unknown source had been reported to the Department of Public Health in accordance with guidance. During an interview on 2/19/26 at 2:35 P.M., the DON reviewed the surveyors' findings with the surveyor and said all the incidents without a known cause or source of how the bruise or discoloration may have occurred should have been reported to DPH in accordance with the facility abuse policy for investigation and to rule out potential abuse. he said she did not have any information on the 5/30 and 10/8/25 incidents. She said she had not reported any of the incidents as she should have. During an interview on 2/19/26 at 3:30 P.M., the Administrator said his expectation is bruises or any injury of unknown origin/cause or source is reported as potential abuse in accordance with the facility policy and that did not occur in these circumstances. During an interview on 2/19/26 at 3:34 P.M., the Chief Operating Officer for the facility said the facility is required to report any injuries of unknown source/origin within two hours to meet the regulatory standard and per the facility's abuse policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage Health & Rehab of New Bedford	200 Hawthorn Street New Bedford, MA 02740

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on document review and interview, the facility failed to investigate injuries of unknown origin for one Resident (#25), out of a total sample of 17 residents. Findings include: Review of the facility's policy titled Abuse, Neglect, and Exploitation, undated, indicated but was not limited to the following: - It is the responsibility of our employees, agency staff, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incidents or suspected incidents of neglect or resident abuse, including injuries of unknown source to facility management- The abuse coordinator in the facility is the Director of Nurses (DON)- To help with recognition of incidents of abuse the following definitions of abuse are provided: injury of unknown source is defined as an injury that meets both of the following conditions: 1. the source of the injury was not observed by any person or the source of the injury could not be explained by the resident AND 2. the injury is suspicious because of the extent of the injury; location of the injury; number of injuries observed at one particular point in time or the incidence of injuries over time. Review of the facility's policy titled Residents Right to Freedom from Abuse, Neglect, Exploitation, dated 2024, indicated but was not limited to the following: - When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately.- Conduct a thorough investigation of the alleged violations - In response to allegations of abuse, neglect, exploitation or mistreatment the facility shall: ensure all alleged violations including injuries of unknown source have evidence that all alleged violations are investigated- Report the results of all investigations to the administrator and other officials in accordance with state law, including the state survey agency within five working days of the incident Resident #25 was admitted to the facility in July 2019 and had diagnoses including Alzheimer's disease, unspecified dementia, hypertension, and history of transient ischemic attack (TIA) (a temporary blockage of blood flow to the brain typically caused by a blood clot). Review of the Minimum Data Set (MDS) assessment, dated 11/20/25, indicated the Resident was dependent for all activities of daily living, including transferring in and out of the bed, used a wheelchair for dependent mobility and had limitations on one side of his/her upper body, was not on any anticoagulant medications (blood thinner medication that decreases the bloods' ability to clot, preventing the formation and growth of harmful blood clots), and did not have any physical behaviors or rejection of care behaviors. Review of the Brief Interview for Mental Status (BIMS) indicated the Resident is rarely or never understood and had severely impaired cognitive skills. Review of the medical record indicated the Resident's Healthcare Proxy (HCP) was activated on 8/19/24. Review of the current Physician's Orders indicated but was not limited to:- Aspirin 325 milligrams(mg) one daily for TIA (3/22/25) During an interview on 2/17/26 at 9:30 A.M., the HCP for Resident #25 said the Resident is dependent on the staff for care and required two staff members for care. She said the Resident frequently suffers from bruises on their arms, legs, and thighs and the facility does not provide them with a source or cause of the bruising but instead uses the excuse that the Resident is on aspirin and therefore will bruise easier. She said they never have a reason of how the bruises occurred and she is concerned and has shared those concerns with the facility. During an interview on 2/18/26 at 11:21 A.M., the DON said she had provided the surveyor with six completed incident report (type: Bruise) and investigations for bruising found on Resident #25 on 5/6/25, 7/7/25, 7/17/25, 9/29/25, 10/15/25 and 2/9/26. She said she did not have any other investigations for the Resident and those provided were completed investigations. Review of the facility provided incident reports/investigations indicated the following: - 5/6/25: Description: at 8:00 P.M. on 5/5/25 the nurse was notified that the patient had a faint bruise to his/her left upper thigh during activities of daily living (ADLs); the area was assessed to be less than pink and miniscule; reassessed on 5/6/25 and the area became more prominent with purple discoloration 0.4 by (x) 0.4 centimeters (cm); skin prep to heels; all other skin to be within normal limits. Predisposing factors left blank. Two witness statements none indicate a source or cause of area. Change in condition assessment indicated bruise (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to maintain an infection prevention and control program which included a complete and accurate system of surveillance to identify any trends or potential infections. Findings include:Review of the facility's policy titled Infection Prevention and Control Program, dated December 2023, indicated, but was not limited to, the following:-An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.