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	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Village at Parkway	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 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** Based on observation and interview the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable/homelike interior on three out of four units. Specifically, the facility's housekeeping and maintenance services failed to clean mice droppings, identify and repair peeled wallpaper, cracked floor tiles, stained and peeling ceilings and gouges in resident rooms. Findings include: A review of the facility policy titled 'Quality of Life-Homelike Environment' with no revision date indicated the following: -Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. -The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include cleanliness and order. On 2/25/26 the surveyor observed the following on the Garden 1 (G1) unit: - At 7:25 A.M., mouse droppings throughout the G1 unit, both in resident rooms and in the hallway. - At 7:43 A.M., mouse droppings and a blue pill behind the double doors in the hallway. - At 7:47 A.M., mouse droppings in resident room [ROOM NUMBER] on the floor in the closet. -At 7:47 A.M., mouse droppings in resident room [ROOM NUMBER], and peeling baseboard. -At 8:00 A.M., mouse droppings in resident room [ROOM NUMBER] behind the door. -At 8:06 A.M., mouse droppings and debris in resident room [ROOM NUMBER]'s closet. -At 8:07 A.M., mouse droppings in resident room [ROOM NUMBER] behind bed A. -At 8:19 A.M., resident room [ROOM NUMBER]'s bathroom ceiling, approximately 18 inches in diameter, to be stained brown with a fuzzy black substance and significant peeling of the plaster, tiles missing on the wall and mouse droppings under the radiator. -At 12:49 P.M., the surveyor observed the G1 unit resident's rooms to have evidence of having been (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mopped. The surveyor also observed that the corners and edges of the rooms still contained the same mouse droppings observed earlier in the morning. -At 12:49 P.M., the surveyor and Unit Manager #2 observed mouse dropping behind the hallway door and along the hallway on the G1 unit. The surveyor and Unit Manager #2 also observed a small round blue pill behind the hallway door. During an interview on 2/25/2026 at 12:49 P.M., Unit manager #2 said that the housekeeper had already cleaned the unit this morning and the mouse droppings and pill should have been cleaned up. On 2/26/26 the surveyor observed the following on the Garden 1 (G1) unit: -At 11:38 A.M., in resident room [ROOM NUMBER]'s bathroom the ceiling was observed to be peeling and to have a black fuzzy substance cracked and missing floor tiles. -At 11:41 A.M., mouse droppings on the floor in resident room [ROOM NUMBER]. -At 11:44 A.M., mouse droppings on the floor in resident room [ROOM NUMBER] as well as cracked floor tiles, and peeling baseboard. -At 11:45 A.M., in resident room [ROOM NUMBER]'s bathroom the surveyor observed bubbled paint on the walls, the sink dirty with enamel around drain worn off. The nightstand with a broken bottom drawer and mouse droppings under radiator. -At 11:48 A.M., in resident room [ROOM NUMBER] behind bed A, the wall was gauged and mouse droppings were observed on the floor. -At 11:52 A.M., mouse droppings on the floor in resident room [ROOM NUMBER] as well as a gauged corner of the wall. In the bathroom the floor tiles were stained and cracked, and the ceiling plaster was cracked, stained brown and peeling. -At 11:55 A.M., the bathroom radiator was rusted and broken with a thick brown substance on the floor under a toilet plunger that was sitting directly on the floor. Mouse droppings were also observed. -At 11:59 A.M., the bathroom in resident room [ROOM NUMBER] had missing wall tiles, the floor tiles were stained brown with a thick brown substance in the corner along with mouse droppings. On 2/26/26 at 7:15 A.M., the surveyor observed the following on the Garden 2 (G2) unit: -Resident room [ROOM NUMBER]: No closet doors, stains on floor -Resident rooms 205 & 207: Have a shared bathroom: The sink constantly running, unable to turn off. Peeling paint off wall tiles. Debris in light fixture making lights cloudy. -Resident room [ROOM NUMBER]: Curtains as closet doors. Cracks in linoleum flooring by bathroom. Sink visibly dirty with unknown substance. Raised toilet chair/set covered in unknown brown staining on seat and legs -Resident room [ROOM NUMBER]: Curtains for closet doors (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident room [ROOM NUMBER]: Curtains for closet doors. rust marks on radiator. Peeling laminate on overbed table. -Resident room [ROOM NUMBER]: Curtains for closet doors, rubber baseboard molding and pulling away from floor of closet. Peeling paint behind bed C. -Resident room [ROOM NUMBER] Bathroom: raised toilet seat on floor, radiator cover on floor, peeling paint on wall tiles. One side of window screen covered with dust/debris and unable to see out of it. During environmental rounds on 2/26/26 at 7:33 A.M., the surveyor observed the