STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225506	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North End Rehabilitation and Healthcare Center	70 Fulton Street Boston, MA 02109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45343 Based on observations, record review and interviews, the facility failed to ensure a comprehensive resident-centered care plan was developed for two Residents (#5 and #33) out of a total sample of 26 Residents. Specifically, 1. For Resident #5, the facility failed to identify the make, model, serial number, cardiologist information, implant date, and pacer rate for the monitoring and care of a pacemaker. 2. For Resident #33, the facility failed to develop an individualized comprehensive resident-centered care plan related to the monitoring and care of a pacemaker. Findings include: Review of the facility policy titled Pacemaker, Care of a Resident with, revised December 2015, indicated the following: Purpose and Procedure: - The purpose of this is to provide information about and guidance for the care of a resident with a pacemaker. Monitoring: - Monitor the resident for pacemaker failure by monitoring signs and symptoms of bradycardia. - The resident will have an EKG (electrocardiogram) annually, or as ordered, to monitor changes in the heart's electrical activity. Documentation: - For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a. The name, address, and telephone number of the cardiologist. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Type of pacemaker. c. Type of pacemaker. d. Manufacturer and model. e. Serial number. f. Date of implant. g. Paced rate. 1. Resident #5 was admitted to the facility September 2024 with diagnoses including chronic obstructive pulmonary disease (COPD) and the presence of a pacemaker. Review of Resident #5's most recent Minimum Data Set (MDS) assessment, dated 3/13/25, indicated a Brief Interview for Mental Status (BIMS) exam score of 14 out of a possible 15, indicating intact cognition. Further review of the MDS indicated Resident #5 was dependent on staff for functional daily activities and had an active diagnosis of a cardiac pacemaker. Review of Resident #5's care plan, initiated 11/21/24, failed to indicate a pacemaker care plan identifying the pacemakers' serial number, make and model, date of implant, paced rate, frequency of pacemaker checks and cardiologist information. During an interview on 5/5/25 at 2:43 P.M., Nurse #3 said she monitors vital signs for any resident with a pacemaker and that she follows the doctors' recommendations. Nurse #3 said she was unsure if the specific pacemaker information and pacer rate should be included in the care plan and that she monitors the vital signs and notifies the doctor of any irregularities. During an interview on 5/5/25 at 3:47 P.M., the Director of Nursing said a pacemaker care plan should include the paced rate, frequency of checks, make and model, cardiologist information, the serial number, and implant date so the nurses are aware. 2. Resident #33 was admitted to the facility in August 2024 with diagnoses including atrioventricular block and the presence of a cardiac pacemaker. Review of Resident #33's most recent Minimum Data Set (MDS) assessment, dated 4/24/25, indicated a Brief Interview for Mental Status (BIMS) exam score of 14 out of a possible 15, indicating intact cognition. Further review of the MDS indicated Resident #33 required partial/moderate to substantial/maximal assistance with functional daily activities and had an active diagnosis of a cardiac pacemaker. Review of Resident #33's care plans, initiated 8/2/24, failed to indicate a pacemaker care plan identifying the cardiologist information, pacemakers' paced rate, and frequency of pacemaker checks. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/5/25 at 2:43 P.M., Nurse #3 said she monitors vital signs for any resident with a pacemaker and that she follows the doctors' recommendations. Nurse #3 said she was unsure if the specific pacemaker information and pacer rate should be included in the care plan and that she monitors the vital signs and notifies the doctor of any irregularities. During an interview on 5/25/25 at 3:47 P.M., the Director of Nursing said she would expect a physician order to be put in place for the monitoring of the pacemaker, and a care plan should include the paced rate, frequency of checks, make and model, cardiologist name and phone number, the serial number, and implant date so the nurses are aware.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to immediately perform cardiopulmonary resuscitation (CPR) according to professional standards of care for one Resident (#89), who was a full code, out of a total sample of 26 residents. Specifically, after Resident #89 was found with no pulse the nurse on duty, whose CPR certification had expired, left the Resident in a room with a Certified Nursing Aide (CNA), while he retrieved life saving materials and called 911, delaying life saving CPR measures for Resident #89. Findings include: Review of the current American Heart Association: CPR (cardiopulmonary resuscitation) and First Aide indicates that CPR - or Cardiopulmonary Resuscitation - is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances of survival after cardiac arrest. The American Heart Association indicates that after successfully completing CPR training, your CPR certification lasts 2 years. Review of the facility policy titled Emergency Procedure- Cardiopulmonary