-The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety.-Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infections) are used as measures of the IPCP effectiveness.-Surveillance tools are used for identifying the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications.-Outbreak management is a process that consists of:1) determining the presence of an outbreak.2) managing the affected residents.3) preventing the spread to other residents.4) documenting information about the outbreak5) reporting the information to appropriate public health authorities.6) educating the staff and the public.7) monitoring for recurrences.8) reviewing the care after the outbreak has subsided.9) recommending new or revised policies to handle similar events in the future.-Specific criteria will be used to help differentiate sporadic cases from true outbreaks or epidemics. During an interview on 02/18/26 at 4:17 P.M., the Infection Preventionist (IP) said the facility utilizes McGeer Criteria (standardized surveillance definitions used to identify and report infections) to determine if an illness rises to the level of an infection. She said she tracks all infections on a monthly line listing document. Review of the facility's monthly line listings for October, November, December 2025 and January 2026 indicated, but was not limited to, the following: October 2025-15 out of 28 residents failed to include signs and symptoms of an illness.-4 out of 10 urinary tract infections treated failed to include culture results identifying the organism/bacteria. November 2025-8 out of 26 resident infections failed to include signs and symptoms of an illness.-2 out of 9 urinary tract infections treated failed to include culture results identifying the organism/bacteria. December 2025-2 out of 11 resident infections failed to include signs and symptoms of an illness.-2 out of 3 urinary tract infections treated failed to include culture results identifying the organism/bacteria. January 2026-31 out of 40 resident infections failed to include signs and symptoms of an illness.-7 out of 11 urinary tract infections treated failed to include culture results identifying the organism/bacteria. During an interview on 2/19/26 at 11:14 A.M., the IP said she obtains the data to include on the monthly line listing from reviewing the 24-hour progress notes and antibiotic use report. She said the line listing document should have included all symptoms and culture results, but she has not been consistent with tracking the information. During an interview on 2/19/26 at 4:21 P.M., the Director of Nursing (DON) said the line listings should have included symptoms and culture results for accurate monitoring of infections within the facility. The DON said the line listings are inaccurate and incomplete.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program. Findings include:Review of the facility's policy titled Antibiotic Stewardship Program, last revised December 2016, indicated but was not limited to the following:-Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program.-The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents.-When a culture and sensitivity is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Review of the facility's policy titled Antibiotic Stewardship Review and surveillance of Antibiotic Use and Outcomes, last revised December 2016, indicated but was not limited to the following:-Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.-All clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP), or designee-The IP, or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics-Therapy may require further review and possible changes if:-The organism is not susceptible to antibiotic chosen.-The organism is susceptible to narrower spectrum antibiotic.-Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics.-At the conclusion of the review, the provider will be notified of the review findings. Review of the facility's policy titled Infection Prevention and Control Program, dated December 2023, indicated, but was not limited to, the following:-An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.-The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety.-Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infections) are used as measures of the IPCP effectiveness.-Surveillance tools are used for identifying the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. During an interview on 02/18/26 at 4:17 P.M., the IP said the facility utilizes McGeer Criteria (standardized surveillance definitions used to identify and report infections) to determine if an illness rises to the level of an infection. The IP said she keeps all McGeer criteria sheets with the line listings organized by month and year. She said she tracks all infections on a monthly line listing document. Review of the facility's monthly line listing documents for December 2025 and January 2026 indicated but were not limited to the following:December 2025Resident #22 had a urinary tract infection (UTI) concern with an onset date of 11/28/25. The surveillance indicated that the concern did rise to the level of infection as determined by the facility criteria, an antibiotic was prescribed for seven days. No McGeer criteria was located for the concern. Review of Resident #22's nursing progress notes indicated an antibiotic was initiated on 12/4/25 with symptoms documented of foul, cloudy urine. No further specific signs or symptoms of infection were indicated in the medical record. During an interview on 2/19/26 at 11:14 A.M., the IP said she cannot locate the McGeer criteria for Resident #22's concern. The IP reviewed the line listing document and progress notes. She said the line listing is inaccurate and the illness did not meet McGeer criteria for infection.Further review of Resident #22's medical record, including nursing, physician and nurse (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practitioner progress notes, failed to indicate reasoning for continued antibiotic usage even though the symptoms did not meet McGeer criteria. January 2026Resident #6 had a UTI concern with an onset date of 1/22/26. The surveillance indicated that the concern did rise to the level of infection as determined by the facility criteria, an