following on the China Garden 1 unit: -Resident room [ROOM NUMBER]: Large water stain on the bathroom ceiling expanding across the room. -Resident room [ROOM NUMBER]: Multiple brown spots were observed expanding across two ceiling tiles above the middle bed. -room [ROOM NUMBER]: The bathroom floor tiles were loose, cracked, and lifted. The floor tiles were covered in a dark brown substance. There were white broken tiles and piles of debris located behind the toilet. -The right of the windowsill had a 3-inch crack with peeling and chipped plaster along the window. The top of the windowsill had plaster that was bulging down and cracked. The there was dark matter observed along the cracked edges. -There was brown discoloration along the floor outside of the bathroom door. -The wall located near the sink was cracked, chipped and had peeling plaster along the bottom approximately 5 inches in length. -The sink/ vanity was chipped, peeling, cracked and had a white substance along the edge and was -The refrigerator seal along the edge inside of the refrigerator was coated with dark gray and black substance. along all of the edges. -The bathroom ceiling had a large dark brown water stain across two tiles. -The ceiling tile located outside of resident room [ROOM NUMBER] had a large brown stain and was chipped. -The Shower Room: There were multipole large brown water stains located across the ceiling tiles. -The shower curtain had multiple dark gray and black spots scattered across the bottom of the curtain and was stained throughout. The following observations and interviews were made in the resident rooms on the Garden 1 (G-1) Unit: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident room [ROOM NUMBER]-On 2/25/26 at 8:28 A.M., the Resident in bed A said he/she sees mice at night. Mice droppings were observed underneath the heater. -Resident room [ROOM NUMBER]-On 2/25/26 at 8:24 A.M., the surveyor observed mice droppings next to the dresser on the left side of bed A, behind the main entrance door and behind the headboard of the C bed. The surveyor also observed peeling wallpaper and a gouge on the wall behind the C bed. -Resident room [ROOM NUMBER]-On 2/25/26 at 8:31 A.M., the Resident in bed C said he/she sees mice every night. He/she said the mice come from the hallway. Resident room [ROOM NUMBER]-On 2/25/26 at 8:54 A.M., the Resident in bed A said he/she sees mice at night, he/she said the mice run from the hallway to the closet, and towards the heater. Mice droppings observed in the closet and between the dresser and the closet in the middle of the room. -Resident room [ROOM NUMBER]-On 2/25/26 at 8:34 A.M., the surveyor observed peeling paint on the wall, on the right side, next to the main entrance. Cracked floor tile next to the room entrance. Mice droppings under the heater. The Resident in bed C said he/she has seen mice running from the hallway towards the heater. Resident room [ROOM NUMBER]-On 2/25/26 at 8:39 A.M., mice droppings were observed in the closet, behind the main entrance door, under the heater. The Resident is bed C said he/she sees mice running under the heater at night. During an interview on 2/26/26 at approximately 12:30 P.M., Corporate Nurse #1 said that rounds are completed weekly on the units. Corporate Nurse #1 said that the mouse droppings should have been cleaned by housekeeping. During an interview and observation on 2/26/26 at 8:52 A.M., the Maintenance Director/Housekeeping Director said he was not aware of the peeling walls, cracked floor tile and gouges in the Resident rooms. The Maintenance Director/Housekeeping Director said Resident rooms should not have mice droppings. The Maintenance Director/Housekeeping Director said he is expected to do rounds in all resident rooms, daily, to identify anything that needs repair. The Maintenance Director/Housekeeping Director said that he expects staff to notify him if resident rooms require repair. He said repair concerns should be documented in the maintenance logbook. He said after the repairs are completed, the completion should also be documented in the maintenance logbook as well. The Maintenance Director said he has not been utilizing the Maintenance logbook. He said staff have been communicating with him about other repairs in the facility via WhatsApp. The Maintenance Director/Housekeeping Director said he expects housekeeping staff to move furniture, clean behind doors, and in closets in Resident rooms. He said Resident rooms should not have mice droppings. During an interview on 2/27/26 at 8:28 A.M., the Corporate Nurse said the Maintenance Director is expected to complete rounds daily, identify any repairs, document the repairs needed in the Maintenance logbook, complete the repairs, and document the completed repairs in the Maintenance logbook. The Corporate Nurse said she is aware of the mice problem in the facility. She said that since mice are disease spreading organisms, she expects housekeeping to move furniture, and clean in closets and behind doors. The facility was not able to provide the surveyor any documentation to indicate environmental rounds had been completed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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) were accurately documented for one Resident (#10) out of a total sample of 32 residents. Specifically, for Resident #10, the facility failed to ensure that Advanced Directives indicated on the MOLST form (Massachusetts Medical Order for Life-Sustaining Treatment form) were consistently documented in the medical record. Findings include:Review of the facility policy, titled Massachusetts Advance Directives revised 8/3/22 indicated, but was not limited to, the following:-It is the policy of the facility to recognize and support the use of advance directives.