Resuscitation and Basic Life Support (BLS), dated 2001, indicated the following: - If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a staff member who is certified in CPR for healthcare providers/BLS will administer CPR unless: * It is known that a do not resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual - General Sequence for Adult Basic Life Support * Ensure scene safety. * Check for response. * Shout for nearby help/activate the resuscitation team * Check for no breathing or only gasping and check pulse (ideally simultaneously) * Retrieve and activate the AED (automated external defibrillator) /Emergency equipment immediately after the check for no normal breathing and no pulse identifies cardiac arrest. * Immediately begin CPR and use the AED/defibrillator when available. * When the second rescuer arrives, provide 2-rescuer CPR and use the AED/defibrillator (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #89 was admitted in [DATE] with diagnoses including chronic kidney disease, hypertension, and type 2 diabetes. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #89 could not participate in the Brief Interview for Mental Status exam due to severely impaired cognition. Review of the MDS indicated that Resident #89 was a full code (a medical term indicating a patient's consent to receive all life saving measures). Review of the nursing progress note, dated [DATE], written by Nurse #1, indicated the following: At 5:00 am this nurse went into residents' room to change his/her feeding but observed that resident do [sic] not have the rising and falling of chest. This nurse touched Resident, and he/she was warm to touch but without response and no pulse. This nurse paged code blue, initiated CPR on patient and called 911. 911 arrived and took over from this nurse, on assessment, they said the patient may have expired about an house [sic] ago. The DON has been notified, so also is the family [sic]. At present, the family do not have a funeral home of choice and will notify the facility as soon as they nominate one. During an interview on [DATE] at 8:27 A.M., Nurse #1 said that he believes Resident #89 was a full code at the time of the code and said the Resident was alive at 2:00 A.M. when he did rounds. Nurse #1 said he went to check on the Resident when doing the morning medication pass, about 5:00 am, and saw that he/she was not breathing and had no pulse. Nurse #1 said he initiated a sternum rub, but got no response. Nurse #1 said he had to call 911 immediately so he asked a Certified Nursing Aide (CNA) to stay with the Resident while he went to call 911 and a code blue (a page made overhead to alert the building that emergency response is necessary). Nurse #1 said that after he called 911 and a code blue, he went to get the crash cart (a cart with supplies to perform life saving measures). After he retrieved the crash cart, he put the board behind the Resident's back and started CPR compressions. Nurse #1 said that Nurse #2, from the other unit, came up to assist with setting up the AED (automated external defibrillator) before EMS (emergency medical services) arrived. Nurse #1 said that the CNA, who was left with the Resident, did not start CPR and was told to wait until he got back from calling emergency response. Nurse #1 said that he wasn't sure if the CNA could start CPR, but it was his judgement call to have the CNA stay with the Resident before he went to call 911. Review of the nursing progress note, dated [DATE], written by Nurse #2, indicated the following: Around 5:00 am assigned nurse reported that resident was found unresponsive. Code blue was called x 3. 911 was called. CPR initiated. 911 came in around 5:20 am and pronounced the resident dead. Physician [sic] was notified and gave order to do the RN (registered nurse) pronouncement and release the body to the family's funeral home of choice. HCP (health care proxy) was notified and said she will be in shortly. During an interview on [DATE] at 10:07 A.M., Nurse #2 said that he was the Registered Nurse in the facility that shift and went up to the unit when he heard the code blue being called. Nurse #2 said that when he arrived, the crash cart had already been set up, the AED had been used, and he saw Nurse #1 performing CPR. Nurse #2 said that he called the pronouncement for Resident #89's death after EMS arrived. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Emergency Medical Services report indicated that emergency services was dispatched at 5:16 A.M. and arrived to the facility at 5:20 A.M. Review of the report indicated the following: 76 yo (year old) patient found supine (lying flat) in bed of dispatched address. Pt unresponsive, skin cool pale, with lividity (reddish-purple discoloration on the skin) on posterior, and apneic (cessation of breathing). Staff reports unknown downtime and performing CPR on pt prior to EMS (emergency medical services) arrival. Upon assessment pt found to have lividity on posterior of back, lung sounds absent bilaterally, pupils fixed and dilated, carotid pulse (a way to assess a patients heart rate) completely absent. Pt declared non-viable (dead), and Pt left with rehabilitation facility for post mortem (after death) handling . Review of the CPR certification for Nurse #1 indicated his CPR certification expired in August of 2024. Review of the current CPR certification indicated Nurse #1 renewed his CPR certification on [DATE], approximately one month after the incident with Resident #89. During an