antibiotic was prescribed for seven days. No McGeer criteria was located for the concern.Review of Resident #6's nursing progress notes indicated an antibiotic was initiated on 1/22/26 with symptoms documented of dark, yellow urine. No further specific signs or symptoms of infection were indicated in the medical record.During an interview on 2/19/26 at 11:34 A.M., the IP said she could not locate any McGeer criteria for Resident #6's concern for infection. The IP reviewed the line listing document and progress notes. She said the line listing is inaccurate and the illness did not meet McGeer criteria for infection.Further review of Resident #6's medical record, including nursing, physician and nurse practitioner progress notes, failed to indicate reasoning for continued antibiotic usage even though the symptoms did not meet McGeer criteria. During an interview on 2/19/26 at 12:21 P.M., the IP said she does not follow up with providers about antibiotics being prescribed when they do not meet McGeer criteria. She said she only tracks antibiotics on the line listing documents. During an interview on 2/19/26 at 4:21 P.M., the Director of Nursing (DON) said all concerns of infection need to have McGeer criteria completed to ensure an accurate overview of antibiotic use in the facility. She said the IP should be communicating with providers and documenting the rationale for continued antibiotic use in the medical record to ensure residents are not being placed on antibiotics unnecessarily.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on document review and interview, the facility failed to develop baseline care plans for two Residents (#78 and #79), out of a total sample of 17 residents. Specifically, the facility failed to develop a baseline care plan:1. For Resident #78, that included the necessary care of a colostomy (a surgical procedure where a portion of the large intestine is brought through the abdominal wall to carry stool out of the body) and Foley catheter (a tube inserted through the urinary tract into the bladder, connected to a drainage bag); and2. For Resident #79, that included strategies to mitigate future falls and offer a copy of those care plans to the Resident/healthcare proxy (HCP).Findings include:Review of the facility's policy titled Care Plans - Baseline, dated 2017, indicated but was not limited to the following: - a person-centered baseline care plan to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission-baseline care plans include a minimum of: physician orders, initial goals based on admission orders, therapy and social services -a copy of the baseline care plan or a summary thereof shall be provided to the resident/representative with documentation in the medical record 1. Resident #78 was admitted to the facility in February 2026 with diagnoses including necrotizing fasciitis (an aggressive skin and soft tissue infection that cause necrosis (death) of the muscle fascia and subcutaneous tissues). During an observation with interview on 2/17/26 at 10:14 A.M., the surveyor observed Resident #78 in bed with the head of bed elevated and a Foley catheter drainage bag hanging on the left side of the bed frame. The Resident said he/she had an ostomy. During an interview on 2/17/26 at 4:07 P.M., Certified Nurse Assistant (CNA) #1 said she cares for the Resident daily and the Resident has had a Foley catheter and ostomy since admission. Review of Resident #78's medical record indicated but was not limited to the following: - 48-hour baseline care plan summary: failed to include any information on colostomy care or Foley catheter care. The treatment and orders frequency section of the document was blank- baseline care plan V2 document with section 3C - Bowel and bladder: failed to indicate the Resident had an indwelling Foley catheter or ostomy, section 5 - Summary and signatures: failed to indicate any resident or staff signatures and was blank- Progress notes at the time of admission indicated the Resident presented to the facility with a colostomy and Foley catheter. During an interview on 2/19/26 at 9:01 A.M., Nurse #1 said he completed the majority of admissions on the unit. He said he completes all the admission paperwork but is never involved in the baseline care plan process. He believes it's completed at the management level. During an interview on 2/19/26 at 12:04 P.M., Unit Manager #1 said the process for baseline care plans is that the interdisciplinary team meets about 72 hours after admission and invites the resident/family to discuss appointments, therapy, and discharge plans. She said care plans are not created based off that meeting they are usually made within 21 days. She said a care plan for an ostomy or indwelling catheter is not necessarily in place until the 21-day comprehensive care plans are done. During an interview on 2/19/26 at 2:25 P.M., the Director of Nurses (DON) said the baseline care plan process should be completed in the first 48 hours following admission and cover all the basic things the resident had been admitted for like catheters and ostomies. She reviewed the medical record for Resident #78 and said the process was not followed as it should have been. 2. Resident #79 was admitted to the facility in February 2026 with diagnoses including: metabolic encephalopathy (a form of abnormal brain metabolism characterized by memory loss, dizziness, and generalized weakness), insomnia, weakness and abnormality of gait and mobility. During the survey the surveyor made the following observations of Resident #79 at the following days and times: - 2/17/26 at 8:10 A.M., lying in bed with his/her feet hanging off the right side of the bed and his/her legs wrapped in the bed sheet, the privacy curtain was closed halfway making the Resident not visible from the hallway- 2/17/26 at 12:00 P.M., sitting in a wheelchair with two leg rests, the Resident had removed their left foot from the leg rest and was trying to self-propel in the chair, with little to no success- 2/18/26 at 6:55 A.M., privacy curtain was closed halfway, the (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was not visible from the hallway; upon entering the room the Resident pulled back the privacy curtain quickly and was sitting on the left edge of the bed by the