STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225485	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Ladys Haven of Fairhaven Inc	71 Center Street Fairhaven, MA 02719

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council Minutes, a resident group meeting, and interviews, the facility failed to ensure grievances/complaints brought forward from the Resident Council were addressed and resolved in a timely manner to ensure the residents felt their concerns were acted upon and included the facility response to the group. Findings include: Review of the facility's policy titled Resident Council, last reviewed 9/2024, indicated but was not limited to the following:- The home will listen to and follow up on resident's complaints and grievances through Resident council meetings and individual resident requests- notify department heads of residents' complaint when presented- schedule department head to answer complaints of the residents at the next meeting or immediately, if required- schedule individual meeting for residents with responsible person to handle complaint or grievances Review of the facility's policy titled Resident/Staff/Family member Grievances, last reviewed 4/2025, indicated but was not limited to the following: The purpose of the policy is to resolve grievances in a timely manner. A grievance will be responded to within 72 hours and resolved. - any resident/staff/family member who has a complaint or suggestion shall report to the charge nurse or social worker on the unit involved, or complete a grievance form- the charge nurse or social worker will respond appropriately and complete the grievance form if one has not already been completed - grievance reports will be submitted to the Administrator/Department head as soon as possible- grievances are resolved utilizing a team approach and the aggrieved will be kept apprised of ongoing progress towards resolution- grievances, actions taken and results are to be documented on the grievance report Review of the Resident Council notes, provided by the facility, from April 2025 to September 2025, indicated but were not limited to the following: - the Activity director was present at each meeting April 10, 2025: 7 residents in attendanceOld Business: Reviewed meeting minutes from last Resident council meeting and they were approved by all in attendance. Other Concerns: Podiatrist comes in very early and sometimes does not alert residents to their arrival in the room. If he could come a little later or make sure the resident is more awake residents would appreciate that instead of being woken up. Residents still stating this is happening will address again with Director of Nurses (DON). May 8, 2025: 4 residents in attendanceOld Business: Reviewed meeting minutes from last Resident council meeting and they were approved by all in attendance. Nursing: 1. During 11:00 P.M. to 7:00 A.M. residents say they are being woken up by the overhead light being put on without warning during rounds and it is startling. 2. Podiatry and lab coming in very early and not waking up residents, just looking at their feet or drawing blood. Not only is being woken up early (between 4:00 A.M. and 5:00 A.M.) unpleasant, but without warning is concerning.3. A few residents have stated that dirty linen is being left in their rooms and not taken out until after lunch, and commodes are not being emptied, and they are not okay with that. Housekeeping: One resident stated that housekeeping comes in at 6:00 A.M. and cleans and moves furniture around and it's disruptive to them. Other concerns: Diet kitchens are not clean with crumbs and food being left out. Also, staff food is being left on counters and not taken home or discarded at the end of the shift. June 19, 2025: 5 residents in attendanceOld Business: Reviewed meeting minutes from last Resident council meeting and they were approved by all in attendance. Nursing:1. During 11:00 P.M. to 7:00 A.M. residents say they are being woken up by the overhead light being put on without warning during rounds and it is startling. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents report this is still an issue.2. Podiatry and lab coming in very early and not waking up residents, just looking at their feet or drawing blood. Not only is being woken up early (between 4:00 A.M. and 5:00 A.M.), but without warning is concerning. Residents report that this has been better. 3. A few residents have stated that dirty linen is being left in their rooms and not taken out until after lunch, and commodes are not being emptied and they are not okay with that. Residents report this has been addressed and dealt with. Housekeeping: One resident stated that housekeeping comes in at 6:00 A.M., and cleans and moves furniture around and it's disruptive to them.*No follow up was documented for this ongoing concernOther concerns: Diet kitchens are not clean with crumbs and food being left out. Also, staff food is being left on counters and not taken home or discarded at the end of the shift. Residents report this has been better. July 24, 2025: 7 residents in attendance; the Administrator also attended this meetingOld Business: Reviewed meeting minutes from last Resident council meeting and they were approved by all in attendance. Nursing: During 11:00 P.M. to 7:00 A.M. residents say they are being woken up by the overhead light being put on without warning during rounds and it is startling. Residents report this is still an issue.Housekeeping: One resident stated that housekeeping comes in at 6:00 A.M. and cleans and moves furniture around and it's disruptive to them. Residents report this is still an issue, but not as bad. Administration: The Administrator attended the meeting to discuss the increase in fire drills and safety education. She also informed the residents if anyone has any questions or concerns, they are always welcome to ask to speak with her. August 20, 2025: 6 residents in attendanceOld Business: Reviewed meeting minutes from last Resident council meeting and they were approved by all in attendance. Nursing:1. During 11:00 P.M. to 7:00 A.M. residents say they are being woken up by the overhead light being put on without warning during rounds and it is startling. Residents report this has been better.2. On the 3:00 P.M. to 11:00 P.M. shift a few residents stated that is seems like there is only one staff member on the floor at times. 