interview on [DATE] at 9:30 A.M., the Director of Nursing said that if a Resident is unresponsive with no pulse, then the Nurse on duty should check the code status of the Resident and immediately start CPR. The Director of Nursing said that it is not the expectation for the CNA to start CPR. The Director of Nursing said that she would have expected CNA to go call 911 and code blue, and retrieve the crash cart while the nurse starts performing CPR. The Director of Nursing said that the facility uses a code sheet (a sheet to record the timing and event of the code) to determine when CPR was started, but it was not completed for the code that occurred with Resident #89. The Director of Nursing said she was unsure if code sheets were being implemented at that time. During an interview on [DATE] at 9:54 A.M., the Physician said that the facility should be following the standard ACLS (Advanced Cardiovascular Life Support) protocol. Review of the American Heart Association's Adult Basic and Advanced Life Support Guidelines indicate the following (https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/adult-basic-and-advanced-life-support): - Recognition of cardiac arrest: 1. If a victim is unconscious/unresponsive, with absent or abnormal breathing (ie, only gasping), the healthcare provider should check for a pulse for no more than 10 s (seconds) and, if no definite pulse is felt, should assume the victim is in cardiac arrest. - It has been shown previously that all rescuers may have difficulty detecting a pulse, leading to delays in CPR, or in some cases CPR not being performed at all for patients in cardiac arrest. Recognition of cardiac arrest by lay rescuers, therefore, is determined on the basis of level of consciousness and the respiratory effort of the victim. Recognition of cardiac arrest by healthcare providers includes a pulse check, but the importance of not prolonging efforts to detect a pulse is emphasized. 2. After identifying a cardiac arrest, a lone responder should activate the emergency response system first (911) and immediately begin CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:27 A.M., the Director of Nursing said she did not know that Nurse #1 was not CPR certified. The Director of Nursing said that the facility should have made sure that Nurse #1 had a current CPR certification upon hire. The Director of Nursing said that both CNAs on the floor confirmed they did not start CPR on Resident #89 at the time of the code. During an interview on [DATE] at 7:55 A.M., the Director of Nursing said that the facility did a house-wide CPR course on all staff on [DATE], as part of the facility's immediate removal plan, and told the surveyors that the fire department educated the staff on immediately performing CPR and having another staff member call emergency response. The Director of Nursing said the fire department instructed the staff that, if there were no other staff around, to immediately perform CPR for at least 2 minutes before running to call 911. Refer to F726.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review and interview, the facility failed to ensure nursing staff adhered to professional standards of practice for the administration of free water flushes and enteral tube feeding (water and nutrition taken through a tube directly into the stomach) for six out of seven Residents (#18, #40, #67, #71, #72 and #73) with a tube feed observed. Specifically: 1. For Resident #18, the facility failed to label and date the enteral free water administration bag. 2. For Resident #40, the facility failed to label and date the water administration bag and failed to ensure the amount of tube feeding administered followed the physician's order. 3. For Resident #67, the facility failed to label the tube feeding bottle and the free water administration bag with the date and time hung. 4. For Resident #71, the facility failed to label the free water administration bag with the date hung and failed to ensure the amount of tube feed administered followed the physician's order 5. For Resident #72, the facility failed to label the free water administration bag with the date hung. 6. For Resident #73, the facility failed to label the free water administration bag with the date hung and failed to ensure the amount of tube feed administered followed the physician's order. Findings include: Review of the facility policy titled Enteral Nutrition, revised November 2018, indicated adequate nutrition support through enteral nutrition is provided to residents as ordered. Review of the facility policy titled Enteral Feedings-Safety Precautions, revised November 2018, indicated that feed formulas are to be discarded 48 hours after opening. Further review failed to indicate that tube feedings and free water administration bags are to be labeled and dated. 1. Resident #18 was admitted to the facility in March 2025 with diagnoses including protein-calorie malnutrition, dependence on ventilator, and muscle wasting and atrophy. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #18 was moderately cognitively impaired and totally dependent of staff for all activities of daily living. Further review indicated that Resident #18 received 51% or more of their nutrition through the use of a feeding tube. Review of the current care plan indicated a focus of enteral tube feeding due to dysphagia with an intervention to administer tube feeding as ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's orders dated May 2025 indicated an order for free water flushes of 200 ml (milliliters) every six hours every shift. On 5/4/25 at 8:30 A.M., the surveyor observed that the water bag, instilling free water into the enteral tube, was not labeled with the date hung. 2. Resident #40 was admitted to the facility in February 2024 with diagnoses including protein-calorie malnutrition, dysphagia, and dependence on ventilator. Review of the Minimum Data Set assessment, dated 2/27/25, indicated that Resident #40 was severely cognitively impaired and totally dependent on staff for all activities of daily living. Further review indicated that Resident #40 received 51% or more of their nutrition through the use of a feeding tube. Review of the physician's orders indicated the following: every shift for nutrition Vital AF 1.2 @ 55 ml/hr (milliliters per hour), may use peptaman 1.5 until vital available. Further review indicated the following order: Enteral Feed order every 6 hours for hydration additional FWF (free water flush) of 200 ml q6h (every 6 hours). Review of the current care plan indicated a focus of enteral tube feeding due to dysphagia with an intervention to administer tube feeding as ordered. Review of the dietician's note dated 2/27/25 indicated the following: Note Text: TF (tube feed) reviewed. Rt (resident) currently on continuous feed of vital AF 1.2 @ 55 ml/hr w/additional FWF of 200 ml q6h (every 6 hours). This current regimen provides a total daily volume of 1320 ml, 1584 kcal, 99g pro (grams protein), 1871 ml fluid, meeting 100% of goal needs. No s/s/x (signs or symptoms) of intolerance noted. Wt (weight) reviewed. Unable to assess wt trend, last wt taken on 11/21/24. Rt (resident) known to refuse wt. Encourage obtaining wt as able to monitor accurate wt trend. Skin remains intact. Labs and meds reviewed. Recent lab notable for abnormally low creatinine. Continue current nutritional care plan and intervention. Continue to monitor. On 5/4/25 at 8:15 A.M., the surveyor observed a 1500 ml tube feed bottle hung, dated 5/2/25, and running at @ 55 ml/hr (milliliters per hour) with the label indicating the feed was started at 1800 (6 P.M.). The surveyor observed that the amount left in bottle was 300 ml. The surveyor also observed that the water bag was not labeled with the date hung. At a rate of 55 ml/hr for 38 hours the amount instilled should have been 2090 ml and not the 1200 ml as indicated on the bottle. 3. Resident #67 was admitted to the facility in September 2023 with diagnoses including protein-calorie malnutrition, dysphagia and Alzheimer's disease. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #67 was severely cognitively impaired and substantially to totally dependent on staff for all activities of daily living. Further review indicated that Resident #67 received 51% or more of their nutrition through the use of a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's orders dated May 2025 indicated the following: every shift for Nutrition Continuous feed of Glucerna 1.0 @ 75 ml (total daily volume of 1800 ml) via J-tube. Further review indicated an order for free water flushes of 75 ml every 4 hours via J-tube (a tube directly inserted into the jejunum for the purpose of administering nutrition). On 5/4/25 at 8:11 A.M., the surveyor observed Resident #67 lying in bed with an enteral tube feeding bottle and enteral water administration bag hanging at bedside. The surveyor observed the tube feed running at 75 ml (milliliters) per hour. The surveyor also observed that the tube feeding bottle, and the free water administration bag were not labeled with the date and time hung. 4. Resident #71 was admitted to the facility in January 2025 with diagnoses including protein-calorie malnutrition, dysphagia, and Guillain-Barre Syndrome. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #71 was severely cognitively impaired as evidenced by a score of 7 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #71 was substantially/dependent on staff for all activities of daily living. Further review indicated that Resident #71 received 51% or more of their nutrition through the use of a feeding tube. Review of the physician's orders dated May 2025 indicated the following order: Enteral: Glucerna 1.2 Cal liquid via feeding tube every shift, feeding pump set at 65 ml/hr (milliliters per hour) for 24 hours, total volume 1560 ml. Further review indicated an order for free water flushes of 200 ml every 4 hours. On 5/4/25 at 7:50 A.M., the surveyor observed Resident #71 lying in bed with a 1500 ml tube feed bottle with a time stamp of 1900 hours (7 P.M.), hanging and running at 65 ml/hr (milliliters per hour). The surveyor also observed the tube feed bottle to be dated 5/2/25 with 1000 ml left in the 1500 ml bottle. Based on the date and volume left in the bottle the amount that should have been instilled from 5/2/25 at 7 P.M. through 5/4/25 at 7:50 A.M. is 2405 ml and not the 500 ml indicated on the tube feed bottle. The surveyor also observed that the free water administration bag was not dated. 5. Resident #72 was admitted to the facility in November 2024 with diagnoses including protein-calorie malnutrition, dysphagia, and amytrophic lateral sclerosis. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #72 cognitively intact as evidenced by a score of 14 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #72 was totally dependent on staff for all activities of daily living. Further review indicated that Resident #72 received 51% or more of their nutrition through the use of a feeding tube. Review of the physician's orders dated May 2025 indicated the following order: Enteral Feed Order: Jevity 1. 