-The Nursing Home Administrator is responsible for appointing staff who will initiate conversation to identify residents' responsible parties. Elected staff will confirm that information is appropriately documented in the medical record. Staff will work in accordance with DPH, CMS regulations and MA state law to ensure resident rights, safety and legal needs are met.Resident #10 was admitted to the facility in November 2025 with diagnoses of Wernicke's Encephalopathy and sarcopenia. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated that Resident #10 had moderate cognitive impairment as evidence by a score of 12 out of 15 on the Brief Interview for Mental Status (BIMS).Review of Resident #10's Health Care Proxy (HCP) activation form dated 2/5/25 indicated the Residents HCP was activated as the Resident lacked capacity to make or communicate health care decisions.Review of Resident #10's MOLST form, signed by the HCP on 12/11/25, indicated do not transfer to hospital.Review of Resident #10's MOLST form, signed by the HCP on 1/16/26, indicated transfer to hospital.On 2/25/26, the surveyor observed in the electronic health record, in the clinical dashboard, that Resident #10's Code Status Advance Directive section indicated the following: DO NOT HOSPITALIZE (DNH)/DNI/DNRReview of Resident #10's active physician orders indicated the following order: DO NOT HOSPITALIZE (DNH)/DNI/DNR, initiated 12/22/25.During an interview on 2/25/26 at 3:34 P.M. Nurse #7 said a Residents code status in the electronic medical record (EMR) would be based on the Resident's MOLST form. Nurse #7 said the EMR and MOLST form should match because if something were to happen we (the staff) would know what to do and so that there was not misinformation in different places. Nurse #7 said Resident #10's advance directives were DNH/DNR/DNI (do not hospitalize, do not resuscitate and do not intubate). Nurse #7 reviewed Resident #10's MOLST form, dated 1/16/26, and said that this was the most up to date MOLST form and that it does not match what was in the EMR. Nurse #7 said Resident #10's MOLST form was recently changed. Nurse #7 said the Residents EMR was incorrect and that a nurse or unit manager should have changed it in the EMR by getting a new physician order when the Resident's MOLST form was updated.During an interview on 2/25/26 at 3:42 P.M. Unit Manager #2 said advance directives were based on the wishes of the family in collaboration with a physician and were documented on a MOLST form. Unit Manager #2 said the EMR and MOLST form should be consistent and that they have to match in order to give proper care. Unit manager #2 said Resident #10 was DNR/DNH/DNI; after reviewing the Resident's MOLST form dated 1/16/26 Unit Manager #2 said that it was the most up to date MOLST form and that the Residents advance directives had changed per the HCP's request.During an interview on 2/25/25 at 4:04 P.M. the Social Worker said advance directives were determined by the Resident or HCP if the HCP was activated and that this would be reflected on a MOLST form. After the Social Worker reviewed Resident #10's MOLST form, dated 1/16/26, and the Residents EMR the Social Worker said the EMR was incorrect, that a new MOLST form was completed and that nursing should have changed the advance directives in the EMR. The Social Worker said the risk of having the incorrect advance directive in the EMR is that in an emergency the Resident may not be hospitalized because the code (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status banner in the EMR was more convenient to review. The Social Worker said that both the EMR and physical MOLST form should be reviewed but that in an emergency situation she could not guarantee that would happen.During an interview on 2/25/26 at 4:26 P.M. the Director of Nursing (DON) said the EMR and MOLST form should be the same and that when a MOLST changes the physician needs to give an updated order.During an interview on 2/26/26 at 8:45 A.M. Corporate Nurse #1 said Resident #10's physician order was wrong and should read may transfer to the hospital and not do not hospitalize as it may not be clear to staff what Resident #10's advance directives were. Corporate Nurse #1 said that when the physician order changes, the code status banner changes automatically.