3. Agency staff do not know resident routines and/or are rushing through care is an issue.4. One resident stated that their commode was being emptied into their sink on more than one occasion and when they tell the nurse aide not to do that they are ignored. The residents requested to invite the DON to the next meeting to discuss some issues with nursing.Housekeeping: AB kitchen has fruit flies September 18, 2025: 5 residents in attendance; the DON also attended this meetingOld Business: Reviewed meeting minutes from last Resident council meeting and they were approved by all in attendance.Nursing: Residents discussed with the DON, some previous concerns from the last meeting. One resident said that their urinal was being emptied into their sink and the DON responded that that was not acceptable and she would talk with staff. A few residents stated that the staff are loud at change of shift and call down the hallways and the DON responded that she would speak with them so they would be more aware. Housekeeping: AB kitchen has fruit flies. This has been dealt with and is no longer an issue The Resident council meeting minutes revealed ongoing concerns without resolution of many concerns over the last six months including repeat issues of: 1. podiatry or lab services coming in too early and not ensuring the residents are awake for 3 of 6 months reviewed2. residents being startled by their overhead light being turned on at night for 4 of 6 months reviewed3. housekeeping disrupting a residents sleep by moving things and cleaning their room at 6:00 A.M. for 3 of 6 months reviewed Review of the facility grievance book failed to indicate any grievances were formulated for any ongoing individual concerns brought forth by one resident or the resident council as a group. During an interview on 9/25/25 at 2:20 P.M., the Administrator said as far as she knows there is no paper trail that is kept to show that department heads are aware of the residents' concerns in resident council and she believes that the Activity Director (AD) communicates with them verbally or possibly through email. She said the AD can explain the process. During an interview on 9/25/25 at 3:41 P.M., the AD said following each resident council meeting she meets with the Administrator to make them aware of the issues and then informs the department head verbally. She said she does not have any emails or a paper trail of notifying the correlating department heads of any concerns brought forth in resident council or any ongoing plans or resolutions to share with the (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents at the next meetings. She said the only way she knows if something is better or worse is when the residents tell her. She said the department heads do not come to the next meeting, as the policy indicates, but they are aware when the next meeting is happening because she will remind them that they had concerns at the previous meeting and when they are having another meeting. She said if a concern is resolved she will document in the notes the issue is resolved or has been dealt with. She said she has no way of knowing if the department heads are working to resolve the concerns she's informed them of, but there are repeated concerns, and the residents will let her know if something is still an issue, better, or dealt with. She said on review of the policy it seems the policy is not being followed. During a group meeting held on 9/26/25 at 10:37 A.M., the eight residents in attendance shared the following information with the surveyor.- 6 out of 8 residents said the issue of being awoken on the overnight shift with their overhead lights being turned on was not resolved, is ongoing and they feel it is intrusive and startling. One resident said, No one seems to mind that I'm not getting any restful sleep, they continued to say they have informed staff their preference is to not be woken up through the night but the staff don't listen. - 3 out of 8 residents said their urinals are still being emptied into the sinks in their rooms. One resident said they felt when they reported the issue, the facility wanted them to solve it for themself and didn't provide them with any offers of a resolution except to tell them to redirect the person who is doing it at the time it is occurring. The resident said, it is an issue that administration and the people who run this building need to take responsibility for and address with their staff to make it better. - 5 out of 8 residents said they do not know where the grievance forms are located, and they do voice their concerns through resident council and verbally tell staff, but staff have never offered them a grievance form or assistance to complete a grievance form. The residents said they get responses from the staff when they voice concerns or complaints including: ok, they're agency so they don't know , or oh let me tell someone who can look into that, or let me check and get back to you, but no response or resolution or follow up of any kind ever occurs. - 5 out of 8 residents said they have verbally complained over and over when they are and are not in the resident council and no one ever follows up with them. They said it's exhausting to have to tell people the same thing every day just for them not to listen or care. - 6 out of 8 residents said there are no resolution to issues brought up consistently - 5 out of 8 residents said they don't feel anyone is listening anymore- 7 out of 8 residents said they felt the resident council was ineffective in consistently addressing concerns and the facility does not respond or listen. One resident commented they have to repeat the same things over and over until it's just not worth saying anymore and 5 out of 8 residents agreed with this comment. During an interview on 9/26/25 at 2:35 P.M., the Administrator said she doesn't feel the resident council is working in the way it is intended to, and the facility cannot provide any documentation of any follow up or attempts to resolve the concerns brought forth in the resident council meetings.