5 liquid via feeding tube hung up at 9 P.M. and take down at 6 P.M., via feeding pump set at 65 ml/hr (milliliters per hour) for 18 hours, total volume 1170 ml. Further review indicated an order for free water flushes of 150 ml every 4 hours. On 5/4/25 at 8:24 A.M., the surveyor observed that the free water administration bag was not dated. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Resident #73 was admitted to the facility in June 2024 with diagnoses including severe protein-calorie malnutrition, dysphagia and amytrophic lateral sclerosis. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #73 was severely cognitively impaired. Further review indicated that Resident #73 was totally dependent on staff for all activities of daily living. Further review indicated that Resident #73 received 51% or more of their nutrition through the use of a feeding tube. Review of the physician's orders dated May 2025 indicated the following order: every shift Enteral: Osmolite 1.5 Cal liquid via feeding tube every shift, feeding pump set at 60 ml/hr for 21 hours. On 5/4/25 at 8:32 A.M., the surveyor observed the tube feed free water administration bag was not labeled with the date hung. The surveyor also observed an enteral feed running at 60 ml/hr, the tube feed bottle was dated 5/2/25, with a time stamp of hung up at 1800 (6 P.M.). The tube feed bottle had 350 ml left in it. At 60 ml/hr for a total of 35 hours, 2100 ml should have been instilled, not 1150 ml as was indicated by what was left in the bottle. During an interview on 5/5/25 at 8:16 A.M., the Director of Nursing (DON) said all enteral free water administration bags and tube feeding bottles should be labeled with the date and time hung as well as the prescribed rate of flow. The DON also said that the nurses should be checking to make sure that the prescribed amount to be instilled over a specific period of time was administered as ordered.

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North End Rehabilitation and Healthcare Center	70 Fulton Street Boston, MA 02109

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, interviews, and record review, the facility failed to ensure staff provided the necessary care and services in accordance with professional standards of practice for two Residents (#47 and #71), out of a total sample of six residents on a ventilator. Findings include: Review of the facility policy titled Departmental (Respiratory therapy)-Prevention of Infection, dated revised November 2011, indicated to change respiratory tubing every seven (7) days, or as needed. 1. Resident #47 was admitted to the facility in April 2025 with diagnoses including respiratory failure, paraplegia and protein-calorie malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #47 has severe cognitive impairment and was unable to complete the Brief Interview for Mental Status exam. Further review indicated that Resident #47 requires total dependence on staff for all activities of daily living and receives a high concentration of oxygen via a tracheostomy mask. On 5/4/25 at 8:15 A.M., the surveyor observed Resident #47 lying in bed receiving humidified oxygen via a trach (tracheostomy) collar. The surveyor also observed that the trach tubing was dated 4/13/25. Review of the physician's orders dated May 2025 indicated an order for Humidified Air via Trach Collar at 35% continuously every shift. Further review failed to indicate an order for when the trach tubing via trach collar is to be changed. During an interview on 5/4/25 at 8:24 A.M., Respiratory Therapist #1 said the Respiratory Therapist changes all ventilator tubing every Sunday. During an interview on 5/5/25 at 3:47 P.M., the Director of Nursing said that all respiratory tubing connected to a trach or vent is to be changed according to the physician's orders. If there are no physician's order, then the tubing would be changed weekly per facility policy. She then said that all respiratory tubing should have a physician's order in place for frequency of tubing changes. 2. Resident #71 was admitted to the facility in January 2025 with diagnoses including protein-calorie malnutrition, dysphagia, and Guillain-Barre Syndrome. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #71 was severely cognitively impaired, as evidenced by a score of 7 out of 15 on the Brief Interview for Mental Stats exam. Further review indicated that Resident #71 was substantially/dependent on staff for all activities of daily living. Further review indicated that Resident #71 was on a ventilator. On 5/4/25 at 8:17 A.M., the surveyor observed Resident #71 in bed on a ventilator. The surveyor also observed that the ventilator tubing was dated 4/20/25. (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 the physician's orders dated May 2025 indicated an order for trach (tracheostomy) mask via cool mist at 35% continuously every shift. Further review indicated an order to change all disposable equipment weekly on Wednesday 11p-7a and PRN (as needed). Review of the current care plan, dated 5/1/25, indicated an intervention to keep respiratory equipment clean and change disposable equipment per facility policy. During an interview on 5/4/25 at 8:24 A.M., Respiratory Therapist #1 said the Respiratory Therapist changes all ventilator tubing every Sunday. During an interview on 5/5/25 at 3:47 P.M., the Director of Nursing said that all respiratory tubing connected to a trach or vent is to be changed according to the physician's orders. If there are no physician's order, then the tubing would be changed weekly per facility policy. She then said that all respiratory tubing should have a physician's order in place for frequency of tubing changes.