STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225497	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	1190 Vfw Parkway Boston, MA 02132

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on interviews, observations, and policy review, the facility failed to ensure staff treated residents in a dignified manner during the dining experience. Specifically, 1. For Resident #56 who was dependent on staff for assistance with meals, the facility failed to provide assistance when his/her meal was delivered. 2. For Resident #66 who was dependent on staff for assistance with meals, the facility failed to provide assistance when his/her meal was delivered. 3. On the [NAME] 2 unit and the China Garden 1 unit, the facility failed to provide a dignified dining experience. 4. On the China Garden 2 unit, the facility failed to provide a dignified dining experience in the dining room. Findings include: Review of the facility policy titled Dignity/Quality of Life, dated 12/6/21, indicated Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. 1. Resident #56 was admitted to the facility in June 2020 with diagnoses that included dementia, dysphagia, type 2 diabetes, and major depressive disorder. Review of Resident #56's most recent Minimum Data Set (MDS) assessment, dated 1/2/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Further review of the MDS indicated the Resident is dependent on staff for eating. On 2/11/25 from 8:14 A.M. to 8:26 A.M., the surveyor observed Resident #56 in bed with his/her breakfast tray in eye sight not set up for consumption. No staff were present in the room to assist the Resident with their meal. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25 from 12:07 P.M. to 12:26 P.M., the surveyor observed Resident #56 in bed with his/her lunch tray within reach not set up for consumption. No staff were present in the room to assist the Resident with their meal. Review of Resident #56's dysphagia care plan, dated 7/17/24, indicated Please do not leave food or drinks in my room unsupervised. I may attempt to eat or drink without supervision which can lead me to choking. Review of Resident #56's activity of daily living care plan, dated 7/17/24, indicated I need your total assistance with eating. I can participate at times. Review of Resident #56's active CNA (Certified Nurse Aide) Kardex (form explaining to staff what level of assistance each resident needs), indicated Total dependence at meal times. During an interview on 2/11/25 at 12:22 P.M., Nurse #1 said the staff are not listening to her to feed the residents who need to be fed. Nurse #1 said the meal trays should not be given to the resident until they are ready to assist them with their meal. Nurse #1 said Resident #56 does need to be assisted with their meals. On 2/13/25 at 11:08 A.M., the Staff Development Coordinator (SDC) said staff should only give a resident a meal once the staff member is ready to assist them with that meal for dignity reasons. 2. Resident #66 was admitted to the facility in April 2019 with diagnoses that included cerebral infraction, dysphagia, bipolar disorder, and paranoid schizophrenia. Review of Resident #66's most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Further review of the MDS indicated he/she is dependent on staff for eating. On 2/11/25 from 8:18 A.M. to 8:27 A.M., the surveyor observed Resident #66 in bed with his/her breakfast tray in eye sight not set up for consumption. No staff were present in the room to assist the Resident with their meal. On 2/11/25 from 12:02 P.M. to 12:22 P.M., the surveyor observed Resident #66 in bed with his/her lunch tray in eye sight not set up for consumption. No staff were present in the room to assist the Resident with their meal. Staff were also observed in the hallway picking up other residents finished meal trays. Review of Resident #66's activity of daily living care plan, dated 2/2/24, indicated I require total assistance from staff with my meals. During an interview on 2/11/25 at 12:22 P.M., Nurse #1 said the staff are not listening to her to feed the residents who need to be fed. Nurse #1 said the meal trays should not be given to the resident until they are ready to assist them with their meal. Nurse #1 said Resident #66 does need to be assisted with their meals. On 2/13/25 at 11:08 A.M., the Staff Development Coordinator (SDC) said staff should only give a resident a meal one the staff member is ready to assist them with that meal for dignity reasons. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45984 3. The following was observed on 2/11/25 at 12:15 P.M., on the [NAME] 2 Unit: - A Nurse was heard referring to residents as feeders outside of dining room within the vicinity of the residents. - A Certified Nursing Assistant was observed assisting a resident with his/her meal while sitting on the arm rest of a chair, not sitting at the level of the resident. The following was observed on 2/11/25 at 12:25 P.M., on the China Garden 1 Unit: - A Certified Nursing Assistant was observed standing while assisting a resident with his/her meal, not sitting at the level of the resident. The following was observed on 2/12/25 at 7:55 A.M., on the China Garden 1 Unit: - A Nurse was heard referring to residents as feeders multiple times outside of dining room within the vicinity of the residents. During an interview on 2/11/25 at 12:30 P.M., the Regional Administration said staff should be seated while assisting a resident with their meal. During an interview on 2/12/25 at 12:32 P.M., Nurse #1 said staff should not refer to residents as feeders for dignity reasons. 4. The following was observed in the China Garden 2 Dining Room: During breakfast service on 2/11/25 the following was observed: - A table containing four residents were served breakfast at 8:21 A.M., 8:30 A.M., 8:33 A.M., and 8:34 A.M. While the last resident was waiting for his/her meal, he/she was signaling to staff by pointing to tablemate's trays, pointing to his/her mouth and waving for his/her food. While the Resident was waiting for his/her food, he/she took another resident's drink, proceeded to drink it and put it back on the tray. The Resident then began eating food from another resident's tray. Staff were in the dining room passing out trays and did not intervene. During lunch service on 2/12/25 the following was observed. - A table containing the same four residents as breakfast on 2/11/25 were served lunch at 12:08 P.M., 12:08 P.M., 12:13 P.M., and 12:17 P.M. While the last resident (the same resident who was served last during breakfast service on 2/11/25) was waiting for his/her meal, he/she was signaling to staff by pointing to tablemate's trays, pointing to his/her mouth and waving for his/her food. While the Resident was waiting for his/her food, the Resident drank a tablemate's juice at 12:14 P.M. At 12:16 P.M., the Resident was signaling to staff for his/her meal, the Resident then opened his/her tablemate's bowl of fruit and began eating it with his/her bare hands and returned the bowl. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/25 at 7:37 A.M., the Food Service Director (FSD) said a nurse from the China Garden 2 unit said dining was a mess on Tuesday (2/11/25) morning and they needed to make a new seating chart for the dining room. During an interview on 2/13/25 at 9:45 A.M., Nurse #6 and Unit Manager #2 said they are aware of the Resident taking food and the dining needs to be better. They continued to say that the certified nursing assistants should be supervising residents in the dining room to make sure residents should not be taking food from other residents.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 41456 Based on observations and interviews, the facility failed to ensure two Residents (#82 and #120) had their call lights within reach, out of a total sample of 27 residents. Findings include: Review of the facility policy titled, Call Light, dated 12/6/21, indicated the following: - Purpose: The purpose of this procedure is to respond to the resident's requests and needs. - Policy: When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 1. Resident #82 was admitted to the facility in November 2022 with diagnoses including stroke and hemiplegia. Review of Resident #82's most recent Minimum Data Set (MDS) assessment, dated 12/10/24, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicating he/she is cognitively intact. During an interview on 2/11/25 at 8:04 A.M., Resident #82 said he/she often cannot reach his/her call light as it is tied up against the wall. During this interview, Resident #82's call light was observed to be tied up and placed above the light structure and out of reach of the Resident. On 2/11/15 at 2:15 P.M. and 3:28 P.M., and on 2/12/25 at 11:11 A.M. and 12:58 P.M., Resident #82's call light was observed to be out of reach of the Resident. During an interview on 2/12/25 at 12:58 P.M., Certified Nursing Assistant (CNA) #5 said call lights should always be within reach of the residents. During an interview on 2/12/25 at 1:48 P.M., the Assistant Director of Nursing said call lights should always be within reach of the residents. 2. Resident #120 was admitted to the facility in October 2024 with diagnoses including dementia and diabetes. Review of Resident #120's most recent Minimum Data Set (MDS) assessment, dated 1/16/25, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 which indicated he/she is cognitively intact. The MDS also indicated the Resident requires partial to moderate assistance with functional daily tasks. During an interview on 2/11/25 at 8:27 A.M., Resident #120 was observed lying in bed with his/her call light not within reach. The call light was hanging down from the wall and the string was behind the light structure. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/15 at 2:15 P.M. and 3:28 P.M., on 2/12/25 at 11:11 A.M. and 12:58 P.M., and on 2/13/25 at 8:14 A. M., Resident #102's call light was observed to be out of reach of the resident. During an interview on 2/12/25 at 12:58 P.M., Certified Nursing Assistant #5 said call lights should always be within reach of the residents. During an interview on 2/12/25 at 1:48 P.M., the Assistant Director of Nursing said call lights should always be within reach of the residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 43846 Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instruct health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) consent was valid in the medical record for one Resident (#66) out of a total sample of 27 residents. Findings include: Review of the facility policy titled Massachusetts Advance Directives, dated 8/3/22, indicated It is policy of the facility to recognize and support the use of advanced directives. If a resident is incompetent, but has evidence of a properly executed advance directive, the facility will implement the resident's choices as outlined in their directive document. Resident #66 was admitted to the facility in April 2019 with diagnoses that included cerebral infraction, dysphagia, bipolar disorder, and paranoid schizophrenia. Review of Resident #66's most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Review of Resident #66's physician order, dated 9/3/21, indicated DNR/DNI (Do Not Resuscitate/ Do Not Intubate). May transfer to Hospital. Review of Resident #66's MOLST (Medical Orders for Life-Sustaining Treatment), dated 9/8/22, indicated his/her advanced directives DNR, DNI consent was obtained over the phone. Review of Resident #66's physician order, dated 11/18/24, indicated Health Care Proxy Activated (HCP). During an interview on 2/13/25 at 8:40 A.M., Social Worker #2 said the MOLST is not valid unless there is a signature on that HCP line. The MOLST can be sent via mail or email for a signature and should have been obtained by now in 2025. During an interview on 2/13/25 at 8:49 A.M., Nurse #2 said a MOLST is not valid unless it is signed by the Resident or the Health Care Proxy. Nurse #2 said a verbal phone consent is not acceptable or valid. During an interview on 2/13/25 at 8:50 A.M., Nurse #1 said a MOLST form is not valid unless there is a signature signed by the Resident or the Health Care Proxy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations and interviews, the facility failed to provide a homelike environment during dining on three of four nursing units. Specifically, on the [NAME] 1, China Garden 1 and China Garden 2 units, residents were observed eating meals on meal trays in the dining rooms. Findings include: The surveyor made the following observations: - On 2/11/25 at 11:50 A.M., the surveyor observed residents eating their lunch on meal trays in the [NAME] 1 dining room. - On 2/11/25 at 12:00 P.M., the surveyor observed residents eating their lunch on meal trays in the China Garden 1 dining room. - On 2/12/25 at 8:20 A.M., the surveyor observed residents eating their breakfast on meal trays in the China Garden 2 dining room. - On 2/12/25 at 8:40 A.M., the surveyor observed residents eating their breakfast on meal trays in the [NAME] 1 dining room. During an interview on 2/12/25 at 8:48 A.M., Certified Nurse Aide (CNA) #8 said the residents normally eat their meals in the dining room off their trays. During an interview on 2/12/25 at 8:52 A.M., Nurse #5 said it is the facility policy for staff to remove resident trays after staff serve their meals. She continued to say this morning's staff forgot to remove the trays. During an interview on 2/12/25 at 9:06 A.M., Nurse #6 said the CNAs are new and they left the breakfast meals on the trays even though they are supposed to be removed from the trays prior to being served. 43846 The surveyor made the following observations: - On 2/11/25 at 8:25 A.M. and 12:15 P.M., the surveyor observed all residents eating their breakfast and lunch on chipped meal trays in the China Garden 1 dining room. - On 2/12/25 at 8:22 A.M., the surveyor observed all residents eating their breakfast on chipped meal trays in the China Garden 1 dining room. During an interview on 2/12/25 at 9:03 A.M., Certified Nurse Aide (CNA) #1 said residents normally eat their meals off the meal tray in the dining room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/25 at 9:05 A.M., Nurse #2 said meal trays should be removed after each resident meal is set up on the table for them and they were not removed today during breakfast. 15016

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for one discharged Resident (#133), out of three applicable discharged resident records reviewed. Findings include: Resident #133 was admitted to the facility in August 2024 and had diagnoses that included but not limited to cervical disc disorder, high cervical region, chronic pain, and monoplegia of upper limb following a cerebral infarction affecting left non-dominant side. Review of the Minimum Data Set assessment, dated 8/26/24, indicated Resident #133 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition and required supervision/touching assistance for ambulation. Review of the Minimum Data Set assessment, dated 11/22/24, indicated a Discharge-Return Not Anticipated was coded. Further review indicated the MDS was coded as a planned discharge and checked as a discharged to short term general hospital (acute hospital, IPPS). Review of Resident #133's medical record indicated in a Discharge Summary with an effective date 11/22/24 that Resident #133 was discharged home. During an interview on 2/12/25 at 3:12 P.M., the MDS Nurse said the MDS should be accurate and that after her review the discharge MDS assessment dated [DATE] was coded inaccurately, and that Resident #133 was discharged home.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 36431 Based on record review and interview the facility failed for one Resident (#11) to ensure a Preadmission Screening and Resident Review (PASARR) level I was requested from DMH/Designee after the Resident was screened to have a Serious Mental Illness (SMI) and exceeded the discharge exception of 30 calendar days, out of a total sample of 27 residents. Findings include: Resident #11 was admitted to the facility in September 2019 and had diagnoses that included but are not limited to bipolar disorder. Review of the Preadmission Screening and Resident Review dated 9/24/19 indicated Resident #11 had a positive SMI screen. Further review of the PASARR indicated Resident #11's expected stay in a nursing facility was for less than 30 calendar days as certified by the hospital's attending or discharge practitioner. Review of the Level 1 PASARR indicated if the nursing facility determines that the resident's stay will exceed the 30-day exemption period, the nursing facility must complete Section G in this form and submit the Level 1 form to the DMH/Designee by no later than the 28th calendar day from admission. Review of Resident #11's medical record indicated Resident #11 has had a continuous stay at the facility. Further, the medical record failed to indicate a Level I PASARR was submitted after Resident #11 exceeded 30 days in the facility to receive a determination if Resident #11 requires specialized services for his/her SMI. During an interview on 2/12/25 at 11:01 A.M., Social Worker (SW) #1 reviewed Resident #11's PASARR and said a level 1 PASARR should have been resubmitted if he/she exceeded 30 days in the facility. SW #1 said it should be in the record, and he will take a closer look. During an interview on 2/13/25 at 1:20 P.M., SW #1 said he could not locate the PASARR Level 1 request after the Resident stayed beyond 30 days. SW #1 said he called and did not hear back from the PASARR office. SW #1 said he would expect the PASARR request and determination to be in Resident #11's medical record.