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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 interview and document review, the facility failed to ensure residents had access to grievance forms to formulate grievances anonymously and implement their grievance process to ensure grievances were addressed, responded to promptly, residents were provided a resolution to their grievance, and the information was documented on the grievance forms in use by the facility. Specifically, the facility failed to:a. Ensure residents were able to formulate grievances anonymously and had grievance forms easily accessible to them to complete a grievance without having to rely on the staff to provide them with the form; andb. Ensure the facility provided follow up and resolution to a grievance of an excessively loud television verbally reported by two separate Residents (#20 and #73) from the AB unit out of a sample of 18 residents and three resident units. Findings include: Review of the facility's policy titled Resident/Staff/Family member Grievances, last reviewed: 4/2025, indicated but was not limited to the following: The purpose of the policy is to resolve grievances in a timely manner. A grievance will be responded to within 72 hours and resolved. - any resident/staff/family member who has a complaint or suggestion shall report to the charge nurse or social worker on the unit involved, or complete a grievance form- the charge nurse or social worker will respond appropriately and complete the grievance form if one has not already been completed - grievance reports will be submitted to the Administrator/Department head as soon as possible- grievances are resolved utilizing a team approach and the aggrieved will be kept apprised of ongoing progress towards resolution- grievances, actions taken and results are to be documented on the grievance report a. During an interview on 9/25/25 at 10:06 A.M., the Administrator said that she was the grievance official for the facility. During a group meeting on 9/26/25 at 10:37 A.M., five out of eight residents in attendance said they do not know where the grievance forms are located in order for them to file a grievance independently and they have never been offered a grievance form when voicing concerns to a staff member. During a tour of the AB and 2 Medical unit on 9/26/25 at 11:37 A.M., the surveyor did not observe or locate any grievance forms or grievance information to be available for the residents/resident's responsible parties on the unit. During an interview on 9/26/25 at 11:39 A.M., Certified Nurse Aide (CNA) #5 said she has no idea where the grievance forms are located and she hasn't seen any, so if a resident were to ask, she would have to alert a nurse. During an interview on 9/26/25 at 11:41 A.M., CNA #6 said she believes the grievance forms are kept in a file or cabinet behind the nurses' stations and the residents would have to request one if they needed one. During an interview on 9/26/25 at 11:58 A.M., Nurse #3 said that grievance forms are not available for residents to access on the units, instead they are stored in a file cabinet behind the nurses' station. During a tour of the 1st floor nursing unit on 9/26/25 at 12:24 P.M., the surveyor did not observe or locate any grievance forms or grievance information to be available for the residents/resident's responsible parties on the unit. During an interview on 9/26/25 at 12:26 P.M., CNA #1 said grievance forms are kept with the nurses at the desk behind the nurses' station. During an interview on 9/26/25 at 12:27 P.M., Unit Manager #2 said grievance forms are kept at the nurses' stations behind the desk, and the residents or families would have to request a form or request staff complete a form for them; they are not available without asking. During an interview on 9/26/25 at 12:48 P.M., the Social Worker said grievance forms are available in the lobby and on each unit behind the nurses' stations. She said the forms are not accessible to the residents on the nursing units and they couldn't complete one anonymously. She said the residents do have the right to complete a grievance anonymously and they should have access to the forms without having to ask a staff member, but they currently do not unless they are capable of making their way to the lobby independently. During an interview on 9/26/25 at 2:25 P.M., the Administrator said the residents are encouraged to report concerns or complaints to the staff who should then be filling out a grievance form for the residents. She said she is unsure how a resident would be able to formulate a grievance anonymously if they cannot (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	independently make their way to the lobby since the grievance forms on the nursing units are kept behind the nurses' stations. b. During a group meeting on 9/26/25 at 10:37 A.M., Resident #20 and Resident #73 said they have voiced concerns and complaints numerous times about another resident on the unit with an excessively loud television in the evening and night and have received no response or resolution to their ongoing concerns. Resident #20 said they were told they have rights, and you don't have a right to complain about that. Resident #73 said they act as if we don't have the right to be able to sleep through the night or enjoy a little peace without disruption. Both Residents #20 and #73 agreed they were speaking about the same resident and Resident #31 said they are also bothered by the excessively loud television but has not complained about it because they feel no one cares to help. Review of the facility's Grievance Book January 2025 to present failed to indicate a grievance had been formulated regarding Resident #20 and Resident #73's concern. During an interview on 9/26/25 at 12:48 P.M., the Social