footboard facing the bedroom door and requesting help to get out of bed During an interview on 2/17/26 at 1:10 P.M., the Resident's HCP said she felt the transition from the hospital to the facility had not been very smooth and that the facility was not communicating well with her. She said the day of admission she informed the staff Resident #79 is impulsive and had a significant fall history with frequent falls at home and she isn't sure the staff understand the Resident's needs. She said a few days later she requested to meet with them to review her concerns for the continued fall risk and the privacy curtain always being closed when she comes in preventing the staff from being able to see or supervise the Resident from the hallway as they pass by. She said the facility told her when she asked to meet with them that they would provide her with care plan information in a few weeks at a meeting to take place in March. She said they did not offer her any documentation of the meeting that occurred the day she requested they speak with her about her concerns. She said the Resident is at the facility because of their confusion and history of falling and she is worried they are not doing what they can to prevent that. Review of the medical record for Resident #79 indicated but was not limited to the following: - no 48-hour baseline care plan summary was in the record- the completed admission assessment indicated the Resident was admitted for weakness and falls at home and the resident was disoriented and required assistance for care and had balance problems- baseline care plan V2 document with section H - Safety risk: no history of falls; section 5 - Summary and signatures: failed to indicate any resident/family or staff signatures and was blank- review of all progress notes from date of admission through 2/18/26 indicated the Resident had advanced dementia, recurrent falls, and poor safety awareness; the notes failed to indicate that the Resident's HCP had baseline care plans developed or reviewed or they were offered a copy of those documents. During an interview on 2/19/26 at 11:46 A.M., Unit Manager #1 said the process for baseline care plans is the interdisciplinary team meets about 72 hours after admission and invites the resident/family to discuss appointments, therapy and discharge plans. She said care plans are not created based off that meeting they are usually made within 21 days. She said care plans for fall prevention are not always put in place prior to the 21-day comprehensive care plan creation. She said there was a meeting with Resident #79's HCP, but no baseline or comprehensive care plan was created at that time and therefore the HCP was not offered any documents or a summary of the care the facility planned to provide prior to the scheduled March care plan meeting. She said she thinks there is a misunderstanding with the process. During an interview on 2/19/26 at 2:28 P.M., the DON said for baseline care plans the facility should be identifying care needs that need to be addressed prior to the comprehensive care plan meeting or development of the comprehensive care plans and that is at the 48-hour mark following admission. She said falls is definitely one of the items that should be addressed on the baseline care plans to be sure the resident can be kept safe. She reviewed Resident #79's documentation and said the Resident did not have a baseline care plan developed or implemented for prevention of falls and he/she should have since it is the reason for their admission to the facility. She said it doesn't seem as though the staff understand the purpose of the baseline care plan process and the process needs work.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services that met professional standards by failing to implement physician's orders to discontinue Oxycodone (a pain medication), for one Resident (#5), out of a total sample of 17 residents, resulting in Resident #5 receiving the medication for 22 extra days. Findings include:Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated:-Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize errors.-In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Medication and Treatment Orders, undated, indicated but was not limited to the following:-Orders for medications and treatments will be consistent with principles of safe and effective order writing-Orders for medications must include quantity or specific duration of therapy Resident #5 was admitted to the facility in August 2025 and had diagnoses which included metabolic encephalopathy (condition which brain function is disturbed due to diseases or toxins), chronic pain syndrome and opioid (pain medication) dependence. Review of the Minimum Data Set (MDS) assessment, dated 12/19/25, indicated Resident #5 was receiving opioid medication. Review of Resident #5's Hospital Discharge summary, dated [DATE], indicated he/she should receive Oxycodone 5 milligrams (mg) by mouth every 6 hours as needed for severe pain (7-10) for up to 10 days max (maximum). Review of Resident #5's Physician's Orders indicated but was not limited to:-Oxycodone 5mg oral tablet, give one tablet by mouth every 6 hours as needed for severe pain (7-10) for up to 10 days max daily amount 20mg, start date 8/28/25 discontinued 9/30/25. Review of Resident #5's August and September 2025 Medication Administration Record (MAR) indicated he/she had received the medication for 22 extra days. Review of Resident #5's progress notes failed to indicate a provider had been consulted to extend the duration of Oxycodone. During an interview on 2/19/26 at 10:02 A.M., Unit Manager (UM) #1 said all orders are reviewed by a second nurse to complete a second check, and she completes a third check the following day to ensure there are no errors. UM #1 reviewed Resident #5's discharge summary and the MARs for August and September 2025. UM #1 said the order should have been transcribed with a stop date of 9/8/25, and it was not. During an interview on 2/19/26 at 4:21 P.M., the Director of Nursing (DON) said the Oxycodone order should have had a stop date, and the physician's order was not followed. She said her expectations are for all medication orders to be triple checked to ensure they are completed accurately.