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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** Based on observation, record review and interview, the facility failed to provide assistance with Activities of Daily Living (ADL) care for two Residents (#81 and #10) out of a total of 32 sampled Residents. Specifically,1. For Resident #81, the facility failed to provide supervision during his/her breakfast meals.2. For Resident #10, the facility failed to remove unwanted facial hair. Findings include: Review of the facility policy, titled Activities of Daily Living, reviewed December 2022, indicated, but was not limited to, the following: -A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. -Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that it was unavoidable. -The facility will provide care and services for the following activities of daily living: a. Hygiene- bathing, dressing, grooming, and oral care. d. Dining - eating, including meals and snacks 1. Resident #81 was admitted to the facility in February 2021 with diagnoses including unspecified dementia, type two diabetes, and essential hypertension. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she had severe cognitive impairment as evidenced by a score of 00 out of a possible 15 on the Brief Interview for the Mental Status Exam. Additional review of the MDS indicated the Resident requires supervision/assistance with eating. Review of Resident #81's Activities of Daily Living (ADL) care plan indicated: Focus: I need assistance/dependent with my ADL's and functional mobility, cognition impairment due to dx (diagnosis) of dementia, dated 10/22/25.Interventions included: I need you to set up and supervise my meals for me to eat. On 2/25/26 at 8:51 A.M., the surveyor observed Resident #81 resting in bed with the curtain pulled. Certified Nursing Assistant (CNA) #1 was present and preparing his/her plate on the overbed table. CNA #1 told Resident #81 to eat and left the room. Resident #81 was not supervised and was not able to be seen from the hallway. On 2/26/26 at 8:38 A.M., the surveyor observed CNA #3 setting up Resident #81's breakfast meal while he/she was in bed and the privacy curtain was pulled. CNA #3 then exited the room. CNA #3 told the surveyor that she is assigned to Resident #81, and he/she is set up for meals and does not require supervision. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/26 at 8:45 A.M., the surveyor observed Resident #81 eating his/her breakfast meal in bed with the privacy curtain pulled. Although CNA #3 was present in the room, she was assisting Resident #81's roommate with his/her meal, CNA #3 was unable to visualize Resident #81 because of the privacy curtain was pulled. On 2/27/26 at 8:39 A.M., Resident #81 was observed in bed with his/her breakfast meal in front of him/her and the privacy curtain pulled. Although there was a CNA present assisting his/her roommate, she could not visualize Resident #81 because the privacy curtain was pulled. During an interview on 2/27/2026 at 8:44 A.M., Unit Manager #1 said that staff should provide assistance or supervision based on the care plan. Unit Manager #1 said that Resident #81 should have received supervision during the breakfast meals. During an interview on 2/27/26 at 9:37 A.M., the Director of Nursing said that staff should follow the residents' plan of care and provide assistance and supervision as indicated. 2. Resident #10 was admitted to the facility in November 2025 with diagnoses of Wernicke's Encephalopathy and sarcopenia. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated that Resident #10 had moderate cognitive impairment as evidence by a score of 12 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS indicated the Resident required substantial/maximum assistance with personal hygiene, including shaving. Review of Resident #10's ADL care plan indicated the Resident had a self-care performance deficit related to recently impaired mobility, medical conditions and recent hospitalization with the following intervention: -Staff to assist with b grooming, dressing, hygiene, toileting tasks/hygiene, bed mobility, transfers assist, toilet transfer lower dressing dependent, eating set up supervision Resident may use scoop plate during meals' he/she needs assist to dependent with w/c (wheelchair) (sic.), initiated on 11/2/25 and revised 2/9/26. On 2/25/26 at 7:55 A.M. the surveyor observed Resident #10 in his/her room, the Resident had facial hair on his/her chin and upper lip approximately an inch in length. On 2/25/26 at 12:42 P.M. the surveyor observed Resident #10 in his/her room, the Resident had facial hair on his/her chin and upper lip approximately an inch in length. On 2/26/26 at 8:05 A.M. the surveyor observed Resident #10 in his/her room, the Resident had facial hair on his/her chin and upper lip approximately an inch in length. Review of Resident #10's physical and electronic medical record, including a review of the Residents CNA ADL (certified nursing assistant/ activities of daily living) flowsheet, failed to indicate that Resident #10 had refused care. During an interview and observation on 2/26/26 at 2:18 P.M. the surveyor observed Resident #10 in his/her room, the Resident had facial hair on his/her chin and upper lip approximately an inch in length. The Resident said staff had not