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to ensure the assigned nurse was competent to perform Cardiopulmonary Resuscitation (CPR) on one Resident (#89), who was a full code, after he/she was found unresponsive, out of a total sample of 26 residents. Findings include: Review of the current American Heart Association: CPR (cardiopulmonary resuscitation) and First Aide indicates that CPR - or Cardiopulmonary Resuscitation - is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances of survival after cardiac arrest. Review of the facility assessment indicated the following: Staff Education and Competency: Department specific training and competencies are completed with staff throughout employment to ensure that they can safely and competently provide the levels and types of care required by our resident population .As a part of ongoing education and training, mock drills are scheduled on a rotating shift and day schedule . The facility also implements additional staff education as a result of QAPI (Quality Assurance and Performance Improvement) actions and those incorporated in plans of correction. Review of the facility assessment also indicated that staff are to receive annual CPR competencies and ensure that CPR certification is renewed every two years. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #89 could not participate in the Brief Interview for Mental Status exam due to severely impaired cognition. Review of the MDS indicated that Resident #89 was a full code (a medical term indicating a patient's consent to receive all life saving measures). Review of the nursing progress note, dated [DATE], indicated the following: At 5:00 am this nurse went into residents' room to change his/her feeding but observed that resident do [sic] not have the rising and falling of chest. This nurse touched Resident, and he/she was warm to touch but without response and no pulse. This nurse paged code blue, initiated CPR on patient and called 911. 911 arrived and took over from this nurse, on assessment, they said the patient may have expired about an house [sic] ago. The DON has been notified, so also is the family [sic]. At present, the family do not have a funeral home of choice and will notify the facility as soon as they nominate one. During an interview on [DATE] at 8:27 A.M., Nurse #1 said that he left Resident #89 with a CNA to go call 911 and a code blue (an overhead page indicating that emergency services are required), then retrieved the crash cart (a cart with supplies to perform life saving measures) before starting CPR on Resident #89. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the CPR certification for Nurse #1 indicated his CPR certification expired in August of 2024. Review of Nurse #1's annual competencies failed to indicate the facility ensured he completed the required annual CPR competency. Review of Nurse #1's CPR certification indicated his CPR certification expired in August of 2024, six months prior to the incident that occurred in February 2025. During an interview on [DATE] at 9:27 A.M., the Director of Nursing said she did not know that Nurse #1 was not CPR certified at the time of the code. The Director of Nursing said that the facility should have made sure that Nurse #1 had renewed his CPR certification at the time of renewal. During an interview on [DATE] at 7:55 A.M., the Director of Nursing said that the Staff Development Coordinator (SDC) was responsible for ensuring staff competencies and CPR recertification. The Director of Nursing said that both the staff development coordinator and human resources had left and she was taking over the assigned duties of both roles. The SDC left on [DATE] and human resources left on [DATE]. The Director of Nursing said that the facility hadn't done any mock codes (practice codes for when a real one takes place) in the past year, as indicated in the facility assessment, and that the CPR certification is what nurses receive for their CPR competencies. The Director of Nursing said that they did another audit during survey, as part of the facility's removal plan, and identified another nurse whose CPR certification had expired. During an interview on [DATE] at 8:20 A.M., the Medical Director said it is his expectation that the facility and the individual nurse ensure that their CPR certifications are renewed on time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 36797 Based on observations, interviews and policy review, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, the facility failed to ensure a medication cart and treatment carts on the fourth floor were locked while a nurse was not present. Findings include: Review of the facility policy titled Medication Labeling and Storage, revised February 2023, indicated the following: - The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. - Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. On 5/4/25 at 7:05 A.M., the surveyor observed a medication cart in the 4th floor hallway unlocked and without a nurse present. The surveyor opened the medication cart drawers and stood there while a certified nurse's aide walked by the surveyor and continued down the