Worker said she was aware of the complaints of a loud television at night by Resident #20 and Resident #73 and it has been an ongoing issue that she has not been able to resolve. She said both Residents have complained about a TV belonging to another resident on the unit that they say is excessively loud in the evening and night. She said she did not complete a grievance form for this issue and has just been trying to keep the peace and make all the residents happy. She said residents have the right to verbally provide a concern or a complaint and that should be addressed through the grievance process, but she did not do that in these instances. She said she has received other concerns or complaints in which she'll ask the resident if they would like her to do a grievance and they will say that they don't want a big deal made out of it, they just want it resolved, but on reflection she can see how all concerns and complaints should be managed through the grievance process as indicated by the regulation and facility policy. During an interview on 9/26/25 at 2:35 P.M., the Administrator said when staff are told a complaint or concern, they should be filling out a grievance form and following the process. She said the Social Worker should have completed a grievance for the two Residents complaining about excessive noise, and she was not aware of that situation. She said it is clear the grievance process is not being followed as intended and she wants to make sure the residents in the facility feel heard and aware the facility is taking their concerns seriously so they must come up with a better way to implement the grievance process.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to properly follow sanitation and food handling practices to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Specifically, the facility failed to:1. Handle ready to eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another);2. Ensure that dietary staff maintained and performed appropriate hand hygiene practices while preparing and serving meals for residents in the facility's main kitchen; 3. Reheat food according to safety standards to prevent food borne illness; 4. Ensure dietary staff wear hair coverings in the kitchen during food service; and5. Ensure thickened beverage items and/or food items were properly dated and stored in three of three kitchenette refrigerators.1. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: 3-302 Preventing food and ingredient contamination; (A) FOOD shall be protected from cross contamination by: (3) Cleaning equipment and utensils as specified under 4-602.11(A) and sanitizing as specified under S 4-703.11; 4-602.11 Equipment Food-Contact Surfaces and Utensils; (A) Equipment food-contact surfaces and utensils shall be cleaned: (3) Between uses with raw fruits and vegetables and with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD; (5) At any time during the operation when contamination may have occurred.During an observation with interview on 9/29/25 at 11:29 A.M., the surveyor observed [NAME] #1 begin taking food temperatures with a thermometer. She inserted the thermometer into a food item. She then took the thermometer out and immediately used it to temp the next food item. The thermometer became submerged in a food item and [NAME] #1 rinsed the thermometer with running sink water and then inserted the thermometer into the remaining food items. She did not wipe or sanitize the probe between food items. [NAME] #1 said this was her process for taking food temperatures prior to food service and at the conclusion of food service. During an interview on 9/29/25 at 12:22 P.M., the Food Service Director (FSD) said [NAME] #1 should have cleaned the thermometer after temping each food item to prevent cross contamination and maintain food safety. 2. During observation of the lunch meal distribution tray line on 9/29/25 starting at 11:29 A.M., the surveyor observed [NAME] #1 utilize her gloved hands to plate sliced meat on individual plates multiple times. She left the tray line and with the same gloved hands, spun a utensil hanger turnstile to retrieve a pair of tongs. She returned to the tray line and resumed plating food with her contaminated gloves. [NAME] #1 then left the tray line, retrieved a pre-made omelet, touched the microwave oven door handle to open it, placed the omelet inside the oven, closed the door and pressed the buttons to start the oven. 30 seconds later, she removed the omelet from the microwave oven and immediately returned to the tray line and resumed plating food with her contaminated gloves.During an interview on 9/29/25 at 12:22 P.M., the FSD said [NAME] #1 should have changed her gloves and performed hand hygiene after touching other items in the kitchen and before resuming food service to maintain sanitation. 3. Review of the facility's policy titled Microwave Reheating of Resident Food, undated, indicated but was not limited to:-All cooked foods being reheated in the microwave are heated to the proper temperature according to Safe Food Handling Guidelines.Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated but was not limited to: 3-403.11). (1) Except as specified under subsections (2), (3), and (5) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding must be reheated so that all parts of the FOOD reach a temperature of at least 165 F (74 C) for fifteen seconds. (2) Except as specified under subsection (3) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD reheated in a microwave oven for hot holding must be reheated so that all parts of the FOOD reach a temperature of at least 165 F (74 C) and the FOOD is rotated or stirred, covered, and allowed to stand covered for two minutes after reheating.On (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/29/25 at 11:50 A.M., the surveyor observed [NAME] #1 retrieve a pre-made omelet, place it in the microwave oven, and start it. The microwave oven sounded after 30 seconds and she removed the omelet from the oven and immediately returned to the tray line and put the omelet on a plate and placed it on a tray. [NAME] #1 did not measure the temperature of the omelet to ensure it had been reheated to a safe temperature prior to serving.During an interview on 9/29/25 at 11:51 A.M., [NAME] #1 said she made the omelet earlier that day and reheated it in the microwave oven for 30 seconds. She said she then put it on a plate and placed it on the tray. She did not measure the temperature of the omelet.During an interview on 9/29/25 at 12:22 P.M., the FSD said [NAME] #1 should have followed food reheating safety protocols and should have temped the omelet after it was reheated in the microwave. 