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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 provider and addressed in a timely manner for one Resident (#5), out of a total sample of 17 residents. Specifically, the facility failed to ensure recommendations by the pharmacy consultant to clarify two as needed (PRN) albuterol orders (respiratory inhaler), review risk versus benefit of Paxil (Paroxetine, an antidepressant) medication dosing of extended release (ER) 50 milligrams (mg) daily which is over the daily recommended dose of 37.5mg and recommend Narcan order (reverses opioid overdose) as needed (PRN) due to history of recent opioid overdose, was reviewed and responded to by the provider timely. Findings include:Review of the facility's policy titled Medication Regimen Reviews, undated, indicated but was not limited to the following:-The Consultant Pharmacist shall review the medication regimen of each resident at least monthly.-The Consultant Pharmacist will provide the Director of Nursing Services and Medical Director with a written, signed and dated copy of the report, listing the irregularities found and recommendations for their solutions. The Director of Nursing Services/designee shall ensure prompt (e.g. 5-7 business days) action and documentation occurs related to the Consultant Pharmacist's review and recommendations.-Copies of drug/medication regimen review reports, including physician responses, will be maintained as part of the permanent medical record. Review of the facility's policy titled Consultant Pharmacist Reports, dated January 2024, indicated but was not limited to the following:-The Consultant Pharmacist observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion.-A record of the Consultant Pharmacist's observations and recommendations is made available in an easily retrievable form to nursing, prescribers, and the care planning team.-This should include Documentation of the date each medication regimen review is completed and notation of the findings in the medical record.-Comments and recommendations concerning medication therapy and irregularities are reported in a timely manner to ensure the resident's safe and appropriate medication utilization. Resident #5 was admitted to the facility in November 2025 with diagnoses which included chronic obstructive pulmonary disease (COPD- chronic lung disorder resulting in blocked air flow in the lungs), major depressive disorder, and opioid dependence. Review of the Physician's Orders indicated Resident #5 was prescribed the following medications:-Albuterol Sulfate Inhalation Nebulization Solution (2.5mg/3 milliliters (ml)) 0.083% (Albuterol Sulfate) 1 Unit inhale orally via nebulizer every 4 hours PRN for Severe shortness of breath (SOB)/Wheezing, discontinued 2/18/26.-Paroxetine ER 25mg give two tablets = 50mg by mouth one time a day for depression, discontinued 10/21/25.-Paxil controlled release (CR) oral tablet ER 37.5mg one tablet by mouth one time a day related to major depressive disorder, start 10/22/26-Naloxone (Narcan) 0.4mg/ml inject 0.4mg/ml intramuscularly every 2 minutes as needed for sign of opioid overdose. May be repeated every two to three minutes until a response is obtained up to a maximum dose of 10mg. Monitor patient until emergency medical team arrives, start 10/21/25. Review of the progress notes indicated the following:-Pharmacy Consultant made recommendations on 9/17/25 to clarify two PRN albuterol orders, review the Paxil dosing of 50mg daily and recommended adding Narcan PRN.-Pharmacy Consultant made recommendations on 10/14/25 to clarify two PRN albuterol orders, review the Paxil dosing of 50mg daily and recommended adding Narcan PRN.-Pharmacy Consultant made recommendations on 12/16/25 to clarify two PRN albuterol orders.-Pharmacy Consultant made recommendations on 1/19/26 to clarify two PRN albuterol orders. Review of the medical record failed to include the pharmacy consultant recommendation reports made in September, October, and December 2025 and January 2026. Further review of the medical record indicated the physician was made aware of the pharmacy recommendations as follows:-Two albuterol orders discontinued on (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/18/2026, 154 days after the initial recommendation was made.