offered to shave his/her facial hair for a few weeks and that (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she would like to have his/her facial hair shaved by staff. Resident #10 said he/she would not been able to shave his/her own facial hair as he/she did not have feeling in his/her hands. During an interview and observation on 2/26/26 at 2:51 P.M. Nurse #6 said when CNAs see that a resident's facial hair has grown that they would offer to shave it. Nurse #6 said she would not want to have facial hair herself, and she couldn't imagine that anyone else would want it either. Nurse #6 said she would expect refusals of care to be documented, that she was currently Resident #10's nurse and that to her knowledge Resident #10 had not refused care that day. Nurse #6 observed Resident #10's facial hair and said that the Residents facial hair was at a point that staff should have offered to shave him/her, Nurse #6 offered to shave Resident #10's facial hair and Resident #10 agreed. Nurse #6 said Resident #10 would not be able to shave him/herself as he/she could barely hold a cup. During an interview and observation on 2/26/26 at 2:57 P.M. Certified Nursing Assistant (CNA) #7 said CNAs check for, and assist residents with, grooming and bathing every day. CNA #7 said she would let a nurse know if a resident refused care and would try again later. CNA #7 said refusals would be documented on the CNA ADL flowsheet. CNA #7 observed Resident #10's facial hair and offered to shave it, Resident #10 agreed. CNA #7 said she would have expected a CNA to offer to shave Resident #10's facial hair based on how long it was, and that Resident #10 would not be able to do it him/herself. During an interview on 2/26/26 at 3:26 P.M. Unit Manager #2 said whenever a Resident's facial hair needed to be shaved a CNA should offer to shave it and that if a Resident refused care that CNAs have to report the refusal to the nurse and document it in the ADL flowsheet; Unit Manger #2 said the nurse should also write a progress note documenting the refusal. Unit Manager #2 said Resident #10 is usually compliant when offered ADL care. Unit Manager #2 reviewed Resident #10's ADL flowsheet documentation and said that there were no refusals documented for Resident #10. During an interview on 2/26/26 at 3:47 P.M. the Director of Rehab Services (DOR) said that rehab services had not assessed Resident #10's ability to shave and so she would expect a staff member to assist the Resident with shaving as a precaution. During an interview on 2/26/26 at 3:38 P.M. the Director of Nursing (DON) said CNAs should check on residents for grooming needs every day and throughout the day, that if a Resident refused care that the CNAs should let the nurse know of the refusal and that the refusal should be documented.

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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. Based on observation, record review and interview the facility failed to provide care, consistent with professional standards of practice, to prevent pressure ulcers for one Resident (#78) out of a total sample of 32 residents. Specifically, for Resident #78 the facility failed to elevate heels off of the mattress to prevent the development of pressure ulcers. Findings include:Review of the facility policy titled Pressure Ulcer Prevention, dated revised 12/22/22, indicated that the facility will implement interventions to minimize and/or eliminate contributing factors for pressure ulcer development on patients/resident at risk. Resident #78 was admitted to the facility in July 2024 with diagnoses including diabetes, non-pressure ulcer of the right foot with muscle necrosis and depression. Review of the physician orders dated 10/4/25, indicated an order to elevate legs and float heels when in bed. Review of the facility document titled Norton Scale for Predicting Risk of Pressure Ulcer dated 2/27/23 indicated Resident # 78 is at very high risk for the development of pressure ulcers with a score of 9. Review of the current care plan indicated that Resident #78 will refuse care at times. Further review indicated a focus for history of PVD (peripheral vascular disease) and potential skin breakdown with an intervention to elevate legs and float heels. Review of the treatment administration record failed to indicate Resident #78 refused to have his/her feet elevated off of the mattress. Review of the progress notes dated February 2026 failed to indicate Resident #78 refused to have his/her heels floated as ordered. On 2/25/26 at 7:48 A.M., the surveyor observed Resident #78 lying in bed and to have both heels directly on the mattress. On 2/25/26 at 12:11 P.M., the surveyor observed Resident #78 lying in bed and to have both heels directly on the mattress. On 2/25/26 at 4:05 P.M., the surveyor observed Resident #78 lying in bed and to have both heels directly on the mattress. On 2/26/26 at 7:22 A.M., the surveyor observed Resident #78 lying in bed and to have both heels directly on the mattress. On 2/26/26 at 12:18 P.M., the surveyor and Nurse #7 observed Resident #78 lying in bed and to have both heels directly on the mattress. During an interview on 2/26/26 at 12:18 P.M., Nurse #7 said that it is the responsibility of the nurse and the Certified Nurse's Aide (CNA) to ensure that heels are elevated. Nurse #5 then said that doctor's orders are to be followed and Resident #78's heels should not be on the mattress. During an interview on 2/26/26 at 12:28 P.M., CNA #7 said that she looks at the care plan and the Kardex (a document that informs the CNA's the level of assistance the resident requires as well as any special equipment the resident requires). CNA #7 said that she didn't remember seeing that Resident #78 required his/her heels elevated off of the mattress.