4. Review of the facility's policy titled Hair Restraints, last reviewed October 2024, indicated but was not limited to the following:-All staff in a food preparation/serving areas or dish room are required to wear a hair restraint that effectively prevents hair from contacting exposed food.-All employees who have facial hair are required to wear a disposable beard protector.Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from FDA Food Code 2022 Chapter 2.During an observation of the facility's kitchen on 9/29/25 from 11:55 A.M. to 12:20 P.M., the surveyor observed one of one dietary staff with a full beard, covering his cheeks and neck in the main kitchen during meal service without wearing a beard covering.During an interview on 9/29/25 at 12:22 P.M., the FSD said Dietary Staff #1 delivers food trucks to the unit and also does dishwashing and is in and out of the main kitchen frequently during tray line service and is supposed to wear a beard covering but is not. 5. Review of the facility's policy titled Storage of Leftover Foods, last reviewed April 2025, indicated but was not limited to the following:-The facility prepares, holds and store foods in accordance with Food Code Standards, observing state and federal regulations.-Stored leftovers must be clearly labeled and dated, including resident name and room number, in food safe containers with secure cover/wrap.Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:3-501.17 Ready to-Eat, Time/Temperature Control for Safety Food, Date Marking.(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date of day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3-29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by-date if the manufacturer determined the use-by-date based on FOOD safety.-On 9/30/25 at 9:05 A.M., the surveyor and FSD observed the first-floor unit. The FSD said the kitchen staff monitors the kitchenettes' cleanliness and police food dating. He said any resident specific food items should be labeled with the resident's name and have a date when it was brought in. The FSD said any opened items should be labeled and dated with the date it was opened. The FSD and surveyor observed the following in the first-floor unit refrigerator:-One opened single serve container of Boost Breeze, undated;-One opened container of thickened orange juice with an illegible opened date observed as a colored splotch with no decipherable lines or numbers.The FSD said the Boost Breeze and thickened orange juice should be labeled and dated with the date they were opened. Any items with no label/date should be discarded.-On 9/30/25 at 9:20 A.M., the FSD and surveyor observed the kitchenette on the second-floor medical unit. The FSD said he had already checked the unit kitchenettes earlier that morning to be sure everything was as it should be. He said he checks kitchenettes twice per week and demonstrated to the surveyor his process of checking unit (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerators which involved ensuring the refrigerator was clean and food items had the appropriate labels and dates. The surveyor observed the FSD check the dates on a sample of items in the refrigerator and failed to check any thickened liquids or the Lactaid milk container. The FSD closed the refrigerator door and confirmed that all items inside were labeled and dated appropriately and safe for consumption.During the same observation, the FSD and surveyor reviewed the refrigerator a second time and observed the following:-five opened containers of thickened liquids, undated, with specific manufacturer instructions on each label indicating the number of days it was acceptable to use the product after opening/when the product should be discarded after opening;-one opened carton of Lactaid milk, undated, with manufacturer instructions indicating to discard 14 days after opening.The FSD said those items should be discarded because they are not labeled with the date they were opened.On 9/30/25 at 9:20 A.M., the FSD and surveyor observed the unit freezer and found a storebought coffee with a straw in the freezer with no name or date. The FSD said it should be labeled and dated.On 9/30/25 at 9:30 A.M., the FSD and surveyor reviewed the kitchenette on the second-floor A&B unit. The FSD demonstrated his process for checking refrigerated items which was to ensure the refrigerator was clean and food items had the appropriate labels and dates. The surveyor observed the FSD check the dates on a sample of items in the refrigerator. The FSD and surveyor observed a wrapped food item in a plastic container that had a resident's name but no date. The FSD said there should be a date on it and placed it back in the refrigerator. The FSD checked a sample of items in the refrigerator and confirmed all items in the refrigerator were appropriate and safe for consumption.During the same observation, the FSD and surveyor reviewed the refrigerator a second time and observed the following:-two opened containers of Lactaid milk, undated, with manufacturer instructions indicating to discard 14 days after opening;-one opened glass jar of prunes with a residents name but no date;-one opened bottle of Gatorade with no name or date.The FSD said the Lactaid should be dated when it was opened. He said the Gatorade should be labeled with a resident's name and dated when opened. He said he was unsure of when the prunes were opened but would ask the charge nurse. He placed the prunes back into the refrigerator.On 9/30/25 at 9:40 A.M., the unit