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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** 41456 Based on record review and interviews, the facility failed to implement the physician orders for five Residents (#59, #11, #132, #131 and #133) out of a total sample of 27 residents. Specifically, 1. For Resident #59, the facility failed to obtain monthly weights as ordered. 2. For Resident #11, the facility failed to obtain a physician's order for a dressing to his/her left shin. 3. For Resident #132, the facility failed to obtain a physician's order for a Registered Nurse (RN) pronouncement of death. 4a. For Resident #131 and 4b. Resident #133, the facility failed to obtain an order to discharge from the facility. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised [DATE], indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber 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 error. 1. Resident #59 was admitted to the facility in [DATE] with diagnoses including diabetes and dysphagia. Review of Resident #59's most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15, indicating he/she had moderate cognitive impairment. The MDS also indicated Resident #59 was dependent on staff for for functional daily tasks. Review of Resident #59's physician orders indicated an order for monthly weights, initiated on [DATE]. Review of Resident #59's weight log failed to indicate his/her weight has been taken since the monthly weight order was written. Review of the Medication and Treatment Administration forms failed to indicate the order to weigh Resident #59 monthly was on the order sheet for the nurses to document as implemented. During an interview on [DATE] at 8:41 A.M., Nurse #3 looked at Resident #59's physician orders and confirmed the order for monthly weights and said this order had not been followed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36431 2. Resident #11 was admitted to the facility in [DATE] and has diagnoses that include nontraumatic subdural hemorrhage, lack of coordination, adult failure to thrive and bipolar disorder. Review of Resident #11's most recent Minimum Data Set assessment dated [DATE], indicated Resident #11 scored a 10 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately intact cognition and requires substantial/maximal assist from staff for bathing and dressing. During an observation and interview on [DATE] at 8:06 A.M., Resident #11 was sitting up in his/her bed with the lower legs visible. Resident #11's left shin was observed with a small round dark red area consistent with a scab. Resident #11 said it has been there for a while. During an observation on [DATE] at 1:25 P.M., Resident #11 self-propelled his/her wheelchair into the Social Workers office. Resident #11's left shin was observed to have a small dressing on it. No date on the dressing could be observed. During an observation on [DATE] at 8:39 A.M., Resident #11 was sitting on the side of his/her bed. Resident #11's had a small dressing on his/her left shin. Review of Resident #11's active physician's orders failed to indicate an order for a dressing to his/her left shin. During an observation and interview on [DATE] at 8:49 A.M., Nurse #3 said the Resident had a small skin tear on Tuesday ([DATE]) that bled a little. Nurse #3 said she covered the area with a small dressing. Nurse #3 observed Resident #11 and said it is the same dressing she applied, and it should be dated. Nurse #3 said when a new skin tear or new skin area is identified a skin incident report should be completed, and an order for a treatment and monitoring of the area should be obtained from the doctor or nurse practitioner. During an interview on [DATE] at 11:05 A.M., the Assistant Director of Nursing said if a resident has a skin tear or new skin finding the nurse does an incident report, documents the finding in the medical record, notifies the Director of Nursing, and notifies the MD (medical doctor) to obtain a treatment order and plan for monitoring the area. (continued on next page)

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Parkway Health and Rehabilitation Center	1190 Vfw Parkway Boston, MA 02132

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Massachusetts General Law, Chapter 46, Section 9 indicated: When a patient suffering from a terminal illness or whose death is anticipated and who is receiving the services of a home health agency, as that term is defined in 42 USC 1395x(o), or of a hospice program licensed by the commonwealth, or who resides in a certified nursing home or who is enrolled in a PACE program as defined in 42 U.S.C. 1396u-4, dies, at home, in a hospice, or a nursing home, a registered professional nurse, licensed by the board of registration in nursing and employed by a certified home health agency, hospice, nursing home or a PACE program as defined in 42 U.S.C. 1396u-4, may declare such person dead; provided, however, that said nurse first makes a reasonable effort to contact the attending physician or medical examiner before making such determination or pronouncement; provided, further, that such determination or pronouncement be made in writing on a form approved by the commissioner of public health and subscribed under pain and penalties of perjury; and provided, further, that said physician or medical examiner be notified forthwith of the exact location to which the decedent has been removed. Resident #132 was admitted to the facility in [DATE] and had diagnoses that included liver cell carcinoma, type 3 diabetes mellitus, and adult failure to thrive. Review of Resident #132's medical record indicated the following: A progress note dated: [DATE] at 16:34 (4:34 P.M.) 2:00 P.M. received oxycodone for pain. 2:30 last seen sleeping in bed. 2:45 PM resident found lying across bed. Unresponsive. Positioned bed. CODE Blue was called. Cardiac Board in place CPR initiated. !!1 (sic) called Oxygen 100% on non-rebreather mask applied. CPR stopped AED applied as directed. Shock advised. Following by continuing CPR with Ambu and rebreather for 2 minutes. EMTs arrived resident intubated by EMT 3 amps of EPI given no response continued CPR cardiac ultrasound completed no cardiac activity. BMC called Dr [NAME] received EMT reports. Pronounced resident at 15:42 (3:42 P.M.) Family called by this writer. Review of the medical record indicated a document titled Commonwealth of Massachusetts, Registry of Vital Records and Statistics RN/PA/NP PRONOUNCEMENT OF DEATH, indicated the name of Registered Nurse, Physician Assistant, or Nurse Practitioner Pronouncing Death, as Nurse #5's signature, per EMT report. Further review of Resident #132's medical record failed to indicate a physician's order for an RN pronouncement During an interview on [DATE] at 2:23 P.M., Nurse #5 said she was present when Resident #132 coded. Nurse #5 said the EMTs took over the code when they arrived and called a doctor at Boston Medical Center to call off CPR and pronounce the Resident as deceased . Nurse #5 said she did not have a physician's order to pronounce the Resident's death and that the pronouncement was done by the EMTs calling a doctor. Nurse #5 said she did postmortem care and assessed Resident #132 as deceased . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:59 P.M., the Assistant Director of Nursing (ADON) said an order from the physician is required for an RN to complete the pronouncement of death. The ADON said she reviewed Resident #132's record and did not see a physician's order for the RN to complete the pronouncement. 4a. Resident #133 was admitted to the facility in [DATE] and had diagnoses that included but not limited to cervical disc disorder, high cervical region, chronic pain, and monoplegia of upper limb following a cerebral infarction affecting left non-dominant side. Review of Resident #133's Minimum Data Set assessment dated [DATE] indicated Resident #133 score a 15 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition and required supervision/touching assistance for ambulation. Review of Resident #133's medical record indicated a progress note dated [DATE] at 14:06 (2:06 P.M.) Note Text: Patient has been discharged . The note did not indicate any further information regarding the discharge. Review of the document in Resident #133's the medical record titled, Discharge Summary with an effective date [DATE] indicated that Resident #133 was discharged home. Review of Resident #133's physician orders failed to indicate an order for discharge. During an interview on [DATE] at 3:03 P.M., the Assistant Director of Nursing said when a resident is discharged from the facility the nurse discharging the resident would review the discharge plan and discharged medications with the resident and responsible party. The ADON said a physician's order is to be obtained when a resident is discharged to home. During an interview on [DATE] at 7:44 A.M., the Regional Administrator said a physician's order was not obtained for Resident #133 to be discharged . 4b. Resident #131 was admitted to the facility in [DATE] and had diagnoses that included chronic obstructive pulmonary disease, bipolar disorder, and type 2 diabetes mellitus. Review of the Minimum Data Set assessment, dated [DATE], indicted Resident #131 scored a 13 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition and requires supervision/touching assistance with ambulation. Review of the document titled Discharge Summary, effective date [DATE] indicated Resident #131 was discharged to a shared living home. Review of progress notes failed to indicate a progress note in relation to Resident #131's discharge from the facility. Review of Resident #131's physician orders failed to indicate an order for discharge from the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:03 P.M., the Assistant Director of Nursing said when a resident is discharged from the facility the nurse discharging the resident would review the discharge plan and discharged medications with the resident and responsible party. The ADON said a physician's order is to be obtained when a resident is discharged to home. During an interview on [DATE] at 7:44 A.M., the Regional Administrator said a physician's order was not obtained for Resident #131 to be discharged .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, record reviews and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for dependent residents for one Resident (#16) out of a total sample of 27 residents. Specifically, the facility failed to provide supervision with meals as per the plan of care for Resident #16. Findings include: Review of the facility policy titled Activities of Daily Living, dated December 2022, indicated the following: - Purpose: To provide support, assistance, and encouragement to remain as independent as possible with activities of daily living, including dining. - The facility will provide care and services for the following activities of daily living: Dining - eating, including meals and snacks. Resident #16 was admitted to the facility in February 2023 with diagnoses including lack of coordination, altered mental status, dysphagia and contracture of the left hand. Review of Resident #16's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview of Mental Status score of 2 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident requires supervision or touching assistance when eating. The surveyor made the following observations: - On 2/11/25 at 8:56 A.M., Resident #16 was observed sitting up on the side of his/her bed eating breakfast on his/her bedside table. Resident #16 was observed to have oatmeal spilled all over his/her meal tray, having eggs on his/her legs and was having wet coughs in between bites of food. No staff were in the room supervising him/her while eating. - On 2/12/25 at 8:45 A.M., staff delivered Resident #16's breakfast tray to his/her room and left the room at 8:47 A.M. Resident #16 was observed sitting up on the side of his/her bed eating breakfast on his/her bedside table without supervision. - On 2/12/25 at 1:02 P.M., staff delivered Resident #16's lunch tray to his/her room and left the room. Resident #16 was observed sitting up on the side of his/her bed eating lunch on his/her bedside table without supervision. A staff member did not check on Resident #16 until 1:07 P.M. The staff member then left after a few minutes while Resident #16 continued eating. Review of Resident #16's Kardex (a resident-centered form displaying the level of a care a resident needs) indicated the Resident requires continuous supervision while eating. Review of Resident #16's care plans indicated the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 8/20/24 - Focus: I need supervision assistance with my ADLS's due to limited mobility, cognition impairment, adjustment disorder with anxiety and poor coordination. Intervention, dated 1/26/24: I need you to supervise me while I eat to provide with assistance as needed. - Dated 3/7/24 - Focus: I am at risk for aspiration r/t dysphagia. Intervention, dated 8/20/24: I need 1:1 supervision and assist as needed. Intervention, dated 3/7/24: Please provide me with verbal, visual and/or tactile cues when necessary get me to swallow my food or drink. During an interview on 2/13/25 at 8:21 A.M., Certified Nursing Assistant (CNA) #2 said Resident #16 should be supervised while he/she is eating meals. During an interview on 2/13/25 at 8:53 A.M., Nurse #5 said supervision with meals means a resident requires supervision at all times while they are eating so they do not aspirate or can get assistance with eating if needed. Nurse #5 said Resident #16 should have continuous supervision while eating meals. During an interview on 2/13/25 at 10:55 A.M., the Assistant Director of Nursing (ADON) said CNAs need to keep eyes on Resident #16 while he/she is eating at all times.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observations, record review and interviews the facility failed to provide an activities program to: 1. the residents on the [NAME] 2 Unit, out of four units, and 2. four Residents (#3, #120, #32 and #52) out of a total sample of 27 residents. Findings include: 1. The following observations were made on the [NAME] 2 unit during survey: - The activity calendar failed to list any group activities on the unit for 2/11/25 and no group activities were held on the unit throughout the day on 2/11/25. - On 2/11/25 from 10:00 A.M. to 12:00 P.M. until lunch was served, there were 11 residents sitting in the dining room with the television on. One resident was watching the television, and the rest of the residents were observed sitting in silence at tables without individualized activity materials. Two of the residents were sleeping. Staff were in the room completing their documentation and were not interacting with the residents. There was no activity staff observed on the unit. - On 2/11/25 at 2:14 P.M., there were 10 residents in the dining room. The television was on, but no one was watching it. There was no floor or activity staff in the room. The activity calendar said one-to-one visits were scheduled for this time and they were not occurring. On 02/11/25 at beginning at 3:13 P.M., eight residents were sitting in the dining room. Two staff were present, one was sitting in the corner of the room. The other was in and out and neither were observed engaging with the residents present. The television was on a national news outlet station. One resident was sitting in a wheelchair at a table with two stuffed animals. One resident sat at a table and fidgeted with a water pitcher on the table in front of him/her. The remaining 5 residents were not looking at the television or exhibiting any interest in the news show. One resident was leaning his/her head on his/her hand. The others were staring out or their eyes were closed. - At 3:46 P.M., there were five residents in the dining room and one staff present. One resident was fidgeting with the water pitcher on the table in front of him/her. One resident was sitting with two stuffed animals; one resident was in a wheelchair facing the television and picking his/her nose. One resident was fidgeting with the buttons on his/her sweater. The television was on a national news station. During the observation no residents were engaged, no individual activity supplies were present, nor did the staff present provide any meaningful engagement. - At 3:59 P.M., five residents were seated in the dining room. One staff member was sitting near the corner of the room. One resident was seated at a table with his/her hands folded and looking out of the room. One resident got out of his/her seat and began walking, staff then escorted the resident out of the room. One resident remained seated at the same table with two stuffed animals. The others were sitting. Aside from the television audio there was no interaction observed within the community. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 4:14 P.M., six residents were in the dining room. One staff member was present. One resident was observed with his/her head leaning on his/her hands. One resident with two stuffed animals was leaning towards the table. The television was on the news and the other residents were sitting and were not observed to be watching the television. - At 4:30 P.M., seven residents were seated in the dining room. The television was on the news. None of the seven residents were looking towards the television or showed interest in the television. One resident was offered and was eating an ice cream. Two staff were present and did not converse, nor engage with the residents present. No activity materials were present for individual interests or pursuits. During an observation on 2/12/25 at 10:05 A.M., review of the posted activity schedule indicated Bible Study at 10:00 A.M. on the G2 unit (Gardener 2) nine residents were in the dining room. One resident was resting his/her head on the stuffed animals on his/her lap while sitting at a table. Shortly after the resident began reaching out to shake a resident's hands who was seated at the table next to him/her. One resident was sitting and holding fake flowers and staring out. Three other residents were seated at a table just staring out, two other residents were seated at table. The television was on a national news network. One staff member was seated in the room and was not interacting with residents in anyway. - At 10:15 A.M. there was no bible study (as listed on the activity calendar), or any other activity occurring in the dining room. 7 residents were seated in the room, one staff member was present and talking with one resident. One resident began walking around the room and then sat back down. A nurse wheeled one resident out of the room. Two residents sitting at a table intermittently reached out for each other and would shake hands and smile. Two other residents were seated at a table and were staring out. Two other residents have their eyes closed. - At 10:21 A.M., One resident stood up and attempted to walk and staff stood up and escorted the resident back to the chair where they were sitting. - At 10:26 A.M., there was no bible study or any activity occurring the dining room. No activity staff were present. There were no activity supplies in the room for individual interest or pursuits. Nine residents were seated in the room. One staff person present. Two residents continued to try to reach out to one another to shake hands. - At 10:33 A.M., one resident stood up and walked out of the room carrying an empty cup, he/she knocked over a wet floor sign and picked it up him/herself. Eight residents remained in the room with no observed engagement. The television was on the news, and no one was watching the television. - At 10:59 A.M., No activities were occurring including Bible Study as posted on the calendar. One resident began putting tablecloths on the tables for lunch. Eleven residents were seated in the room and not engaged in any way. - At 11:16 A.M., nine residents were observed in the dining room. The television was on, and no one was watching it. None of the residents had any individualized activity materials in front of them and there was no social interaction. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 11:35 A.M., the same nine residents were still in the dining room. There were now staff present in the room, not interacting with any residents. There were no activity materials present. - At 11:50 A.M., one of the Certified Nursing Assistants was observed to have her eyes closed while sitting in the room with the residents. During an observation on 2/13/25 at 10:03 A.M., review of the posted activity calendar on the [NAME] 2 unit indicated 10:00 (A.M.) Music Relaxation and Sensory Games. Eleven residents were seated in the dining room. The television was on a national news network. The residents present were sitting, not engaged and did not have any sensory items or any other activity supplies for their interest for individual pursuits. There was no music playing. - At 10:15 A.M. 12 residents were seated in the dining room, not engaged. Nurse #3 was sitting at a table with residents with a lap top opened and providing some conversation. One resident had his/her hand on his/her head holding it up. One resident entered the room and was talking in a loud repetitive tone consistent with being upset or angry. One resident was at a table with two stuffed animals and not engaged, nor was there any activity occurring per the posted schedule. At this time a rehabilitation staff member entered the room, talked with a few residents including the one resident who had a loud tone. The residents looked up and responded to the rehab staff's brief verbal interaction. The television was changed from news to another station and the residents present did not show interest by looking in the direction of the television. No music relaxation or sensory activity was occurring. During an interview on 2/13/25 at 10:22 A.M., Nurse #3 said she tried to put music on her phone to play for the residents while she was sitting in the room. Nurse #3 said they do not have many activities since the facility was without an activity director for a few months. During an interview on 2/13/25 at 10:32 A.M., an activities staff said he was the Director of the Activities for another building and did not know what the current activity staffing was for this facility, and he is here to help. The activities staff said he would expect the activities listed on the activity calendar to be followed and that residents have engagement. During an interview on 2/13/25 at 9:43 A.M., Nurse #7 said many of the activities listed on the activity calendar do not take place. Nurse #7 said residents have nothing to do. Nurse #7 said residents are not provided supplies for their interest, like fabric for a resident who likes to weave. Nurse #7 said there is no engagement for the residents, which increases them to have behaviors and look vacant and hopeless. During an interview on 2/13/25 at 11:56 A.M., the Activity Assistant said she is primarily responsible for the activities on the [NAME] 1 and 2 units. She said she has been working in the activity department by herself, and she is unable to complete activities throughout the facility and complete one-on-one visits with all the residents with only herself. The Activity Assistant said she attempts to make the activity calendar, but she is unable to hold the groups listed because she cannot be on two units at once. The Activity Assistant said it is the expectation that the nursing staff assist with activities when she is unavailable for the unit, however the staff often do not help with either the transportation for activities or the activities themselves. The Activities Assistant said she is aware activities are lacking for the residents on the [NAME] 2 unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/25 at 12:18 P.M., the Regional Administrator said they have been without an activities director and interviewing for the position. The Regional Administrator said she recently had staff come from their sister facility to help. The Regional Administrator said she would expect staff to assist residents to attend activities on the G1 floor or engage when they are in the sitting room. 2a. Resident #3 was admitted to the facility in September 2018 with diagnoses including end stage renal disease, diabetes and dementia. Review of Resident #3's most recent Minimum Data Set (MDS) assessment, dated 12/5/24, indicated the Resident scored a 7 out of a possible 15 on the Brief Interview of Mental Status (BIMS) which indicated he/she has severe cognitive impairment. The MDS also indicated the Resident required partial to moderate assistance with functional daily tasks. Review of the MDS dated [DATE], listed the following as the Resident's preferences: - It was somewhat important for the Resident to have books, newspapers, and magazines to read; - It was somewhat important for the Resident to have music to listen to; - It was very important to do things with groups of people; - It was very important to participate in his/her favorite activities; - It was very important to have fresh air; and - It was somewhat important to participate in religious services. During interviews on 2/11/25 at 8:31 A.M., and 2/13/25 at 11:11 A.M., Resident #3 said he/she was very bored in the facility. The Resident said he/she does not get invited to activities, does not know when activities are occurring and would like to attend some if they are of interest to him/her. On 2/11/25 there were no group activities listed on the calendar for Resident #3's unit. No activity staff were observed on the unit running individualized activities and Resident #3 spent the day sitting in his/her room or the lobby of the facility by himself/herself. There were no activity materials observed in the room and the Resident did not have the television or radio on. On 2/12/25 prior to Resident #3 leaving the facility for an appointment, the Resident was observed sitting in his/her room alone. No activity staff were observed on the floor visiting with the Resident. There was no activity materials observed in the room and the Resident did not have the television or radio on. On 2/13/25 Resident #3 spent the day sitting in his/her room or the lobby of the facility by himself/herself. There were no activity materials observed in the room and the Resident did not have the television or radio on. Review of Resident #3's quarterly activities assessment dated [DATE], indicated the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Resident prefers activities in and out of the room; - The Resident's favorite activities are: coffee chat, cooking, baking, drawing, and arts and crafts. Review of Resident #3's activity care plan last revised 11/25/24, indicated the following interventions: - encourage me to participate in ethnic celebrations and family visits; - I need consistent routine with the same activity personnel; - I need cues to assist me with improving stimulation and relaxation; - interview me and/or my family at least quarterly to determine any changes in activity preferences that I may have; - (the Resident) needs a structured activity program for intellectual stimulation and relaxation; - (the Resident) alright yeah needs brief activities as (he/she) has a short attention span; - When I am unable to enjoy group activities provide one to one visits in a quiet location; - When possible and when I can tolerate it I would like community activity. During an interview on 2/13/25 at 11:56 A.M., the Activity Assistant said she has been working in the activity department by herself, and she is unable to complete activities throughout the facility and complete one-on-one visits with all the residents with only herself. The Activity Assistant said Resident #3 enjoys watching cooking shows but was unable to say which type of group activities the Resident would like to attend. The Activity Assistant said Resident #3 does not participate in activities. 2b. Resident #120 was admitted to the facility in October 2024 with diagnoses including dementia and diabetes. Review of Resident #120's most recent Minimum Data Set (MDS) assessment, dated 1/16/25, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 which indicated he/she is cognitively intact. The MDS also indicated the Resident requires partial to moderate assistance with functional daily tasks. Review of the MDS dated [DATE], listed the following as the Resident's preferences: - It was somewhat important for the Resident to have books, newspapers, and magazines to read; - It was very important for the Resident to have music to listen to; - It was somewhat important to do things with groups of people; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	1190 Vfw Parkway Boston, MA 02132

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- It was very important to participate in his/her favorite activities; - It was somewhat important to have fresh air; and - It was somewhat important to participate in religious services. During an interview on 2/11/25 at 8:27 A.M., Resident #120 said he/she is very bored and would like to attend activities, however staff never invite her or inform her of the activities. On 2/11/25 at 2:10 P.M., the surveyor observed Bingo was occurring in the lobby activity room. At 2:16 P.M., the surveyor observed Resident #120 sitting on the side of his/her bed in a room without lights on. The surveyor informed the Resident that Bingo was occurring, and the Resident said no one informed him/her about Bingo and said he/she would have liked to go and play. Resident #120 said he/she was bored. On 2/12/25 at 1:11 P.M., Resident #120 was observed sitting on the side of his/her bed without the bedroom lights on. The Resident said he/she was bored and was not invited to attend any activities on this day. The Resident was informed that bible study had been on the calendar, and he/she said he/she would have liked to attend that. On 2/13/25, Resident #120 was again observed in his/her dark room and staff were not observed inviting her to the dining room for social engagement or activities. Throughout survey there were no individual activity materials observed in the Resident's room, his/her light was never on, and the television or music was never on. Review of Resident #120's personalized care plans failed to indicate a focused activity care plan had been developed. Review of Resident #120's dementia care plan last revised 11/12/24 indicated the following intervention: - Engage in simple, structured activities that avoid overly demanding tasks. Review of Resident #120's initial activity assessment dated [DATE], indicated the following: - the Resident enjoys cooking and parties, - the Resident prefers the activity room as the place to participate in activities - Resident was cooperative and very social. (He/she) enjoys cooking, parties and going outside. She does go to the activity room period (he/she) enjoys coffee cart and coffee social. Staff will invite (him/her) to cooking and baking programs, on the patio groups, weather permitting. Staff will visit (him/her) in the AM with the daily chronicle and to remind (him/her) of the daily programs with encouragement. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/25 at 11:56 A.M., the Activity Assistant said she has been working in the activity department by herself, and she is unable to complete activities throughout the facility and complete one-on-one visits with all the residents with only herself. The Activity Assistant said Resident #120 sleeps a lot and does not participate in activities. The Activity Assistant could not identify activities of interest for Resident #120. 2c. Resident #32 was admitted to the facility in March 2024 and has diagnoses that include but are not limited to adjustment disorder with depressed mood, acute kidney failure, congenital malformation of the heart, and legal blindness. Review of Resident #32's most recent Minimum Data Set (MDS) assessment, dated 12/11/24, indicated Resident #32 scored a 7 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severely impaired cognition and requires supervision with eating and requires substantial/maximal assistance for bathing and transfers. Further review of the comprehensive Minimum Data Set assessment dated [DATE] indicated at Section F, Interview for Activity Preferences the following: - How important is it to you to have books, newspapers and magazines to read? not important at all - How important is it to listen to music you like? Very Important - How important is it to you to be around animals such as pets? Not very important - How important is it to you to keep up with the news? Not very important - How important is it to you to do things with groups of people? somewhat important. - How important is it to do your favorite activities? Very important - How important is it to you to go outside to get fresh air when the weather is good? somewhat important - How important is it to you to participate in religious services or practices? somewhat important. Primary respondent Resident Review of the MDS CAA (care area assessment) Activities analysis of findings indicated Activities: Resident (#32) is at risk for social isolation, d/t (due to) little interest in group activities and verbal behaviors. Review of Resident #32's care plans indicted the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- I have an alteration in my vision r/t (related to) being legally blind, revised 9/15/2024, with the goal, I will be able to maintain navigate the environment, engage in meaningful activities with your assistance if needed through next review date, target date 5/28/2025. - I wander around with no purpose. I wonder into other resident's residents' rooms, revised 10/2/2024, with associated interventions of Provide activities based on my prior lifestyle and interests, dated 4/3/2024. - I have vision loss, and I am at risk for social isolation, date initiated 3/13/2024, with an associated intervention dated 3/13/2024, I want activities based on my interests and abilities, Inform of the daily activities and help me to activities located out of my room, Please assist me by reading my mail to me and Please supply me with audio materials. During an observation and interview on 2/11/25 at 8:32 A.M., Resident #32 was observed sitting up in a chair eating his/her breakfast. Resident #32 responded to the surveyors greeting. A large box was on his/her bedside table. On 2/11/25 at 3:13 P.M., Resident #32 was observed in the dining room, seated at a table. Resident #32 fidgeted with a water pitcher on the table in front of him her. At 3:46 P.M., Resident #32 remained in the dining room, not engaged and intermittently picked up the water pitcher and fidgeted with it. During an observation and interview on 2/12/25 at 9:08 A.M., Resident #32 was sitting in in his/her room. The television in his/her space was off. A box on his/her bedside table was observed to contain books on tape. Resident #32 said he/she had books on tape but did not know where the player was. The box did not contain the Player, and it was not observed in the vicinity of his/her space. During an interview on 2/13/25 at 9:05 A.M., Certified Nursing Assistant (CNA) #6 said Resident #32 likes to eat, does not see good and likes to listen to the radio. CNA #6 went with the surveyor to Resident #32's room. Resident #32 was sitting in a chair. CNA #6 said where is your radio? Resident #32 said he/she did not know where it was, and he/she wanted to listen to the radio. CNA #6 said the radio plays the books. CNA #6 looked in the box and around his/her room and did not locate the radio (book on tape player). Resident #32 was observed over the past three days without the book on tape player. On 2/13/25 at 9:22 A.M., CNA #6 said she found the radio, (book on tape player) and put it on for the Resident. Resident #32 said this is good. During an interview on 2/13/25 at 11:56 A.M., the Activity Assistant said she has been working by herself trying to provide activities for G 1 and G 2 ([NAME] 1 and [NAME] 2). The AA said she was not sure about the books on tape for Resident #32 and that if he/she has them, staff should assist him/her in using it. AA said if it was missing staff should have helped locate it so it could be used. 2d. Resident #52 was admitted to the facility in February 2017 and has diagnoses that include but are not limited to type 2 diabetes mellitus, unspecified lack of expected normal physiological development in childhood, and unspecified dementia. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #52's comprehensive MDS assessment, dated 1/16/25 indicated Resident #52 scored a 6 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severely impaired cognition and requires supervision for eating and assistance from staff for bathing and transfers. Further review of the comprehensive Minimum Data Set assessment dated [DATE] indicated at Section F, Interview for Activity Preferences the following: - How important is it to you to have books, newspapers and magazines to read? Not important - How important is it to listen to music you like? Not very important - How important is it to you to be around animals such as pets? Somewhat important - How important is it to you to keep up with the news? Not important - How important is it to you to do things with groups of people? Not very important - How important is it to do your favorite activities? Somewhat important - How important is it to you to go outside to get fresh air when the weather is good? Not very important - How important is it to you to participate in religious services or practices? Not very important Primary respondent: family or significant other. On 2/11/25 at 8:57 A.M., Resident #52 was observed in bed. He/she was repetitively calling out 'nurse' and pointing to a piece of paper on the floor, which was the daily activity chronicle. A nurse responded and said she would read the chronicle to him/her and the resident smiled. Review of Resident #52's care plans indicated the following: - I have impaired cognition function r/t (related to) dementia, anxiety and depression revision date 5/8/24. Interventions included: Engage me in simple, structured activities that avoid overly demanding tasks, dated 8/6/2019. - I am totally dependent on staff for activities, cognitive stimulation, social interaction r/t cognitive deficits, revision date 10/8/2024. Goal: I will maintain involvement in cognitive stimulation, social activities as desired through review date, target date 1/28/2025. Interventions indicated: I need assistance/escort (sic)activities functions. I preferred arts and crafts, drawing, socials, drawing, and taking my baby dolls with me, invite me to scheduled activities, I prefers (sic) activities which do not involve overly demanding cognitive tasks. Engage is simple, structured activities such as (specify) blank, dated 10/8/2024. On 2/11/25 at 10:00 A.M., review of the posted activity calendar had no activities for [NAME] 1 or [NAME] 2 after 1:30 1:1 visits. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:13 P.M., through 4:30 P.M. Resident #52 was sitting in a wheelchair at a table in the dining room. He/she had 2 stuffed animals on his/her lap. There were other residents in the room. At 3:46 P.M., Resident #52 periodically glanced around the room. The television was on a news channel. There was one staff present in the room, sitting with her hands folded on her lap and not providing social interaction. - At 4:14 P.M., Resident #52 remained seated at a table. There were no individualized activity materials in front of the Resident. Resident #52 was leaning in his/her chair with his/her hand on his/her mouth. The television was set to a news channel. Staff did not socially interact or engage Resident #52. On 2/12/25 at 10:05 A.M. review of the [NAME] 2 posted activity calendar indicated Bible Study 10:00 G2 and Word Games and Trivia on G1. On 2/12/25 from 10:05 A.M. through 10:59 A.M., the following observations were made by the surveyor on the [NAME] 2 unit, there were nine residents in the dining room including Resident #52, who was observed seated at a table with his/her head leaned forward resting on the stuffed animals in his/her lap. Shortly after Resident #52 began reaching out to another resident seated at the table and they shook hands. Resident #52 and the resident intermittently reached out to each other to shake hands. At no time did staff offer any engagement, or activity materials to Resident #52. The television remained on a new station and Resident #52 did not exhibit any interest and did not look at the television. During an observation on the [NAME] 2 unit at 2/13/25 10:03 A.M., review of the posted activity calendar indicated 10:00 (A.M.) Music Relaxation and Sensory Games G2. Eleven residents were in the dining room including Resident #52. The television was on a news channel. Resident #52 was seated at a table with two stuffed animals on his/her lap. There was no activity materials, music or sensory items, nor was any structured or non-structured activity or engagement occurring. During an interview on 2/13/25 at 9:43 A.M., Nurse #7 said many of the activities listed on the activity calendar do not take place on [NAME] 2. Nurse #7 said residents have nothing to do. Nurse #7 said residents are not provided supplies for their interest and that she has brought in coloring materials and tries to help engage residents. Nurse #7 said Resident #52 will engage easily, will answer some trivia, and becomes very proud when of him/herself when he/she is involved. During an interview on 2/13/25 at 10:22 A.M., Nurse #3 said she tried to put music on her phone to play for the residents while she was sitting in the dining room. Nurse #3 said they do not have many activities since the facility was without an activity director for a few months. During an interview on 2/13/25 at 11:56 A.M. the Activity Assistant that she covers the [NAME] 1 and [NAME] 2 units and it is a challenge to provide activities since they are without an Activity Director. The Activity Assistant said the residents on [NAME] 2 need someone there to engage them and require more sensory items and liked to do a coloring group. The Activity Assistant said Resident #52 will participate in some activities and will show off his/her personality. 41456

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to provide quality of care for one Resident (#11) out of a total sample of 27 residents. Specifically, the facility failed to identify a round dark red area on Resident #11's left shin and failed to identify areas on his/her right shin, consistent with being bruised. Findings include: Resident #11 was admitted to the facility in September 2019 and has diagnoses that include nontraumatic subdural hemorrhage, lack of coordination, adult failure to thrive and bipolar disorder. Review of the Minimum Data Set assessment dated [DATE], indicated Resident #11 scored a 10 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately intact cognition and requires substantial/maximal assist from staff for bathing and dressing. During an observation and interview on 2/11/25 at 8:06 A.M., Resident #11 was sitting up in his/her bed with his/her lower legs visible. Resident #11's left shin was observed with a small round dark red area consistent with a scab. Resident #11 said it has been there for a while. Resident #11's right shin had several scattered bluish areas, with varying discoloration. Resident #11 held up his/her hands and said he/she has thin skin, and you can see my veins. During an observation on 2/11/25 at 1:25 P.M., Resident #11 self-propelled his/her wheelchair into the Social Worker's office. Resident #11's left shin was observed to have a small dressing on it. Resident #11's right shin had scattered round areas of varying discoloration. During an observation on 2/12/25 at 8:39 A.M., Resident #11 was sitting on the side of his/her bed. Resident #11 had a small dressing on his/her left shin and his/her right shin was observed with areas of varying discoloration. Review of Resident #11's medical record indicated the following: - The physician's orders failed to indicate an order for a dressing to Resident #11's left shin. - A physician's order dated 5/13/22, Weekly skin check on Monday 7-3pm (sic). - A care plan, I am at risk for skin breakdown due to limited mobility, incontinence dated 10/7/2019. Associated interventions included, a licensed nurse should check my skin weekly. Review of the weekly skin check dated 2/10/25 indicated the following: 1. Does the resident have any open areas or marks on skin? Checked off as 'No'. This is not consistent with the observation made of Resident #11's right and left shin on 2/11/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/13/25 at 8:49 A.M., Nurse #3 said Resident #11 had a small skin tear on Tuesday (2/11/25) that bled a little. Nurse #3 said she covered the area with a small dressing. Nurse #3 and the surveyor went to Resident #11's room. Nurse #3 observed Resident #11 and said Resident #11's right shin had three yellowing ecchymotic (a medical term for a type of bruise) areas that are getting better and may be one to two days old. Nurse #3 said she did the skin check on 2/10/25 and did not note the skin areas on Resident #11's right and left shins. Nurse #3 said when a new skin tear or new skin area is identified a skin incident report should be completed, and an order for treatment and monitoring of the area should be obtained from the Doctor or Nurse Practitioner.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 41456 Based on observations, record reviews and interviews, the facility failed to provide one Resident (#88) with hearing devices out of a total sample of 27 residents. Findings include: Resident #88 was admitted to the facility in October 2022 with diagnoses including sensorineural hearing loss. Review of Resident #88's most recent Minimum Data Set (MDS) assessment, dated 1/2/25, indicated the Resident scored 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment. The MDS also indicated the Resident has moderate difficulty hearing. During an interview on 2/11/25 at 11:00 A.M., Resident #88 was unable to be interviewed secondary to his/her hearing impairment. During this interview, Resident #88 was not wearing a hearing aid in either ear. Throughout all days of the survey, Resident #88 was not observed to be wearing hearing aids. Review of Resident #88's physician orders indicated the following order: - Resident has both hearing aide(s). Apply in AM (morning) and remove at HS (every night). Store in med cart. Review of Resident #88's hearing impairment care plan indicated the following intervention initiated on 1/7/25: Resident has both hearing aide(s). Apply in AM and remove at HS. Store in med cart. During an interview on 2/12/25 at 11:14 A.M., Certified Nursing Assistant (CNA) #7 said Resident #88 does not have hearing aids. During an interview on 2/12/25 at 11:26 A.M., Nurse #4 said Resident #88 has hearing aids, does not refuse to wear them, but is not wearing them because the batteries are dead. Nurse #4 said Resident #88's hearing aids are kept in the medication cart when not in use. The surveyor asked to see the Resident's hearing aids and when the nurse looked through the medication cart he was unable to locate the hearing aids and said they must be lost. During an interview on 2/12/25 at 1:48 P.M., the Assistant Director of Nursing (ADON) said Resident #88 has hearing aids and at times does not like to wear them. The ADON said if the Resident refuses to wear his/her hearing aids the refusal should be documented and when not worn the hearing aids should be kept in the medication cart. The ADON said she was unaware the hearing aids were missing and that she would look for them. The ADON said missing hearing aids should be documented as missing and replaced if lost. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 2/13/25 at 7:58 A.M., the ADON said she looked for Resident #88's hearing aids and could not find them.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45984 Based on observations, interviews and record review, the facility failed to ensure residents at risk for developing pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to prevent new ulcers from developing for one Resident (#20) out of a total of 27 sampled residents. Specifically, the facility failed to ensure that Resident #20 was wearing prevalon boots to offload heels while in bed as ordered. Findings include: Review of the facility policy titled Pressure Ulcer Prevention, dated and revised 12/22/22, indicated the following: - The facility will implement interventions to minimize and/or eliminate contributing factors for pressure ulcer development on patients/residents at risk. - The facility will provide education for treatment and prevention of pressure ulcers to caregivers. - Positioning: Use pillows or specialty devices and support surfaces to float or off-load heels. Resident #20 was admitted to the facility in December 2023 with diagnoses including pressure ulcer of left heel and lack of coordination. Review of Resident #20's most recent Minimum Data Set (MDS) assessment, dated 12/12/23, indicated that the Resident was unable to complete the Brief Interview for Mental Status exam indicating severe cognitive impairment. Further review of the MDS indicated that the Resident requires assistance with all activities of daily living and is at risk of developing pressure ulcers. The surveyor made the following observations: - On 2/11/25 at 8:08 A.M., Resident #20 was observed sleeping in his/her bed. Resident #20's heels were directly on the mattress. Next to Resident #20's bed was a bedside table with two Prevalon boots not being worn by the resident. - On 2/11/25 at 6:43 A.M. and 7:59 A.M., Resident #20 was observed sleeping in his/her bed. Resident #20's heels were directly on the mattress. Next to Resident #20's bed was a bedside table with two Prevalon boots not being worn by the resident. Review of Resident #20's physician's order, dated 9/9/24, indicated the following: - Nursing to don (put on) bilateral prevalon shoes on resident bilateral feet while in bed for the purpose of pressure relief. Resident to wear prevalon shoes while in bed at all times as tolerated with nursing to provide daily skin check. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's Kardex indicated the following under skin care: Resident to wear bilateral prevalon shoes while in bed for the purpose of skin protection. Resident to wear prevalon shoes on both feet at all times as tolerated while in bed and nursing to provide daily skin check. Review of Resident #20's ADL (activities of daily living) care plan, dated 9/11/24, indicated the following intervention: - Resident to wear bilateral prevalon shoes while in bed for the purpose of skin protection. Resident to wear prevalon shoes on both feet at all times as tolerated while in bed and nursing to provide daily skin check. Review of Resident #20's risk for skin breakdown care plan, dated 12/27/24, indicated the following: - Focus: I am at risk for skin breakdown due to limited mobility, r/t (related to) hx (history) healed pressure unstageable DTI (deep tissue injury) (L) plantar heel and right toe trauma injury wound. Hx non pressure ulcer on left second toe. Review of Resident #20's medical record failed to indicate any nursing progress notes of the Resident refusing or removing his/her prevalon boots. During an interview on 2/13/25 at 9:34 A.M., Nurse #6 and Unit Manager #2 said Resident #20 should be wearing his/her prevalon boots while in bed as he/she has a history of pressure injuries to his/her feet. They continued to say if Resident #20 removes them or refuses them then the night staff need to document those occurrences. During an interview on 2/13/25 at 10:55 A.M., the Assistant Director of Nursing (ADON) said staff should be following physician's orders and Resident #20 should be wearing his/her prevalon boots while in bed. The ADON continued to say if Resident #20 refuses or removes the prevalon boots then it needs to be documented.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 43846 Based on observations, record review, and interviews, the facility failed to ensure one Resident (#80), out of a total sample of 27 residents received proper care and treatment to maintain good foot health. Findings include: Review of the facility policy titled Nursing Care of the Resident with Diabetes Mellitus, dated 2015, indicated Skin and Foot care: 8. Toenails should only be trimmed by personnel qualified to do so (this can be regular associates, and does not have to be a podiatrist. Documentation: Documentation should reflect the carefully assessed diabetic resident and include the following: 12. Assessment of the feet include the following: a. Hygiene; g. The condition of the toes and toenails. Resident #80 was admitted to the facility in December 2024 with diagnoses that included end stage renal disease, type 2 diabetes, aphasia, and cerebral infarction. Review of Resident #80's most recent Minimum Data Set (MDS) assessment, dated 12/17/24, indicated he/she scored a 10 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairments. The MDS further indicated he/she was dependent on staff for hygiene, bathing and dressing. On 2/11/25 at 8:03 A.M., the surveyor observed Resident #80 in bed his/her toenails on both feet all nails were long thick and curling down around the toes. On 2/12/25 at 7:53 A.M., the surveyor observed Resident #80 in bed his/her toe nails on both feet all nails were long thick and curling down around the toes. Review of Resident #80's contacted provider request for service form, dated 12/23/24, indicated the healthcare proxy consented to have podiatry services. Review of Resident #80's physician order, dated 12/24/24, indicated Provide Diabetic Foot Care every day at HS (hour of sleep). Document adverse findings and notify MD (medical doctor). (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #80's February 2025 Treatment Administration Record (TAR), indicated Diabetic Foot Care was completed as ordered every night. Review of Resident #80's nursing progress notes from December 2024 through 2/11/25 failed to indicate that the MD was made aware of the Resident's long overgrown toe nails or that nursing wrote about the condition of his/her nails. Review of Resident #80's dialysis communication form, dated 2/6/25, indicated Pt (patient) needs to see podiatry toe nails overgrown. Review of Resident #80's weekly skin checks since admission failed to indicate the condition of his/her toenails. On 2/12/25 at 7:54 A.M., the surveyor with the Regional Administrator and the Staff Development Coordinator (SDC) observed Resident #80 in bed his/her toe nails on both feet all nails were long thick and curling down around the toes. The Regional Administrator and the SDC said nursing should be writing a progress note on the condition of his/her nails when they do their nightly diabetic foot care and the doctor should be notified.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review and interview the facility failed to implement the use of a hand carrot (orthotic) in accordance with the physician's order and the rehabilitation plan of care for one Resident (#16), out of a total sample of 27 residents. Findings include: Resident #16 was admitted to the facility in February 2023 with diagnoses including lack of coordination, altered mental status, and contracture of the left hand. Review of Resident #16's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview of Mental Status score of 2 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident had functional limitation in range of motion on his/her upper extremity. The surveyor made the following observations: - On 2/11/25 at 8:56 A.M., Resident #16 was eating breakfast in his/her room. The Resident's left hand was closed into a fist, the surveyor asked if he/she was able to open it and he/she could only flex open his/her thumb. Resident #16 said his/her left hand was painful. Resident #16 was not using a hand carrot. The surveyor did not observe a hand carrot in the resident's room. - On 2/11/25 at 2:14 P.M., Resident #16 was observed laying in his/her bed, the Resident was not using a hand carrot in his/her left hand. The surveyor did not observe a hand carrot in the resident's room. - On 2/12/25 at 8:09 A.M., Resident #16 was awake in his/her wheelchair in his/her room. The Resident was not using a hand carrot in his/her left hand, Resident #16 proceeded to say that his/her left hand was hurting. The surveyor did not observe a hand carrot in the resident's room. - On 2/12/25 at 11:26 A.M., Resident #16 was observed in the hallway, he/she was not using a hand carrot in his/her left hand. Review of Resident #16's physician's order dated 12/6/24 indicted the following: - Nursing to don left hand carrot splint to left hand for the purpose of contracture prevention. Resident to wear splint at all times/per resident preference daily with nursing to provide daily skin inspection every shift for contracture prevention. Review of Resident #16's impaired functional mobility r/t (related to) left hand contractures care plan, dated 3/7/24, indicated the following intervention: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 12/16/24: Resident #16 wears a left carrot splint on his/her left hand for the purpose of contracture prevention. Nursing to don (put on) and he/she prefers to wear it at all times as tolerated. Resident #16 occasionally is noncompliant with application of hand splint, please encourage to wear daily. Review of Resident #16's document titled Care Plan Updates, dated 12/6/24, indicated the following: Splint Instructions: a splint will be applied to L (left) hand carrot, remove splint each shift and check skin integrity. Review of Resident #16's Occupational Therapy OT Discharge Summary, dated from 11/28/23 - 2/22/24, indicated the following: - Discharge Recommendations: Nursing to don left hand splint or L hand carrot (accommodate Pt's tolerance/preference) for the purpose of contracture prevention to left hand. Resident to wear splint for up to 8 hours daily as tolerated with nursing to provide daily skin inspection. Review of Resident #16's document titled Resident Interdisciplinary Screen Form, undated, indicated that the Resident uses a hand-held assistive device and he/she has a left hand contracture. Review of Resident #16's documents titled Clinical Education Sign Off presented by Therapy staff with nursing signatures indicating they completed education indicated the following: - Dated 4/11/23: Resident #16 Left hand contracture exercise program during morning/afternoon care for contracture prevention. - Dated 1/24/24: Left hand carrot application and positioning - Dated 3/2/24: hand splint application/hand carrot application, skin checks Review of a document, dated 2/5/25, that was hanging up at the nursing station indicated the following: - The following residents have splinting programs that should be monitored daily for wear, fit, compliance, should also have daily skin check to ensure bony prominences are intact/no skin breakdown. If there are any issues (splint is missing, resident reports pain, not fitting well, resident refuses splinting) please refer resident for therapy/alert rehab department. - Resident #16: left hand carrot splint at all times as tolerated. Review of Resident #16's medical record failed to indicate any progress notes indicating that the Resident refused to wear the left hand carrot. During an interview on 2/13/25 at 8:02 A.M., the Director of Rehabilitation (DOR) said Resident #16 has a left hand contracture and he/she should be using his/her hand carrot as tolerated. The DOR continued to say the carrot should be in his/her room so he/she uses it. The DOR said the occupational therapist teaches nursing on the orthotic use and nursing should be encouraging Resident #16 to use the hand carrot. The surveyor told the DOR that the carrot has not been seen in Resident #16's room. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 8:53 A.M., Nurse #5 said Resident #16 should be wearing his/her hand carrot and nursing should be encouraging him/her to be wearing it. During an interview on 2/13/25 at 10:55 A.M., the Assistant Director of Nursing (ADON) said Resident #16 should be wearing his/her hand carrot as ordered by the physician and if he/she refuses it needs to be documented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 15016 Based on record review and interview, the facility failed to investigate falls for two Residents (#13 and #133) of 27 sampled residents. Specifically, 1. For Resident #13, the facility failed to investigate his/her fall to the ground in the outdoor smoking area. 2. For Resident #133, the facility failed to ensure an incident report and investigation was completed after getting his/her hand caught in the elevator. Findings include: Review of the facility's policy titled Accidents and Incidents - Investigation and Reporting, not dated, indicated, but was not limited to, the following: - In the event that a fall occurs, the facility will investigate the factors contributing to the fall and develop a plan of action to minimize further falls. - All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. - Evaluate why the resident may have fallen, clarify the details of the fall. 1. Resident #13 was admitted to the facility in August 2020 and had diagnoses which included multiple sclerosis, cerebral vascular accident and psychotic disorder. Review of Resident #13's Minimum Data Set (MDS) assessment, dated 12/4/24, indicated he/she had a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. The MDS also indicated that the Resident used a wheelchair, has had no recent falls, and required staff supervision or touching assistance when stood from a seated position. Review of Resident #13's care plan for falls, last reviewed on 12/4/24, indicated he/she was at risk for falls related to an unsteady gait, muscle weakness, multiple sclerosis and non-compliance with safety awareness. Interventions included: - Please do a fall assessment on admission and quarterly every quarter and if I have a fall. During an interview on 2/12/25 at 1:00 P.M., with a resident, he/she said they were with Resident #13 in the outdoor smoking area at approximately 11:00 A.M. this morning when they witnessed the Resident fall to the concrete pavement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's medical record on 2/13/25 at 7:10 A.M., indicated a post-fall investigation had not been initiated. During an interview with Resident #13 on 2/13/25 at 8:24 A.M., and at 10:18 A.M., the Resident said he/she fell yesterday while in the outdoor smoking area. The Resident said he/she stood up from a chair and lost his/her balance and fell backwards into the chair and fell to the ground. The Resident said he/she hit his/her head on the ground. The Resident said staff helped pick him/her up off the ground and offered a wheelchair. The Resident said he/she refused the wheelchair and used a walker to ambulate. Resident #13 said he/she told Nurse #5 he/she fell to the ground and hit his/her head. During an interview on 2/13/25 at 8:29 A.M., Nurse #5 said a staff person told her Resident #13 fell outside. Nurse #5 said she saw Resident #13 walking in the hallway with a walker, and he/she appeared unharmed. Nurse #5 said Resident #13 told her he/she did not fall and refused to allow her to physically assess him/her. Nurse #5 said she did not initiate a post-fall investigation because the Resident said he/she did not fall. During an interview on 2/13/25 at 9:01 A.M., the Director of Rehab said that on the morning of 2/12/25 a staff member entered the rehab office and asked for a wheelchair. The staff person told her that Resident #13 fell outside and hit his/her head. During an interview with the Administrator, the Infection Preventionist and the Regional Administrator on 2/13/25 at 9:50 A.M., they said staff had not informed them that Resident #13 fell outside in the smoking area. The Regional Administrator said a post-fall investigation should have been immediately initiated. 