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review and interviews, the facility failed to develop a person-centered Post Traumatic Stress Disorder (PTSD) care plan and complete a trauma assessment for one Resident #14 out of a sample of 32 Residents. Specifically, the facility failed to identify the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the Resident.Findings include:Review of the facility policy titled ?Trauma Informed Care' revised 12/6/21 indicated the following:-To identify residents with a history of trauma or PTSD and provide the appropriate care and services.-The facility will ensure that all residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the individuals.-Further, for residents with identified history of trauma or PTSD, the facility will provide appropriate person centered and individualized treatment and services to meet their assessed needs.-Upon admission, a social service/designee will screen all new admissions by using the primary care TSD screen (PC-PTSD) within 5 days of admission.-To prevent triggers that may cause re-traumatization, this screen will not be completed again unless there is an experience that occurs after the initial screen that would trigger a new assessment.Resident #14 was admitted to the facility in August 2019 with diagnoses including PTSD.Review of the Minimum Data Set (MDS) assessment, dated 2/11/26, indicated a Brief Interview for Mental Status (BIMS) Score of 4 out 15 indicating severe cognitive impairment.Review of the Resident's active PTSD care plan indicated the following:Focus-I have a diagnosis of PTSD. Initiated 6/24/23.Goal-I will not experience any new traumatic reactions through the next review. Initiated, 8/26/24.Interventions -identify relationships I can draw from, 1:1 social work or psych support as needed, encourage involvement in recreation, socialization and leisure, encourage me to notify staff if I am feeling or have identified a traumatic response/triggers, psych evaluation and treatment as indicated, report any emergence of signs of isolation, altered mental status or change in behaviors to medical doctor. Initiated, 6/24/23.During an interview and medical record review on 2/27/26 at 7:37 A.M., the Social Worker reviewed the medical record and said a trauma assessment was not completed for the Resident on admission. The Social Worker said this assessment is completed only once. The Social Worker said a trauma assessment should be completed in the electronic health record for all residents admitted with a diagnosis of PTSD. The Social Worker said the trauma assessment provides information to add in the PTSD care plan. The Social Worker reviewed the Resident's PTSD care plan and said it was generic and not person- centered with the Resident's trauma and lacked person centered interventions to mitigate triggers.During an interview on 2/27/26 at 8:46 A.M., the Corporate Nurse said trauma assessments should be completed at admission for residents with a diagnosis of PTSD. The Corporate Nurse said PTSD care plans should be person centered with the Resident's trauma and include person centered interventions to mitigate the Resident's triggers.

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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. 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 one Resident (#106) out of a total sample of 32 residents. Specifically, the facility failed to ensure recommendations from behavioral health services were relayed to the physician and implemented for Resident #106. Findings include:Resident #106 was admitted to the facility in January 2020 with diagnoses that included schizophrenia and anxiety. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/1/26, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. Further review of the MDS indicated the use of antipsychotic, antidepressant and antianxiety medications. The MDS indicated that antipsychotic medications were received on a daily basis. During an observation and interview on 2/25/26 at 7:51 A.M., the Resident was observed awake in bed. Resident #106 said that he/she was recently made aware that he/she has been sticking his/her tongue out a lot and moving his/her mouth a lot. Resident #106 said that he/she takes antipsychotic medications. On 2/27/26 at 7:19 A.M., the surveyor observed Resident #106 in bed. The surveyor observed involuntary movements of the Residents tongue and mouth. Review of the Behavioral Health note, dated 2/19/26, indicated the following:-Recommend GDR (gradual dose reduction) Risperidone (an antipsychotic medication) due to TD (tardive dyskinesia, a movement disorder that can develop due to certain medications, especially antipsychotics).