nurses said they were unsure of when the jar of prunes were opened.During an interview on 9/30/25 at 11:57 A.M., the Administrator said all items in the unit kitchenettes should be labeled and dated appropriately and any opened item should have the date it was opened so staff knows when to discard it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to follow infection control and prevention practices. Specifically, the facility failed to:1. Ensure staff removed personal protective equipment (PPE) appropriately when exiting the room of Resident #54, who was on transmission-based precautions (TBP);2. Implement remediation measures in response to positive Legionella (a type of bacteria that can grow in water systems and can cause Legionnaires' disease, a serious lung infection); and3. Ensure staff wore appropriate PPE in accordance with the TBP/ isolation precaution signs posted outside of Resident #74's room.Findings include:Review of the facility's policy titled Coronavirus Guidelines, updated 5/2023, indicated, but was not limited to, the following:-Use of PPE:*Ensure that healthcare personnel are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient/resident, including attention to correct use of PPE.*Monitor staff adherence to hand hygiene and correct PPE use-Positive Resident:*Isolation sign should be placed outside door*Full PPE including N95 masks Review of the Centers for Disease Control and Prevention (CDC)'s Infection Control Guidance: SARS-CoV-2, dated 6/24/24, indicated, but was not limited to, the following:-If they [face masks] are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned. Review of the Massachusetts Department of Public Health Isolation Droplet/Contact Precautions sign, updated 1/4/22, indicated in addition to standard precautions, staff and providers must: clean hands when entering and exiting, change gown between each resident, and wear an N95 respirator, eye protection, and gloves. 1. Review of the facility's Resident COVID/Flu/RSV Testing Log indicated Resident #54 tested positive for COVID-19 on 9/23/25. On 9/25/25 at 11:07 A.M., the surveyor observed a red Isolation Droplet/Contact Precautions sign hanging outside of Resident #54's room with a PPE supply container below. The surveyor observed Housekeeper #1 enter the Resident's room wearing an N95 mask, gloves, and gown. Housekeeper #1 did not don eye protection before entering the room. Housekeeper #1 exited the room on 9/25/25 at 11:10 A.M., removed her gown and gloves and sanitized her hands. Housekeeper #1 did not remove her N95 mask. During an interview on 9/25/25 at 11:12 A.M., Housekeeper #1 said staff should wear an N95 mask, gown, and gloves when entering the room of a resident on isolation precautions for COVID-19. When asked if staff should wear eye protection when entering the room of a resident on isolation precautions for COVID-19, Housekeeper #1 said staff may need to wear eye protection if performing care. During an interview on 9/30/25 at 2:19 P.M., the Infection Prevention Nurse said that when a staff member enters the room of a resident on isolation precautions for COVID-19, he/she should wear full PPE, including an N95 mask, gown, gloves, and eye protection regardless of whether or not they are providing direct care. The Infection Prevention Nurse said that upon exiting the room, the staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	member should remove the N95 mask, sanitize their hands, and don a new N95 mask. The Infection Prevention Nurse said it was difficult for staff to comply with this on units with residents with active COVID-19 infection because the facility staff were to utilize N95 masks at all times while on the unit for source control and they did not always remember that they needed to change the N95 mask after exiting the room of a resident on isolation precautions. 2. Review of the facility's Legionella Management Plan, dated 11/9/17, indicated, but was not limited to, the following:-Legionella Management Plan Program Team members include: the facility's Administrator, the facility's Director of Facility Operations, Plumber, Consultant Account Manager and District Manager, and the facility's Infection Control Nurse.-This plan focuses on controlling the specific hazardous bacterium, Legionella Pneumophilia, which may develop and proliferate in potable water systems – to include both cold water and hot water distribution systems.-The mist from devices connected to water distribution systems contains water droplets. If the Legionella Pneumophilia bacteria is present in the water droplets, people exposed to the mist can become sick from Legionnaire's Disease by inhaling that mist. -Hot water temperature is monitored daily by the maintenance department. In-room hot water temperature should be between 108 degrees Fahrenheit (F) and 110 degrees F. If below 108 degrees F, the temperature should be increased and if above 110 degrees F, the temperature should be decreased.-Strategies employed under this plan to control the hazard include –1. Testing and monitoring of systems, including water samples2. Chemical treatment of the potable water system if needed (secondary building disinfection)3. Cleaning and disinfection4. Implementing shut-down and start-up procedures5. Maintenance steps to address low-flow and stagnant zones6. Contingency plans to be undertaken in response to actionable test results. -Testing shall be carried out on a semiannual basis.-These additional requirements are to be addressed as part of this plan and recorded in the Water Management Plan log book:*Note any out-of-compliance item*A relevant corrective action taken*Develop and document specific procedures for implementing water system disinfection in the event that future Legionella is found. -External Microbiology Monitoring – This shall consist of bacteria and Legionella Pneumophilia sampling as necessary. Samples are collected and tested through a qualified laboratory. This work is carried out semi-annually, at the time of the CWT (Certified Water Technologist) water system inspection visit. Laboratory reports are emailed to program team members. One sample will be as close to the main entering the facility [sic], one sample will be directly from the hot water tank, the others will be distill sites throughout the building.