-Paxil ER dosing clarified 10/21/25, 41 days after the initial recommendation was made.-Narcan PRN clarified 10/21/25, 41 days after the initial recommendation was made. During an interview on 2/19/26 at 10:02 A.M., Unit Manager (UM) #1 said the pharmacy consultant emails the recommendations to the unit managers and Director of Nursing (DON) monthly. She prints them and gives them to the provider for review. She documents the findings in a nursing note and gives the recommendations to the DON. During an interview on 2/19/26 at 1:59 P.M., the Pharmacy Consultant said she reviews all of the residents' medication orders monthly. She completes this remotely and in the facility. She said she sends all recommendations over through email to the unit managers and DON. The Pharmacy consultant said the facility has not been achieving 100% compliance with addressing her recommendations and she has seen an increase in duplicate recommendations. The surveyor and pharmacy consultant reviewed the recommendations for Resident #5 together. She said the facility did not address the recommendations timely as they should have. During an interview on 2/19/26 at 4:21 P.M., the DON said all pharmacy recommendations should be reviewed with the providers within a week or sooner of receiving them. She said they should be kept in the Resident's medical record, with the providers response documented. The DON said Resident #5's pharmacy recommendation reports for September, October, and December 2025 and January 2026 could not be located and were not reviewed and completed timely as required.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation and interview, the facility failed to ensure the appropriate modified texture diet was prepared and served for one test tray. Specifically, the facility failed to ensure broccoli was prepared and served in a form designed to meet the individual needs of Residents on a dysphagia advanced diet. Findings include:Review of facility's Diet Guide Sheet indicated the facility was to serve chopped broccoli florets to residents on a dysphagia advanced diet with their lunch on 2/18/26. On 2/18/26 at 12:11 P.M., a test tray was performed; the meal requested included dysphagia advanced texture. The test tray included broccoli florets and stalks. The surveyor observed the florets ranged approximately between dime-sized to quarter-sized and the stalks ranged approximately between dime-sized to nickel-sized on the test tray. On 2/18/26 at 12:11 P.M., the surveyor sampled two broccoli stalks noting the flesh was very tender and easily crushed between the tongue and roof of the mouth while the outer skin remained intact. On 2/18/26 at 12:25 P.M., the surveyor observed one Resident, dining on the second floor, who was on a dysphagia advanced texture and had received broccoli cuts that consisted of all broccoli stems. During an interview on 2/18/26 at 2:30 P.M., the Food Service Director (FSD) said she orders broccoli florets when the food vendor has them in stock and broccoli cuts when the broccoli florets are unavailable. The FSD said she had not collaborated with the Speech Language Pathologist (SLP) regarding this substitution. The FSD said she believed broccoli cuts were comparable to the chopped broccoli florets that were indicated for the dysphagia diet. During an interview on 2/19/26 at 9:14 A.M., Rehabilitation Services Staff (RSS) #2, who was the SLP, said chopped broccoli florets should be served for the dysphagia advanced texture, which could include a portion of the upper tender stalk. RSS #2 said broccoli stalks from the lower stem should not be served on the dysphagia advanced diet. During an interview on 2/19/26 at 9:40 A.M., RSS #2 said dysphagia advanced texture meals should leave the kitchen in the appropriate modified texture and staff on the floor were available to assist with additional cutting of food beyond the recommended diet texture. During an interview on 2/19/26 at 3:16 P.M., the Director of Nursing (DON) said she expected residents on dysphagia advanced diets to receive chopped broccoli florets per the Diet Guide Sheet.