-Clinical Assessment: tongue protrusion noted.-GDR Rationale: Recommend GDR-Test Scores: Completed today, AIMS (abnormal involuntary movement scale, a test used to assess the severity of dyskinesias, specifically orofacial movements and extremity and truncal movements in patients taking certain medications): score: 7.-Plan/ Recommendations: Recommended to decrease Risperidone to 0.75 mg in the evening. Monitor for tongue protrusion. Monitor for increase in auditory hallucinations. F/up (follow up) in 2 weeks. Review of Resident #106's active physician's orders indicated the following:-Risperdal (Risperidone) 1 mg (milligram), give one tablet by mouth in the evening for schizophrenia, dated as revised 8/17/23. Review of the medical record, including nursing and physician progress notes, failed to indicate that the recommendation was communicated to the physician or provider for review. During an interview on 2/27/26 at 7:35 A.M., Nurse #5 said that whenever recommendations are made from consultants, the nurse is responsible for calling the physician or nurse practitioner to communicate those recommendations. He said the provider in the facility can choose to implement or not implement those recommendations but that it should be documented either way in a progress note. He said recommendations should be communicated to the facility providers within 24 hours. During an interview on 2/27/26 at 8:05 A.M., Unit Manager #1 said that behavioral health sees residents on Thursdays at the facility. She said that any recommendations made must be communicated to and approved by the facility providers. She said within 24 hours of receiving the recommendations they should be reported to the facility providers for approval and it should be documented in a progress note. She said she was not aware of the recommendations for Resident #106 to have a GDR and had not communicated it to the physician. She said especially because he/she is having symptoms as indicated on the AIMS testing it should have been reviewed and implemented immediately. During an interview on 2/27/26 at 8:53 A.M., the Director of Nurses said that when recommendations are obtained from consultants, the nurses must call the physician to verify and confirm the orders. She said that for Resident #106, given the symptoms that he/she is exhibiting, it is concerning to continue the antipsychotic medication as ordered and the recommendations should have been reviewed immediately with the provider.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interviews, the facility failed to ensure laboratory services were provided for one Resident (#6) out of a sample of 32 Residents. Specifically, the facility failed to ensure weekly labs were obtained according to the physician's orders. Findings include:Resident #6 was admitted to the facility in July 2023 with diagnoses that included hyperkalemia and chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/21/26, indicated a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15, indicating moderate cognitive impairment. Review of Physician's orders indicated the following:-Please schedule BMP (Basic Metabolic Panel, a common blood test that measures key substances in your blood to assess metabolism, kidney function, and electrolyte balance) labs every Tuesday to be drawn weekly (Wednesday). Document if the resident refuses to have labs done. Alert the provider and DON (Director of Nursing) of any refusal, dated 10/7/25. Review of the Electronic Medical Record (EMR) indicated lab results including a BMP on the following dates:10/8/25, 10/25/25, 10/31/25, 11/8/25, 12/6/25, 1/16/26, 2/13/26. Review of paper medical record failed to include any lab results since 10/7/25. Review of the January 2026 Treatment Administration Record indicated that on 1/6/26 and 1/27/26 a BMP was not scheduled with the lab. Review of the February 2026 Treatment Administration Record indicated that on 2/3/26, 2/10/26, 2/17/26 and 2/24/26 a BMP was not scheduled with the lab. Review of progress notes from 11/24/25- 2/27/26 indicated the following:-A progress note from 2/25/26: Resident refused lab technician to draw [his/her] blood for lab work. Further review of progress notes failed to indicate further documentation that the Resident refused to have labs drawn, or that the physician was aware. During an interview on 2/27/26 at 7:32 A.M., Nurse #5 said that lab results are posted in the EMR or in the labs portal. He said that labs are reviewed with the physician or nurse practitioner when they have resulted. He said that when labs are reported it should be documented in the medical record. Nurse #5 further said that if a resident refuses lab work, then it should be documented in the medical record, and the physician should be notified. During an interview on 2/27/26 at 8:00 A.M., Unit Manager #1 said that lab results are in the facilities EMR but may also be in the labs portal. She reviewed the medical record as