-Disinfection and Response Procedures for Potable Water Systems – Legionella testing will be used to drive any remediation actions. Results are reported promptly to Program Team members, and authorization for work to be carried out occurs through the Director of Facility Development and Planning. -If the percentage of positive Legionella test sites is greater than 30%, response includes:*Immediately institute short-term control measures (temporary interventions that may include, but are not limited to, heating, and flushing, the water system, hyperchlorination, or temporary instillation of treatment such as copper silver ionization or chlorine dioxide) in accordance with the direction of a qualified professional, and notify the department.*The water system shall be re-sampled no sooner than seven days and no later than four weeks after disinfection to determine the efficacy of the treatment.*Retreat and retest.-For both hot and cold water systems, the Water Management Program documents shall include:*Procedures for emergency disinfection*Procedures for other actions identified as necessary by the Program Team to prevent exposure to contaminated water Review of the facility's Legionella test results indicated that on 8/28/25, eight samples were collected from the facility's water system for Legionella testing. Five of those samples were taken from residential room handwashing (HW) sinks. The test results were reported 9/5/25 at 10:31 A.M. Results included:-room [ROOM NUMBER] HW sink – 2.6 MPN (Most Probable Number, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	equivalent to colony forming units per milliliter [CFU/ml]).-room [ROOM NUMBER] HW sink – 2.2 MPN-room [ROOM NUMBER] HW sink – 4.7 MPN-room [ROOM NUMBER] HW sink – 50.7 MPN Review of the attached Interpretation of Legionella Culture Results indicated that for results between 10 and 100 CFU/ml, immediate disinfection should be initiated within 24 hours and water should be retested in three to seven days. Review of the facility's hot water temperature logs provided by the facility's Director of Facility Operations on 9/30/25 indicated four hot water temperature checks were completed per month. Further review of the hot water temperature logs indicated:-On 7/7/25, the hot water temperature in room [ROOM NUMBER] was 101 degrees F-On 7/14/25, the hot water temperature in room [ROOM NUMBER] was 104 degrees F-On 8/11/25, the hot water temperature in room [ROOM NUMBER] was 103 degrees F-On 8/18/25, the hot water temperature in room [ROOM NUMBER] was 102 degrees F-On 8/25/25, the hot water temperature in room was not recorded-On 9/15/25, the hot water temperature in room [ROOM NUMBER] was 106 degrees F The facility failed to provide evidence of any action taken in response to out of compliance items and actionable test results. The facility's Director of Facility Operations provided the surveyor with documentation of an email he received from the Consult Account Manager on 9/10/25 that indicated results of the facility's recent Legionella testing included multiple positives. The Account Manager requested to set up a risk assessment of the site to identify what potential issues may have been. During an interview on 9/30/25 at 12:06 P.M., the Director of Facility Operations said the facility's Legionella test results were usually negative, but there had been positive results with their most recent testing. The Director of Facility Operations said that the consultant company had come in and were working on finding out what the underlying cause for the positive results was, but he had not received any documentation with that information. The Director of Facility Operations said he was responsible for checking water temperatures and maintained those records in an electronic log. During an interview on 9/30/25 at 12:39 P.M., the Administrator said the consultant company performed a water system disinfection, which she believed was in August. The Administrator said she was not sure if the disinfection was performed before or after the Legionella testing samples were obtained. The Administrator said the consultant company had come out to do a risk assessment, but the facility had not received any documentation related to that yet. During an interview on 9/30/25 at 12:57 P.M., the Administrator said she was informed that the Legionella test samples were taken by the consultant company after the disinfection was done and she was waiting to receive the report containing the disinfection information from the consultant company. During a telephone interview on 9/30/2025 at 1:58 P.M., the Consultant Account Manager said that it is the company's responsibility to report the test result findings to the facility and refer the facility staff to their water management plan, but the facility staff were responsible for implementing corrective action. The Consultant Account Manager said there was a Legionella specialist that he would refer the surveyor to. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	As of 10/1/25 at 11:36 A.M., the Consultant Account Manager had failed to provide the surveyor with further contact information for the Legionella specialist. During an interview on 9/30/25 at 2:19 P.M., the Infection Control Nurse said she was aware that the facility's water testing had had positive Legionella results, but it was her understanding the results were within acceptable standards and the Director of Facility Operations had been working with the consultant company to address the issue. The Infection Control Nurse said the facility had not tested any residents for Legionella and had not identified any residents with Legionnaire's Disease. During an interview on 9/30/25 at 4:30 P.M., the Administrator provided the surveyor with the Risk Assessment Report and disinfection documentation from the consultant company that she had just received. She said the bi-annual chlorine disinfection took place over multiple dates due to difficulty obtaining high enough chemical levels for disinfection but was completed successfully on 8/25/25. Review of the Risk Assessment Survey Comments and Recommendations section, completed by the consultant company on 9/17/25, indicated, but was not limited to, the following:-The chlorine residual entering the building was very low (0.08 parts per million (ppm), desired residual is 0.50ppm).