36431 2. Resident #133 was admitted to the facility in August 2024 and has diagnoses that include but not limited to cervical disc disorder, high cervical region, chronic pain, and monoplegia of upper limb following a cerebral infarction affecting left non-dominant side. Review of the Minimum Data Set (MDS) assessment, dated 8/26/24, indicated Resident #133 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating he/she had intact cognition, and required supervision/touching assistance for ambulation. Review of Resident #133's medical record indicated the following progress notes: - 11/21/24 at 11:43 (A.M.), Note Text: x-ray of right wrist ordered. No trauma seen after getting hand caught in elevator closure on 11/20/24. full range of motion no bruising today. - 11/21/24 at 11:46 (A.M.) Note Text: care plan updated to monitor right hand. - 11/22/24 at 14:06 (2:06 P.M.) Note Text: Patient has been discharged . Review of the medical record indicated there was no progress note dated 11/20/24. A review of incident reports indicated there was no incident report initiated or completed for Resident #133's 11/20/24 elevator incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 10:48 A.M., with the Assistant Director of Nursing (ADON) and the Staff Development Nurse (SDC), the ADON said she recalled issues with the elevator, but did not recall an incident with Resident #133. The SDC said she would expect an incident report to be completed, as well as a nursing assessment, provider notification, and an investigation into the incident, including the operation and functioning of the elevator.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 15016 Based on observations, record review and interview, the facility failed to provide respiratory care services in accordance with professional standards of practice for three Residents (#30, #68 and #74) out of a total sample of 27 Residents. Specifically, the facility failed to: 1. Ensure Resident #30's nebulizer equipment was bagged and dated. 2. Ensure that Resident #68's oxygen flow rate followed physician orders. 3. Ensure that Resident #74's oxygen flow rate followed physician's orders and ensure his/her a bilevel positive airway pressure (BiPap) mask was kept clean and sanitary. Findings include: Review of the facility policy titled Oxygen Administration Policy and Procedure, dated 12/6/22, indicated the following: - Orders should specify the oxygen equipment and flow rate or concentration required as routine or PRN (as needed). - Oxygen equipment will be checked daily for: Correct flow and concentration. - Procedures: Check physician's order. If it is unclear, clarification must be obtained. - Resident compliance with therapy. 1. Resident #30 was admitted to the facility in November 2024 and had diagnoses which included chronic obstructive pulmonary disorder and diabetes. Review of Resident #30's Minimum Data Set (MDS) assessment, dated 12/2/24, indicated a Brief Interview for Mental Status exam score of 13 out of 15, indicating intact cognition. The MDS also indicated he/she received respiratory therapy, was not resistant to care, had impaired range of motion to his/her upper and lower extremities, and required substantial/maximal staff assistance for bed mobility. Review of Resident #30's February 2025 physician orders, indicated there was no order for the frequency of changing the nebulizer tubing. Review of the February 2025 Treatment Administration Record (TAR) did not reference nebulizer tubing or the frequency of nebulizer tubing changes. During an observation on 2/11/25 at 8:43 A.M., the surveyor observed Resident #30 lying in bed, awake. A nebulizer machine was located on the windowsill, next to the Resident's bed. The nebulizer mask was not bagged and was in direct contact with the sill. The nebulizer tubing was undated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/12/25 at 7:46 A.M., the surveyor observed Resident #30 lying in bed, awake. A nebulizer machine was located on the bedside table, and it was running. The tubing was detached from the machine and lying on the floor, and the mask was on the Resident's lap. The tubing was undated. The Resident said that staff changed the nebulizer tubing this morning. During an interview on 2/12/25 at 8:24 A.M., the Regional Administrator said it was facility policy for nebulizer masks to be bagged when not in use to maintain cleanliness, and tubing to be dated and changed weekly. The Regional Administrator said the frequency for changing the nebulizer tubing should be listed on the TAR. 2. Resident #68 was admitted to the facility in November 2024, and has active diagnoses which include respiratory failure, asthma and coronary artery disease. Review of Resident #68's Minimum Data Set (MDS) assessment, dated 12/21/24, indicated a Brief Interview for Mental Status exam score was not obtained, but indicated he/she had moderately impaired cognition. The MDS indicated the Resident used a wheelchair for ambulation, and did not exhibit resistance to care, or other behaviors. Review of Resident #68's physician order dated 11/16/24, indicated: - Oxygen at 2-6 liters nasal cannula continuous. Every shift for Oxygen Therapy. Review of Resident #68's respiratory care plan last reviewed on 12/21/24, indicated he/she used continuous oxygen through a nasal cannula. On 2/11/25 at 8:13 A.M., the surveyor observed Resident #68 lying in bed, awake. A nasal cannula was in the Resident's nares and oxygen was flowing. An oxygen concentrator next to the bed indicated the flow rate was set to 10 liters. Resident #68 said he did not know the proper setting for the oxygen flow rate. On 2/12/25 at 7:31 A.M., the surveyor observed Resident #68 lying in bed, asleep. A nasal cannula was in the Resident's nares and oxygen was flowing. The oxygen concentrator was set to 8.5 liters. During an interview on 2/12/25 at 7:31 A.M., Unit Manager #1 and the Infection Preventionist said Resident #68 was known by staff to self-adjust the oxygen flow rate. They said they were unaware that yesterday the flow rate was set to 10 liters, or that today it was set to 8.5 liters. They said the flow rate should be between 6 to 8 liters. Unit Manager #1 and the Infection Preventionist said staff try to monitor Resident #68's oxygen flow rate. They said the care plan should be revised to address this behavior. 45984 3. Resident #74 was admitted to the facility in April 2024 with diagnoses including chronic obstructive pulmonary disease (COPD) and congestive heart failure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #74's most recent Minimum Data Set (MDS) assessment, dated 1/ 29/25, indicated that the Resident had a Brief Interview for Mental Status exam score of 15 out of 15, indicating intact cognition. Further review of the MDS indicated that the Resident requires oxygen therapy, does not reject care and requires staff assistance with activities of daily living. The surveyor made the following observations: - On 2/11/25 at 7:51 A.M. and 3:37 P.M., Resident #74 was sleeping in his/her bed receiving supplemental oxygen via nasal cannula. The oxygen machine was delivering oxygen at 5 liters. - On 2/12/25 at 6:47 A.M., Resident #74 was sleeping in his/her bed receiving supplemental oxygen via nasal cannula. The oxygen machine was delivering oxygen at 5 liters. - On 2/13/25 at 8:20 A.M., Resident #74 was awake in bed receiving supplemental oxygen via nasal cannula. The oxygen machine was delivering oxygen at 5 liters. During an interview on 2/13/25 at 8:20 A.M., Resident #74 said he/she does not adjust his/her oxygen machine. Resident #74 then said his/her BiPAP mask has not been changed in a month. The Resident showed the surveyor the mask and it had spots of white residue on it. The Resident proceeded to scratch the residue with his/her fingernail and a scraping noise was heard indicating it was crusted on. Review of Resident #74's physician's orders indicated the following: - Dated 10/24/24: 4 L (liters) oxygen every shift. - Dated 2/2/25: Clean BiPAP mask and hoses weekly and PRN (as needed) with warm soap and water. Review of Resident #74's care plans indicated the following: - Dated 5/1/24: Focus - I am on oxygen therapy continuous at 4 LPM (liters per minute) r/t (related to) COPD. Interventions: Maintain supplemental oxygen via nasal cannula as prescribed, please change nasal cannula tubing, nasal cannula, (face mask) weekly and as needed. Review of Resident #74's lab results report dated 2/3/25 indicated the following: - Test: CO2 (carbon dioxide), Result: 37, Reference Range: 22-33 mmol/L. This result was flagged as being high (elevated). Review of the nursing progress note dated 2/8/25 at 11:33 P.M., indicated the following: Resident c/o (complaint of) of dryness to nares, nostrils. Resident requests, wanted nasal spray to help ease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 8:59 A.M., Nurse #5 said when residents receive supplemental oxygen, settings are determined by a physician's order. Nurse #5 reviewed Resident #74's physician's orders and said he/she should be receiving oxygen at 4 liters. Nurse #5 said Resident #74 has COPD and a resident receiving too much oxygen could result in an accumulation of CO2 within the body. Nurse #5 and the surveyor observed Resident #74's oxygen machine and Nurse #5 said the oxygen was set to 5 liters when it should be set to 4 liters. Nurse #5 also observed Resident #74's BiPAP mask and said it was dirty and had caked on residue. Nurse #5 said the BiPAP mask was dirty and needed to be cleaned. During an interview on 2/13/25 at 10:55 A.M., the Assistant Director of Nursing (ADON) said if a resident is receiving too much oxygen they can have high CO2 levels. The ADON said Resident #74 should be receiving oxygen as indicated by the physician's order and his/her BiPAP mask should be cleaned if it is visibly dirty and it likely has not been cleaned in a long time if there is crusty residue on it.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 36876 Based on record review, the facility failed to perform annual performance reviews for three of three sampled Certified Nursing Assistant (CNA) records. Findings include: Review of three out of three CNA employment records indicated that annual performance reviews were not completed as required. During an interview on 2/13/25 at 11:58 P.M., the Regional Administrator said that CNA's should have annual performance evaluations.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 36431 Based on observation and interview, the facility failed to post the nurse staffing information daily as required. Findings include: During the survey the surveyor was unable to locate the staffing posting that is required to be available for residents and visitors to view. During an observation and interview on 2/12/25 at 12:16 P.M., the Appointment Coordinator, found an empty plastic frame by the receptionist and said it is used for the daily staff posting. The facility appointment coordinator said that when she was the scheduler, she would post the staffing daily and that the current scheduler should be posting the daily staffing. During an interview on 2/12/25 at 12:22 P.M., the Scheduler said she did not post the staffing today or yesterday and then said she has not posted the staffing since she started working here a few months ago.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 36431 Based on observation, record review and interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental, and psychosocial well-being for two Residents (#85 and #16) out of a total sample of 27 residents. Specifically, the facility failed to: 1. Ensure an individualized care plan for Resident #85, who has a secondary diagnosis of Substance Use Disorder (SUD), was developed. 2. Ensure recommendations from behavioral health services were relayed to the physician and implemented for Resident #16. Findings include: 1. Review of the facility policy titled 'Substance Use Disorder' last revised March 15, 2021, indicated the Purpose: The purpose of this policy is to avoid relapse of residents who have a substance use disorder and to remain a drug free environment where residents receive exceptional healthcare services. Substance Use Disorders (SUDs) have lasting adverse effects on an individual's functioning, mental, physical, social emotional and, or spiritual well-being. It is our role as healthcare workers to mitigate negative effects and provide a safe residence for those admitting to our center. Policy: the Facility ensures that residents who are diagnoses or have a history of substance use disorders are provided services in accordance with professional standards of practice to mitigate triggers that may cause relapse of the resident. Procedure: 1. Upon admission, the center will notify all residents of the center of the expectations to remain a drug and alcohol-free-facility. Illegal substances are prohibited, and the use of any legal substance must be ordered by the resident's attending physician. 2. The interdisciplinary team will assess each resident upon admission to inquire whether or not a resident has a history of substance use, is receiving treatment for substance use or had received treatment in the past. 3. Social Service personnel will conduct the assessments to identify resident triggers to prevent relapse and determine whether a referral to psych and or SUD treatment is necessary. 9 Substance use interventions will be documented in the resident's individualized, person-centered care plan upon admission, quarterly, and annually if not more often, if necessary, based on any change in the resident's physical and/or psychosocial needs well-being. As we evaluate resident specific interventions, we will determine whether referrals to psychological health or social service personnel is necessary for additional support. Resident #85 was admitted to the facility in January 2025 with diagnoses that include infection of intervertebral disc cervical region, pneumonitis, depression, and opioid dependence uncomplicated. Review of the comprehensive Minimum Data Set assessment, dated 1/21/24, indicated Resident #85 scored a 14 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition and requires partial/moderate assistance from staff for bathing and dressing. Further review of the MDS indicated under Section I Active Diagnoses that Resident #85 has opioid dependence, uncomplicated. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital Medicine Discharge Summary, date of service 1/16/25, indicated: outstanding issues at discharge: OUD (opioid use disorder) Due for injectable buprenorphine (sublocade) (an opioid used to treat opioid use disorder) on 3/31/25. Evaluate if patient has naloxone and consider re-prescribing intranasal naloxone. Review of the physician's orders indicated the following: Appointment at Verta (sic) Beach (sic) (doctor's office) monthly appointment for SUD injection, active 1/29/25. During an interview on 2/11/25 at 4:08 P.M., Resident #85 said he/she has a history of drug use and has a PCP and case manager at the shelter where he/she resides. Resident #85 said he/she was not aware of any support services or anything like that here. Review of Social Service Substance Use assessment dated , January 2025 indicated next to history of opioids/heroin use as 'no'; which conflicted with the discharge summary and admission diagnoses. Review of Resident #85's medical record failed to indicate an individualized care plan with person-centered interventions for his/her SUD history was developed. During an interview on 2/12/25 at 11:07 A.M., Social Worker (SW) #1 said the facility does admit residents who have secondary diagnosis of SUD. SW #1 said Residents are assessed for a history of SUD as part of the admission assessment. SW #1 said they use the resident interview and medical record review to gather information about the resident and their SUD. SW #1 said nursing and social service staff can develop care plans and that a resident with a SUD would require a specific care plan related to the resident's journey for recovery, treatments, supports, or potential triggers for relapse. On 2/12/25 at 3:01 P.M., the Assistant Director of Nursing said a resident who has a SUD diagnosis should have a care plan developed. 45984 2. Resident #16 was admitted to the facility in February 2023 with diagnoses including dementia, mood disturbance, anxiety and altered mental status. Review of Resident #16's most recent Minimum Data Set (MDS) assessment, dated 11/14/24, indicated that the Resident had a Brief Interview of Mental Status score of 2 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident exhibits verbal behavior symptoms towards staff and others. Review of Resident #16's Behavioral Health Visit from the Psychiatric Nurse Practitioner, dated 1/9/25, indicated the following: - Staff reported that Resident #16 has been confused with paranoid delusions, his/her appetite is poor, he/she sleeps at night, he/she refuses to go to appointments and is agitated at times. - Clinical Assessment: When asked about not being compliant with outpatient appointments, pt (patient) states he/she feels anxious. Informed pt we could start on Ativan (a psychotropic medication) for his/her anxiety. Will recommend Ativan PRN (as needed) if pt agrees to take it. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Plan/Recommendations: Agree with MD (medical doctor) recommendations to start pt on Ativan PRN for combativeness, agitation. Start Ativan 0.5 mg BID (twice daily) PRN for 14 days. Monitor and document changes in mood, behavior, mental status and cognition. Review of Resident #16's document titled Resident Daily Flow Sheet for January 2025 and February 2025, completed by Certified Nursing Assistants indicated that the Resident exhibited wandering, verbally abusive and disruptive/socially inappropriate behaviors throughout the months of January and February. Review of Resident #16's physician's orders failed to indicate that an active, discontinued, or completed order for Ativan 0.5 mg BID (twice daily) PRN for 14 days as recommended by the Psychiatric Nurse Practitioner. Review of Resident #16's Medication Administration Record for the months of January and February 2025 failed to indicate that an active, discontinued, or completed order for Ativan 0.5 mg BID (twice daily) PRN for 14 days as recommended by the Psychiatric Nurse Practitioner. During an interview on 2/13/25 at 9:21 A.M., the Psychiatric Nurse Practitioner (NP) said that she comes into the building once week and each resident is seen by her at least once a month. The NP said she is familiar with Resident #16 and he/she can be agitated and physically aggressive with staff. The NP said when she makes a recommendation she sends the paperwork to the Director of Nursing who will then call the medical doctor. The NP and surveyor reviewed the visit notes from 1/9/25 and the NP said she was not sure why the Ativan was not implemented as Resident #16 would benefit from it if he/she needed it for a behavior. The NP showed the surveyor her summary and recommendations that she sent in an email to the Director of Nursing, the NP said she would have expected the Director of Nursing to implement them. During an interview on 2/13/25 art 10:55 A.M., the Assistant Director of Nursing (ADON) said the facility should have followed the recommendation made by the NP and implemented the Ativan order for Resident #16. The ADON said if the NP and MD recommended a treatment it should be implemented. The ADON said the recommendations go right to the Director of Nursing and she would put the order in. The Director of Nursing was unavailable to be interviewed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review and interview, the facility failed to ensure the pharmacy identified irregularities for one Resident (#15) of 27 sampled residents. Specifically, an antidepressant was incorrectly prescribed for the treatment of chronic obstructive pulmonary disorder (COPD). Findings include: Resident #15 was admitted to the facility in October 2024 and had diagnoses that included chronic obstructive pulmonary disease (dated 8/19/20), depression, cerebral vascular accident and Parkinson's disease. Review of Resident #15's Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status exam score of 2 out of 15, indicating severe cognitive impairment. The MDS also indicated he/she was prescribed an antidepressant. Review of Resident #15's physician's order dated 10/9/24, indicated: - Sertraline HCL (antidepressant medication) capsule 150 mg (milligrams). Give 1 tablet by mouth one time a day for nausea and vomiting related to chronic obstructive pulmonary disease with acute exacerbation. The order indicated it was reviewed by the pharmacy on 10/10/24. Review of the manufacturer's medication information (Pfizer), last revised October 2021, indicated Sertraline is a hormone that helps increase the amount of serotonin in the brain and to regulate mood. Sertraline is prescribed to treat mental illnesses, including diagnoses of depression, anxiety, obsessive-compulsive disorder, post-traumatic stress disorder and premenstrual dysphoric disorder. During an interview on 2/13/25 at 8:35 A.M., Nurse #5 said Sertraline was prescribed for a diagnosis of depression, not for nausea and vomiting or a diagnosis of COPD. Nurse #5 said the pharmacy is expected to identify incorrect uses for medications and notify the physician. During an interview on 2/13/25 at 9:06 A.M., the Regional Administrator said the order for Sertraline was to treat Resident #15's diagnosis of depression, not to treat COPD, or nausea and vomiting. The Regional Administrator said the pharmacy should have identified the error in its monthly medication reviews.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 43846 Based on record review, policy review, and interview, the facility failed to ensure residents were free of unnecessary medications for one Resident (#66) out of a total of 27 sampled residents. Specifically for Resident #66, the facility failed to ensure there was a re-assessment date for his/her as needed (PRN) Ativan. Findings include: Resident #66 was admitted to the facility in April 2019 with diagnoses that included cerebral infraction, dysphagia, bipolar disorder, and paranoid schizophrenia. Review of Resident #66's most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Review of Resident #66's physician order, dated 1/28/25, indicated Ativan (a benzodiazepine medication used to treat anxiety) Oral Tablet 0.5 MG (milligrams), Give 1 tablet by mouth every 4 hours as needed for anxiety agitation. On 2/13/25 at 8:49 A.M., Nurse #2 said an as needed Ativan order needs a stop and re-assessment date. On 2/13/25 at 11:08 A.M., the Staff Development Coordinator (SDC) said an as needed Ativan order needs a stop and re-evaluation date.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on interview, observation, and policy review, the facility failed ensure medications were properly labeled and dated with an expiration, on 1 of 4 nursing units. Findings include: The United States Pharmacopoeia (USP) General Chapter 797 [16] recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. The manufacturer's expiration date refers to the date after which an unopened multi-dose vial should not be used. The beyond-use-date refers to the date after which an opened multi-dose vial should not be used. The beyond-use-date should never exceed the manufacturer's original expiration date. Review of the facility policy Storage of Medications, not dated, indicated: When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The Nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. On 2/12/25 at 9:52 A.M., on the [NAME] 2 nursing unit, the surveyor observed the medication cart contained the following: - One opened and actively used aerosol inhaler of Budensonide and Formoterol Fumerate Dihydrate (used for the treatment of asthma). The inhaler was not labeled with a resident's name or a date of opening or expiration. - One opened and actively used aerosol inhaler of Albuterol Sulfate. The inhaler did not have a date opened or expiration date. During an interview on 2/12/25 at 9:52 A.M., Unit Manager #1 said that prescription medications including inhalers should be labeled with the resident's name, the date opened and date of expiration.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to ensure one Resident (#82) was seen by the dentist for routine cleaning and had his/her dentures replaced once missing, out of a total sample of 27 residents. Findings include: Review of the facility policy titled, Dental Services and Denture Services, dated December 2022, indicated the following: -Purpose: To ensure that residents receive routine and emergent dental services to meet their individual needs. -Policy: Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. -Oral heath services are available to meet the resident's needs. -Our facility has a contract with a dentist that comes to the facility and provided dental services on a routine basis. -Nursing services or designee is responsible for scheduling dental services as needed. -Should a resident's dentures become lost or damaged, the facility will refer the resident to a dentist within three (3) days. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. -If the loss or damage of a resident dentures is a result of the facility's actions, the facility will cover the expense of denture repair or replacement in accordance with the established fee schedule with its' contracted dental service provider. Resident #82 was admitted to the facility in November 2022 with diagnoses including stroke, hemiplegia and dysphagia (difficulty swallowing). Review of Resident #82's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicating he/she is cognitively intact. The MDS also indicated Resident #82 required supervision or touching assistance for self-feeding tasks. During an interview on 2/11/25 at 8:04 A.M., Resident #82 said he/she would love to see a dentist for a cleaning and also said his/her top dentures were missing. The Resident said he/she would love to have his/her top dentures replaced. The Resident was observed to only have bottom teeth and the existing teeth were discolored. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #82's physician orders indicated the following order: Podiatry, audiology, dental, ophthalmology consults as needed, initiated on 1/18/24. Review of Resident #82's medical record failed to indicate the facility obtained consent for the Resident to be seen by the dentist or had conversations with him/her about having dental visits. Review of Resident #82's admission nursing assessment, dated 11/8/22, indicated the Resident had upper dentures that fit well. Review of the nursing assessment, dated 8/9/24, failed to indicate the Resident had dentures. Review of Resident #82's oral assessment, dated 12/5/24, failed to indicate the Resident had dentures. Review of Resident #82's oral health care plan, last revised 12/5/24, indicated the following intervention: When indicated, I want you to schedule a consult with the dentist for me. During an interview on 2/12/25 at 11:55 A.M., Unit Manager #1 said all residents should have a discussion about ancillary services such as the dentist and consents should be obtained to be treated. During an interview on 2/12/25 at 1:48 P.M., the Assistant Director of Nursing (ADON) said consents for the dentist should be obtained upon admission and as needed. The ADON said she is unaware if Resident #82 ever had dentures and if he/she was ever seen by the dentist and would follow-up. During a follow-up interview on 2/13/25 at approximately 8:30 A.M., the ADON said she was unable to find a consent for dental services for Resident #82 and said she reviewed the nursing assessment which indicated the Resident had been admitted with dentures and is not sure where those dentures are now. During an interview on 2/13/25 at 8:41 A.M., Nurse #3 said she did not know if Resident #82 ever had dentures.

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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. 45984 Based on observations and interview, the facility failed to properly store food items to prevent the risk of foodborne illness and ensure food trays and dinnerware were in good condition. Specifically: 1. The facility failed to separate staff's personal food items from resident food items in the walk-in refrigerator and properly label and date food. 2 The facility failed to ensure resident's meal trays and food domes were in good condition. Findings include: 1. During the initial walk-through of the kitchen on 2/11/25 at 7:03 A.M., the surveyor made the following observations in the reach-in refrigerator: - A box of opened, unlabeled, undated donuts with resident food. - A container of unlabeled, undated brown, congealed food in a plastic Tupperware container. - A container of red paste not labeled or dated. During an interview on 2/11/25 at 7:11 A.M., the Food Service Director (FSD) said the donuts and Tupperware of brown material were a staff member's food and they should not be stored with resident food. The FSD continued to say the red paste was a container of ketchup and all food should be labeled and dated. 2. During lunch service on 2/12/25 at 12:42 P.M., the surveyors made the following observations: - The edges and corners of numerous meal trays holding resident food were chipped and worn down. Some of the trays had exposed metal that was underneath the plastic coating on the trays. - The meal domes that cover the resident's meals were very worn down, scratched and rough to the touch. During an interview on 2/13/25 at 7:37 A.M., the FSD said the resident's meal trays and domes should be in good condition and not be cracked or chipped. The surveyor showed the FSD the photos of the meal trays and domes and she said she needs to get new ones.