hall. The surveyor also observed another staff member sitting in a room at the end of the hall looking at the surveyor at the open medication cart. The surveyor was able to access the medication cart for 4 minutes without staff interference. During an interview on 5/4/25 at 7:09 A.M., Nurse #6 said that she is the only one allowed access to the medication cart and it should not be open. On 5/4/25 at 8:03 A.M., the surveyor observed a treatment cart, unlocked, next to the nurse's station on the 4th floor. The surveyor then observed the Admissions Director walking by the unlocked treatment cart multiple times without locking it. The surveyor was able to access the treatment cart without staff interference. On 5/4/25 at 8:04 A.M., the surveyor observed a treatment cart in the hallway of the 4th floor, unlocked, without a nurse in the surrounding area. The surveyor was able to access the treatment cart without staff interference. On 5/4/25 at 8:41 A.M., the surveyor observed a treatment cart next to the nurse's station unlocked, without the nurse present. Multiple other staff members were around the unlocked treatment cart. During an interview on 5/5/25 at 8:16 A.M., the Director of Nursing said that all medication carts and treatment carts are to be locked at all times when not in use.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review, and interview, the facility failed to maintain an accurate medical record for two Residents (#71 and #72), out of a total sample of 26 residents. Specifically: 1. For Resident #71, the facility documented the ventilator tubing was changed when it was not. 2. For Resident #72, the facility documented the Resident recieved tube feedings at the wrong time. 1. Resident #71 was admitted to the facility in January 2025 with diagnoses including protein-calorie malnutrition, and dysphagia. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #71 was severely cognitively impaired, as evidenced by a score of 7 out of 15 on the Brief Interview for Mental Stats exam. Further review indicated that Resident #71 was substantially/dependent on staff for all activities of daily living. Further review indicated that Resident #71 was on a ventilator. On 5/4/25 at 8:17 A.M., the surveyor observed Resident #71 in bed on a ventilator. The surveyor also observed that the ventilator tubing was dated 4/20/25. Review of the physician's orders dated May 2025 indicated an order for trach (tracheostomy) mask via cool mist at 35% continuously every shift. Further review indicated an order to change all disposable equipment weekly on Wednesday 11p-7a and PRN (as needed). Review of the current care plan, dated 5/1/25, indicated an intervention to keep respiratory equipment clean and change disposable equipment per facility policy. Review of the facility document titled Respiratory Administration Record, dated April 2025, indicted the respiratory therapist signed, on 4/23/25 and 4/30/25, that the ventilator tubing was changed when it was not. During an interview on 5/4/25 at 8:24 A.M., Respiratory Therapist #1 said the Respiratory Therapist changes all ventilator tubing every Sunday. During an interview on 5/5/25 at 3:47 P.M., the Director of Nursing (DON) said that all respiratory tubing connected to a trach or vent is to be changed according to the physician's orders. The DON then said that the respiratory therapists should not be documenting that they changed the tubing when they did not. 2. Resident #72 was admitted to the facility in November 2024 with diagnoses including protein-calorie malnutrition, dysphagia, and amytrophic lateral sclerosis. (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 the Minimum Data Set assessment dated [DATE], indicated that Resident #72 cognitively intact as evidenced by a score of 14 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #72 was totally dependent on staff for all activities of daily living. Further review indicated that Resident #72 received 51% or more of their nutrition through the use of a feeding tube. Review of the physician's orders dated May 2025 indicated the following conflicting orders: 1. Enteral Feed Order: Jevity 1.5 liquid via feeding tube hung up at 9 P.M. and take down at 6 P.M., via feeding pump set at 65 ml/hr (milliliters per hour) for 18 hours, total volume 1170 ml. 2. Enteral Feed Order: Jevity 1.5 liquid via feeding tube hung up at 9 A.M., and take down at 6 A.M., via feeding pump set at 65 ml/hr (milliliters per hour) for 18 hours, total volume 1170 ml. Review of the Medication Administration Record (MAR) dated May 2025 indicated that nurses signed for both conflicting orders 5/1/25, 5/2/25, 5/3/25 and 5/4/25. During an interview on 5/5/25 at 3:47 P.M., the Director of Nursing (DON) said that the tube feed orders were in error and the nurses should be signing only for one time frame.