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

Based on interview and record review, the facility failed to maintain complete medical records for two Residents (#5 and #72), out of a sample of 17 residents. Specifically, the facility failed: 1. For Resident #5, to ensure the medical record accurately reflected advance directives as indicated on the Resident's Massachusetts Medical Orders for Life Sustaining Treatment form (MOLST); and2. For Resident #72, to ensure the medical record included the physician's documentation of encounters with the Resident from May 2025 through August 2025. Findings include:

1. Review of the facility's policy titled Advance Directives, dated as revised September 2022, indicated but was not limited to the following:

-The resident has the right to formulate an advance directive, including the right to accept or refuse medical treatment. Advance directives are honored in accordance with state law and facility policy.

-The Director of Nursing (DON) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record.

Resident #5 was admitted to the facility in November 2025 with diagnoses which included chronic obstructive pulmonary disorder (COPD- chronic lung disorder resulting in blocked air flow in the lungs), major depressive disorder, and opioid dependence.

Review of the medical record indicated the Resident and Attending Physician initiated a new MOLST on 2/16/26. The MOLST reflected the following advance directives: Do Not Resuscitate (DNR); Do Not Intubate and Ventilate; Do Not Use Non-invasive Ventilation; Do Not Transfer to Hospital; No Dialysis; No Artificial Nutrition; and Do Not Use Artificial Hydration.

Review of Resident #5's current Physician's Orders indicated, but was not limited to, the following:

-Full Code/MLOST [sic], active, 8/28/25

During an interview on 2/18/26 at 10:31 A.M., Nurse #2 said the code status is put into the computer from what is determined on the MOLST form. Nurse #2 reviewed Resident #5's MOLST and the physician's order in the record and said the Resident should not have an order for a full code. The order was not transcribed correctly.

During an interview on 2/19/26 at 4:21 P.M., the Director of Nursing (DON) said the information in the medical record should be accurate and complete.

2. Review of the facility's policy titled Charting and Documentation, dated as revised in 2008, indicated but was not limited to:

Policy Statement – All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record;

Policy Interpretation and Implementation – All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #72 was admitted to the facility in August 2023 with diagnoses including congestive heart failure, dementia, dysphagia, sepsis, and chronic kidney disease. Review of Resident #72's medical record failed to indicate documentation of provider visits from 4/30/25 through 8/31/25, a total of 124 days. During an interview on 2/19/26 at 11:47 A.M., Unit Manager (UM) #2 reviewed Resident #72's medical record and could not find provider visit notes from 4/30/25 through 8/31/25. During an interview on 2/19/26 at 2:56 P.M., UM #2 said the facility was still trying to locate provider notes from April to August 2025. UM #2 said she would expect provider notes to be in the Resident's medical record. During an interview on 2/19/26 at 3:16 P.M., the Director of Nursing (DON) said Resident #72's medical record should include all provider notes.