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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. 41456 Based on observations, record review and interview, the facility failed to ensure staff maintained an accurate medical record for two Residents (#88 and #16) out of a sample of 27 residents. Specifically, they failed to: 1. For Resident #88, the facility failed to accurately document if he/she was wearing his/her hearing aids. 2. For Resident #16, the facility documented that the Resident was wearing his/her left hand splint when he/she was not. Findings include: 1. Resident #88 was admitted to the facility in October 2022 with diagnoses including sensorineural hearing loss. Review of Resident #88's most recent Minimum Data Set (MDS) assessment, dated 1/2/25, indicated the Resident scored 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment. The MDS also indicated the Resident has moderate to difficulty hearing. During an interview on 2/11/25 at 11:00 A.M., Resident #88 was unable to be interviewed secondary to his/her hearing impairment. During this interview, Resident #88 was not wearing a hearing aid in either ear. Throughout all days of the survey, (2/11/25 through 2/13/25), Resident #88 was not observed to be wearing hearing aids. Review of Resident #88's physician orders indicated the following order: - Resident has both hearing aid(s). Apply in AM (morning) and remove at HS (every night). Store in med cart. Review of the Medication Administration Record for February 2025 indicated the nurses had documented the above order as implemented, indicating Resident #88 had worn his/her hearing aids on 2/11/25 and 2/12/25. During an interview on 2/12/25 at 11:26 A.M., Nurse #4 said Resident #88 has hearing aids, does not refuse to wear them, but is not wearing them because the batteries are dead. Nurse #4 said Resident #88's hearing aids are kept in the medication cart when not in use. The surveyor asked to see the Resident's hearing aids and when the nurse looked through the medication cart he was unable to locate the hearing aids and said they must be lost. (continued on next page)

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	225497	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	1190 Vfw Parkway Boston, MA 02132

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 1:48 P.M., the Assistant Director of Nursing (ADON) said Resident #88 has hearing aids and at times does not like to wear them. The ADON said if the Resident refuses to wear his/her hearing aids the refusal should be documented and when not worn the hearing aids should be kept in the medication cart. The ADON said she was unaware the hearing aids were missing and that Resident #88 was not wearing his/her hearing aids. The ADON said orders should not be marked as implemented if the nurses had not actually implemented the order. 45984 2. Resident #16 was admitted to the facility in February 2023 with diagnoses including lack of coordination, altered mental status, and contracture of the left hand. Review of Resident #16's most recent Minimum Data Set (MDS) assessment, dated 11/14/24, indicated that the Resident had a Brief Interview of Mental Status score of 2 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident has functional limitation in range of motion on his/her upper extremity. The surveyor made the following observations: - On 2/11/25 at 8:56 A.M., Resident #16 was eating breakfast in his/her room. The Resident's left hand was closed into a fist, the surveyor asked if he/she was able to open it and he/she could only flex open his/her thumb. Resident #16 said his/her left hand was painful. Resident #16 was not using a hand carrot. The surveyor did not observe a hand carrot in the resident's room. - On 2/11/25 at 2:14 P.M., Resident #16 was observed laying in his/her bed, the Resident was not using a hand carrot in his/her left hand. The surveyor did not observe a hand carrot in the resident's room. - On 2/12/25 at 8:09 A.M., Resident #16 was awake in his/her wheelchair in his/her room. The Resident was not using a hand carrot in his/her left hand, Resident #16 proceeded to say that his/her left hand was hurting. The surveyor did not observe a hand carrot in the resident's room. - On 2/12/25 at 11:26 A.M., Resident #16 was observed in the hallway, he/she was not using a hand carrot in his/her left hand. Review of Resident #16's physician's order, dated 12/6/24, indicted the following: - Nursing to don left hand carrot splint to left hand for the purpose of contracture prevention. Resident to wear splint at all times/per resident preference daily with nursing to provide daily skin inspection every shift for contracture prevention. Review of Resident #16's impaired functional mobility r/t (related to) left hand contractures care plan dated 3/7/24 indicated the following intervention: - Dated 12/16/24: Resident #16 wears a left carrot splint on his/her left hand for the purpose of contracture prevention. Nursing to don (put on) and he/she prefers to wear it at all times as tolerated. Resident #16 occasionally is noncompliant with application of hand splint, please encourage to wear daily. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's document titled Care Plan Updates,dated 12/6/24, indicated the following: Splint Instructions: a splint will be applied to L (left) hand carrot, remove splint each shift and check skin integrity. Review of a document, dated 2/5/25, that was hanging up at the nursing station indicated the following: - The following residents have splinting programs that should be monitored daily for wear, fit, compliance, should also have daily skin check to ensure bony prominences are intact/no skin breakdown. If there are any issues (splint is missing, resident reports pain, not fitting well, resident refuses splinting) please refer resident for therapy/alert rehab department. - Resident #16: left hand carrot splint at all times as tolerated. Review of Resident #16's Treatment Administration Record (TAR) documentation for the months of January and February 2025 indicated that staff had signed off that Resident #16 was wearing his/her hand carrot splint when he/she did not wear it. During an interview on 2/13/25 at 8:02 A.M., the Director of Rehabilitation (DOR) said Resident #16 has a left hand contracture and he/she should be using it as tolerated. The DOR continued to say the carrot should be in his/her room so he/she uses it. The DOR said the occupational therapist teaches nursing on the orthotic use and nursing should be encouraging Resident #16 to use the hand carrot. The surveyor told the DOR that the carrot has not been seen in Resident #16's room. During an interview on 2/13/25 8:53 A.M., Nurse #5 said Resident #16 should be wearing his/her hand carrot and nursing should be encouraging him/her to be wearing it. Nurse #5 continued to say that staff should not be documenting that Resident #16 is wearing his/her hand splint when he/she has not been. During an interview on 2/13/25 at 10:55 A.M., the Assistant Director of Nursing (ADON) said staff should be accurately documenting in the medical records. The ADON then said staff should not be documenting that Resident #16 is wearing his/her hand carrot splint when he/she has not been.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation and interview, the facility failed to implement an effective pest control program. Specifically, the facility failed to implement recommendations made by the contracted pest control company to reduce the risk of pest infestations. Findings include: Review of the facility titled Pest Control policy, undated, indicated: This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Pest control services will be provided by a licensed contractor. Maintenance services assist, when appropriate and necessary, in providing pest control services During the Resident Group Interview on 2/12/25 at 10:07 A.M., all participating residents said the facility had mice, roaches, and fruit flies. They said the facility has an exterminator once a week but reported the problem persists. Review of the pest control log visits indicated: - 1/4/25: Comments: Upon arrival I inspected all exterior areas of the building finding moderate rodent activity within bait stations. I replenished all bait within all exterior rodent bait stations. I treated all appliances, common harborage areas and sighting areas with roach bait as the roach population is quite high especially within the kitchen and employee break rooms.One rodent capture in the first floor [NAME] wing kitchenette within a tin can next to the fridge. Open Conditions: Interior basement level - Front door: Door not rodent proof - Front entrance door does not close properly and all the doors need door sweeps to keep mice and rats out. Action: add/replace door sweep. Created/last inspected: 12/27/23 [NAME] wing: Rm 122 - Floor tiles loose. Gaps in floor tiles in bathroom by toilet. Action: Repair floor tiles: Created/last inspected: 1/26/24 - 1/9/25: Comments: Scanned exterior devices all feeding was found toward the back parking area and near water spiket [sic]. Serviced interior stations then proceeded to service kitchen due to roach captures in my zone monitors. Gel baited throughout kitchen, deployed several roach killer bait stations and deployed new zone monitors dispersed throughout kitchen. Open Conditions: Interior basement level - Front door: Door not rodent proof - Front entrance door does not close properly and all the doors need door sweeps to keep mice and rats out. Action: add/replace door sweep. Created/last inspected: 12/27/23 (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] wing: Rm 122 - Floor tiles loose. Gaps in floor tiles in bathroom by toilet. Action: Repair floor tiles: Created/last inspected: 1/26/24 - 1/17/25: Comments: Full interior inspection was performed checking and replenishing all existing monitors and bait stations as needed. One capture and removal was made within the kitchen area; mouse. Several conditions were added within the basements employee break room, loose tiling at rear left corner, peeling baseboards at rear left corner as well as broken cabinetry housing beneath kitchen sink area. These areas were highlighted to on-site maintenance and staff as having high potential for cockroach breeding activity. Moderate German cockroach activity was found in this area during todays inspection. Additional monitoring was performed in this room as well as preventative treatment. First floor inspection yielded light cockroach activity around the nurses station. Second floor inspection yielded no signs of activity. Open Conditions: Interior basement level - Front door: Door not rodent proof - Front entrance door does not close properly and all the doors need door sweeps to keep mice and rats out. Action: add/replace door sweep. Created/last inspected: 12/27/23 [NAME] wing: Rm 122 - Floor tiles loose. Gaps in floor tiles in bathroom by toilet. Action: Repair floor tiles: Created/last inspected: 1/26/24 Employee Break Room: Floor tiles need repair/group. old linoleum floor tiling is in desperate need of repair. Multiple areas in back left corner of break room where tile is completely lifted from floor and breaking away. Additionally, the baseboard along the wall in the back left corner is broken away, these areas provide habitat risk for cockroach breeding. Hole in wall located near floor, kitchen cabinetry beneath sink has broken flooring. Significant exposure at rear base of cabinet exists leading into recess of cabinetry housing. These areas provide significant potential for cockroach reading activity. Created/last inspected 1/17/25 Action: repair tile/grout. - 1/30/25: Comments: Checked in with maintenance manager who reported roach sightings in kitchen. Ham slicer showed fecal focal point. Attacked it with a flushing agent through the motor and roaches' started pouring out and dying. I then bated around and underneath counter top and roach killer stations were also deployed. Light roach activity found behind breakroom fridge. Attacked it with a flushing agent. Open Conditions: Interior basement level - Front door: Door not rodent proof - Front entrance door does not close properly and all the doors need door sweeps to keep mice and rats out. Action: add/replace door sweep. Created/last inspected: 12/27/23 [NAME] wing: Rm 122 - Floor tiles loose. Gaps in floor tiles in bathroom by toilet. Action: Repair floor tiles: Created/last inspected: 1/26/24 (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee Break Room: Floor tiles need repair/group. old linoleum floor tiling is in desperate need of repair. Multiple areas in back left corner of break room where tile is completely lifted from floor and breaking away. Additionally, the baseboard along the wall in the back left corner is broken away, these areas provide habitat risk for cockroach breeding. Hole in wall located near floor, kitchen cabinetry beneath sink has broken flooring. Significant exposure at rear base of cabinet exists leading into recess of cabinetry housing. These areas provide significant potential for cockroach reading activity. Created/last inspected 1/17/25 Action: repair tile/grout. - 2/6/25 Comments: Flushed motor of ice machine in break room where roaches were breeding in. This breeding spot was found thanks to a previously deployed monitor which allowed me to find their nest. After using the flushing agent I then performed a baseboard roach treatment, where the perimeter of the break room was treated, including cabinets. New zone monitors were deployed throughout break room. Proceeded to service kitchen where a new condition was found and recorded. In kitchen roach activity was found in my monitors deployed underneath one of the prep tables near fridge. Performed a perimeter roach treatment throughout kitchen. Roaches were found on the ham slicer cover. Treated as needed and new zone monitors were deployed. Treated fridges in kitchen, treated dishwash machine and behind stoves. Open Conditions: Interior basement level - Front door: Door not rodent proof - Front entrance door does not close properly and all the doors need door sweeps to keep mice and rats out. Action: add/replace door sweep. Created/last inspected: 12/27/23 [NAME] wing: Rm 122 - Floor tiles loose. Gaps in floor tiles in bathroom by toilet. Action: Repair floor tiles: Created/last inspected: 1/26/24 Employee Break Room: Floor tiles need repair/group. old linoleum floor tiling is in desperate need of repair. Multiple areas in back left corner of break room where tile is completely lifted from floor and breaking away. Additionally, the baseboard along the wall in the back left corner is broken away, these areas provide habitat risk for cockroach breeding. Hole in wall located near floor, kitchen cabinetry beneath sink has broken flooring. Significant exposure at rear base of cabinet exists leading into recess of cabinetry housing. These areas provide significant potential for cockroach reading activity. Created/last inspected 1/17/25 Action: repair tile/grout. Kitchen: hole behind triple sink - a hole that is exposing the pipes that are behind the triple sink can become an entry way for pest like mice or a breeding ground for roaches due to humidity. Created/last inspected: 2/6/25. Action: fix wall. During an interview on 2/13/25 at 9:37 A.M., the Maintenance Director said that pest control services visits with facility weekly, rounds, and baits and meets with the Maintenance department to discuss their findings. The Maintenance Director said that the pest control service will document their tasks and make recommendations that he will then follow up on, like repairs. The surveyor and the Maintenance Director reviewed the ongoing documented concerns including the repairs needed to the front door, resident room [ROOM NUMBER], the employee breakroom and kitchen. The Maintenance Director said that the items had been fixed and the pest control servicer did not delete the recommendations. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/25 at 9:49 A.M., the Pest Control Employee said that he rounds the building, performs treatments and baiting and meets with the Maintenance Director weekly. The Pest Control Employee said that he completes his documentation and will delete recommendations for repairs if they have been made. On 2/13/25 at 10:10 A.M., the surveyor observed the front door with a visible gap between the doors at the bottom as indicated by the pest control documentation. On 2/13/25 at 10:26 A.M., the surveyor observed multiple tiles missing next to and behind the toilet in room [ROOM NUMBER] as indicated in the pest control documentation. On 2/13/25 at 10:29 A.M., the surveyor observed multiple broken and missing tiles near the ice machine along with the baseboard pulling away from the wall as indicated by the pest control documentation. On 2/13/25 at 10:30 A.M., the surveyor observed the flooring under sink in employee breakroom broken and in disrepair as indicated in the pest control documentation.