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to implement adverse event monitoring to potentially prevent future adverse events from occurring. Specifically, one Resident (#89), who was a full code, was found unresponsive and expired and the facility failed to identify and investigate the death, as it relates to Quality Assurance and Performance Improvement (QAPI). Findings include: According to the U.S. Department of Health and Human Services Office of Inspector General, an adverse event is defined as the following: An event in which care resulted in an undesirable clinical outcome-an outcome not caused by underlying disease-that prolonged the patient stay, caused permanent patient harm, required life-saving intervention, or contributed to death. https://oig.hhs.gov/reports/featured/adverse-events/ Review of the Facility Assessment, dated [DATE], indicated the following: Risk Identification and Quality Assurance Performance Improvement (QAPI) - The facility utilizes a comprehensive approach to risk identification and mitigation to ensure continous quality of care for its residents. - The interdisciplinary team addresses both the reactive and proactive aspects of risk identification and mitigation. Resident incidents are reviewed to ensure appropriate interventions have been implemented to prevent reoccurrence. A root cause analysis is conducted to ensure causal factors have been identified and addressed. - The QAPI committee will prioritize topics for performance improvement projects based on the current needs of the residents and our facility. Priority will be given to areas we define as high-risk to residents and staff, high- prevalence, or high-volume areas that are problem prone. Consideration of staff affected, and anticipated training needs will be reviewed prior to implementation of a performance improvement project. Resident #89 was admitted in [DATE] with diagnoses including chronic kidney disease, hypertension, and type 2 diabetes. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #89 could not participate in the Brief Interview for Mental Status exam due to severely impaired cognition. Review of the MDS indicated that Resident #89 was a full code (a medical term indicating a patient's consent to receive all life saving measures). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], Resident #89, who was a full code, was found unresponsive and pulseless. Nurse #1 left the Resident in the room with a certified nursing aide and proceeded to dial 911, call a code blue, then retreive the crash cart before initiated CPR. Nurse #1's CPR certification had expired 6 months prior to the incident. Review of the nursing progress note, dated [DATE], written by Nurse #1, indicated the following: At 5:00 am this nurse went into residents' room to change his/her feeding but observed that resident do [sic] not have the rising and falling of chest. This nurse touched Resident, and he/she was warm to touch but without response and no pulse. This nurse paged code blue, initiated CPR on patient and called 911. 911 arrived and took over from this nurse, on assessment, they said the patient may have expired about an house [sic] ago. The DON has been notified, so also is the family [sic]. At present, the family do not have a funeral home of choice and will notify the facility as soon as they nominate one. During an interview on [DATE] at 7:55 A.M., the Director of Nursing said she was unaware that Nurse #1's CPR certification had expired and that Nurse #1 should not have provided CPR. The Director of Nursing said that it was the responsibility of the Staff Development Coordinator and Human Resources to ensure staff are up to date with their certification, but that both staff had left the facility, one on [DATE] and one on [DATE] . The Director of Nursing said she had taken over responsibilities of both positions until filled. The Director of Nursing said the positions had not been filled yet, but an SDC was starting soon. The Director of Nursing said that the facility had implemented a code sheet (a sheet used to record the event and timing of a code) to keep track of full code incidents in the building, but she was unsure of when they initiated the code sheets and said that sheet was never completed for the Resident that Nurse #1 performed CPR on. The Director of Nursing said that when an adverse event occurs, she will do an investigation into the event, however; the Director of Nursing said that she reviewed the notes in the electronic medical record and said that nothing stood out to her that would warrant an investigation of the situation. The Director of Nursing said she was notified of the incident, but was not aware that Nurse #1 did not start CPR immediately. During an interview on [DATE] at 8:33 A.M., the Administrator (at the time of the event) said when a death occurs (for someone who is a full code), the facility staff complete a code sheet and the Director of Nursing and Physician will review the code sheet, especially if the death was unexpected. The Administrator said that the facility will typically look into an unexpected death to find out what occurred in real time. The Administrator said that the Medical Director is very involved and would help the facility look into an unexpected death. The Administrator said that in January and February, the facility did an audit of human resources and employee files to improve the process, but CPR certification was not something that was identified during that audit and it was not brought to QAPI. During an interview on [DATE] at 8:20 A.M., the Medical Director said that it his expectation that all staff are recertified every 2 years. The Medical Director said he remembers being notified of the incident with Resident #89 because he is the one who completes the death certificates. The Medical Director said this Resident was tricky because he/she had a lot of comorbidities, but was not considered an expected death because the Resident was not on hospice. After a facility-wide audit, conducted during survey as part of the facility's removal plan, the facility identified that one more additional staff member's CPR certification had expired.