-Secondary disinfection is recommended. Room for this equipment in the boiler room is limited. There are old domestic hot water heat exchangers that could be removed.-The hot water heater is insufficient to heat a facility of this size. There are 89 rooms, a commercial laundry and a commercial kitchen.-Piping in the boiler room takes quite a bit of time to understand. There have been many things added to keep the building going that are likely counterproductive to the system's proper operation.-Develop and implement a Water Management Plan for the control of Legionella in building water systems, with special attention to flow, temperature and disinfectant control measures.-Conduct sampling at minimum once per quarter interval to establish baseline data and demonstrate system control. Recommended sampling plan for 12 total samples.-Monitor free chlorine in cold and hot water fixtures weekly at six distal points (near, mid, and far points of distribution).-Regarding hot water temperatures, consider raising setpoints so that 120 degrees F is attainable at all sentinel outlets.-Develop SOP (standard operating procedures) for shut down, isolation, refilling of water service areas. During an interview on 9/30/25 at 4:40 P.M., the Administrator said she was not aware that the positive Legionella testing samples were collected from the facility on 8/21/25, before the chlorine disinfection had been completed. 3. Review of the Isolation sign in use by the facility, dated as last updated 1/4/22, indicated but was not limited to the following: STOP Isolation Droplet/Contact Precautions, In addition to standard precautions staff and providers MUST: Clean hands when entering and exiting; wear a gown, N-95 respirator mask, eye protection (goggles or face shield) and gloves (change between residents) During an interview on 9/25/25 at 7:41 A.M., the Administrator said they had COVID-19 positive residents in the facility. She said residents have signs posted outside of their rooms and the expectation is the staff are using the PPE in accordance with the signage. Resident #74 was admitted to the facility in May 2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #74's medical record indicated the Resident tested positive for COVID-19 on 9/20/25 and had symptoms consistent with a fever on that day. The Nurse Practitioner (NP) evaluated the Resident on 9/22/25 and indicated to continue quarantine per facility protocol. On 9/25/25 at 8:56 A.M., the surveyor observed a red Isolation sign posted directly outside of Resident #74's bedroom door. Certified Nursing Assistant (CNA) #3 was observed in the room assisting the Resident with his/her breakfast. CNA #3 was not observed to have any eye protection in place during this task, in accordance with the posted sign outside of the Resident's door. Nurse #1 was standing outside the Resident's room preparing medications for Resident #74 and donned (put on) all necessary PPE in line with the posted sign including: gown, gloves, N95 mask and eye protection and entered the room. Nurse #1 was not observed or heard to redirect CNA #3 for not wearing the appropriate PPE while being in the COVID-19 positive room. At 9:05 A.M., CNA #3 exited the Resident's room. During an interview on 9/25/25 at 9:05 A.M., CNA #3 said Resident #74 was on isolation for COVID-19. She said staff are required to follow the posted signs outside the rooms when determining which PPE to use prior to entering the room. On review of the sign, CNA #3 said she was not wearing eye protection in the room and just forgot about it. During an interview on 9/25/25 at 9:06 A.M., Nurse #1 said the expectation is that the staff are using PPE in accordance with the signs posted outside the residents' doors. She said that CNA #3 should have had eye protection on and did not while she was in Resident #74's room. During an interview on 9/30/25 at 10:52 A.M., the Director of Nurses said the expectation for staff entering a COVID-19 positive room is for them to wear full PPE and follow the signs posted outside of the residents' rooms, including Resident #74's. She said full PPE includes gloves, gown, N95, and eye protection. During an interview on 9/30/25 at 2:19 P.M., the Infection Preventionist said when staff are entering a room with an isolation precaution sign, they should be wearing full PPE.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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 one Resident (#64), out of a sample of 18 residents. Specifically, for Resident #64, the facility failed to ensure the medical record included the physician's documentation of encounters with the Resident. Findings include:Review of Resident #64's medical record included but was not limited to nursing progress notes, dated 10/8/24, 10/15/24, 11/19/24, and 2/11/25, that indicated the Resident had been seen by the physician on those dates: -10/8/24: Seen by the physician for positive COVID;-10/15/24: Seen by the physician for 60 day visit; -11/19/24: Seen by physician for coated tongue;-2/11/25: Seen by physician for psych recommendation review. Further review of Resident #63's medical record failed to include the physician's documentation for the encounters. During an interview on 9/30/25 at 11:06 A.M., the Director of Nursing (DON) said the nursing progress notes indicated the physician had visited Resident #63 on 10/8/24, 10/15/24, 11/19/24, and 2/11/25. The DON said the facility had not received the physician's documentation for those dates. The DON said a complete medical record would include the physician's documentation of his encounter with the Resident for 10/8/24, 10/15/24, 11/19/24, and 2/11/25.