well as the lab portal and said that there were no reported labs in the lab portal that were not in the Resident's medical record. She said that the labs should be drawn weekly as indicated in the physician's orders and if the Resident is refusing then it should be documented and the physician should be notified. During an interview on 2/27/26 at 8:57 A.M., the Director of Nurses said that Resident #6 should be having weekly labs as indicated in the physician's orders. She said the Resident has hyperkalemia (elevated potassium levels) and takes a medication to lower it that he/she sometimes refuses. She said it is important to know current potassium levels for the Resident to monitor that it does not get too high. She further said that if the Resident refuses lab work, then the physician should be notified as indicated in the order and it should be documented in the medical record.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews and record review, the facility failed to have an adequately equipped communication system for one Resident (#1) out of a sample of 32 Residents. Specifically, the facility failed to have a functioning call light.Findings include:Review of the facility policy titled ?Call Light' revised 12/6/21 indicated the following:-Report all defective call lights promptly.Resident #1 was admitted to the facility in April 2024 with diagnoses including polyneuropathy and shortness of breath.Review of the most recent Minimum Data Set (MDS) assessment, dated 2/4/26, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition.Review of the Resident's Activities of Daily Living (ADL) care plan indicated the following:-Please assist me in toileting. I need 1 staff to assist me. Initiated: 5/1/24.-Please assist me with transfers. I need 1 staff to assist me. Initiated:5/1/24.During an observation and interview on 2/26/26 at 8:04 A.M., Resident #1 told the surveyor that he/she reported to a Nurse and the Maintenance Director months ago that his/her call light was not working. The Resident pressed the call light with the surveyor present, the code alert in the room started to flash, the indicator light outside the resident room did not turn on and no staff responded to the call light.During an interview and observation on 2/26/26 at 8:27 A.M., Nurse #7 and the surveyor pressed the Resident's call light. The code alert started flashing, the light outside and above the Resident's room did not turn on. Both the Surveyor and Nurse #7 walked to the Nurse's station. The Resident's room did not show up on the call light alert screen. Nurse #7 said, when the Resident presses the call light, the code alert in the room starts to flash, the light above the Resident's room turns on and the Resident's room number appears on the call light screen at the Nurse's station. Nurse #7 said the staff respond to the call light and after they have assisted the Resident in the room, they turn off the flashing code alert in the room.During an interview on 2/26/26 at 8:33 A.M., the Maintenance Director said the Resident told him approximately a week ago that his/her call light was not working. The Maintenance Director said he changed the batteries. The Maintenance Director said he was not sure why the call light was not functioning currently. The Maintenance Director said after the Resident told him his/her call light was not working, he did not document the broken call light in the Maintenance log, and he did not document in the Maintenance log that he had fixed the call light.During an interview on 2/27/26 at 8:28 A.M., the Corporate Nurse said all residents' call lights should be functional. The Corporate Nurse said the Maintenance Director is expected to document in the Maintenance log that a call light needs repair and document in the Maintenance log that the call light has been repaired.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to notify the Resident and the resident's representative(s) of the transfer/discharge and the reasons for the move in writing and in a language and manner they understand and failed to provide in writing the facility's bed hold policy, for one Resident (#128) out of one hospitalized resident sampled. Findings include:Review of the facility policy titled Transfer/Discharge Notification, dated September 2019, indicated that the facility will issue residents appropriate transfer/discharge notifications and guidance on their right to appeal, in a manner in which the resident/representative understand. Resident #128 was admitted to the facility in September 2025 with diagnoses including cancer of the stomach and esophagus and severe malnutrition. Review of the progress notes indicated that Resident #128 was discharged to the hospital on [DATE]. Further review failed to indicate a transfer/discharge notice or a bed hold policy was provided to the Resident or the Residents health care proxy.During an interview on 2/26/26 at 11:02 A.M., Corporate Nurse #1 said that she was not able to locate the required transfer/discharge and bed hold policy in Resident #128's medical records. Corporate Nurse #1 also said that both documents should have been provided upon discharge.