STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225511	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
NAME OF PROVIDER OR SUPPLIER Regalcare at Lowell		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Princeton Boulevard Lowell, MA 01851	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide an environment free from accidents and hazards for two Residents (#9 and #39) out of a total sample of 25 residents. Specifically,1. For Resident #9, the facility failed to identify Resident #9's needs to receive 1:1 supervision with meals upon admission, and while eating unsupervised in his/her room, the Resident choked and required the Heimlich maneuver to be administered by facility staff. The Resident was subsequently transferred to the hospital, admitted to the intensive care unit, intubated and required a bronchial scope to remove a piece of chicken from his/her bronchial tube (the main airway leading to the lung), placing the resident at the likelihood of serious harm or death.2. For Resident #38, the facility failed to provide supervision with meals as indicated in his/her care plan. Findings include: Review of the facility policy titled, Activities of Daily Living, dated 3/2002, indicated the following:-Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with dining (meals and snacks). Review of the facility policy titled, Baseline Care Plan, dated 4/2022, indicated the following:-To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission.-The interdisciplinary team will review the health practitioner's orders (e.g dietary needs, medications, routine treatments, etc.) And implement A baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders, c. Dietary orders.-The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. 1. Resident #9 was admitted to the facility in November 2025 with diagnoses including dementia and Wernicke's encephalopathy. Review of Resident #9's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 00 out of a possible 15 on the Brief Interview for Mental Status which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #9 required assistance from staff for meals. Resident #9 was unable to be interviewed during survey due to his/her cognitive status. During an interview on 3/5/26 at 10:23 A.M., Resident #9's Legal Guardian said a social worker on her staff had visited Resident #9 in the facility and had concerns regarding activity of daily living care being provided. She was unable to provide more detailed information. Review of the hospital Discharge summary dated the day prior to the Resident's admission to the facility indicated the following:-Dietary order: Adult Diet, no room service; regular. Comments: 1:1 (one-to-one) feed, please leave tray at nurse's station, initiated on 11/3/25. -Dietary recommendations: Continue current adult regular diet (as listed with the above with comments). -Monitoring/evaluation: PO (by mouth) intake. Review of the Clinical and Alerts paperwork sent from the hospital at the time of the Resident's admission to the facility indicated the following:-Problem area: Swallowing Impairment (stroke/transient ischemic attack). Goal: optimal eating and swallowing without aspiration. Outcome: ongoing, not progressing.-The clinical alert indicated Resident #9 was a 1:1 (one-on-one) feed throughout the document for a total of 10 times. -The nutritional assessment (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented it, and an intervention should have been put into place in the Resident's care plan. The Nursing Supervisor said interventions to eat with supervision due to the Resident's increased pacing with eating should have been in place back when it was noted by the nursing staff and the speech therapist's recommendations in November. The Nursing Supervisor said all speech therapy recommendations should be followed and is not sure why the recommendation for Resident #9 to eat supervised was not. During an interview on 3/6/26 at 11:42 A.M., Physician #1, who also acts as the facility's Medical Director, said that he expects all information from the hospital to be thoroughly read at the time of admission and any pertinent information on the discharge summary be included in a resident's plan of care. Physician #1 said Resident #9's plan of care should have included supervision for dining if both the hospital discharge summary and speech therapist recommended this. 2. Resident #38 was admitted to the facility in March 2022 with diagnoses including stroke and right sided hemiplegia. Review of Resident #38's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 00 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicate he/she had severe cognitive impairment. The MDS also indicated Resident #38 required maximal assistance from staff for self-care tasks. On 3/4/26 at 8:02 A.M., Resident #38 was observed lying in bed, eating breakfast with the privacy curtain half drawn and the Resident not visible from the hallway. There were no staff present while the Residet was eating. On 3/5/26 from 8:15 A.M. to 8:25 A.M., Resident #38 was observed lying in bed, eating breakfast with the privacy curtain half drawn and the Resident not visible from the hallway. There were no staff present while the Residet was eating. On 3/6/26 at 8:07 A.M., Resident #38 was observed lying in bed, eating breakfast with the privacy curtain half drawn and the Resident not visible from the hallway. There were no staff present while the Residet was eating. At 8:11 A.M., a nurse walked by room and stepped in and asked the Resident if he/she was okay and then left within the same minute. The Resident ate alone until 8:12 A.M., when a nursing assistant walked in and then left at 813 A.M. At 8:15 A.M., a nursing assistant went back into the room and remained for the remainder of the meal. Review of Resident #38's Activities of Daily Living care plan indicated the following interventions:-Provide resident/patient with tray and plate set-up for eating. Continual supervision with 1:8 ration, cue and assist as needed. -Provide cueing for safety and sequencing to maximize current level of function. Review of Resident #38's Kardex (a form indicating the level of assistance needed with tasks) indicated:--Provide resident/patient with tray and plate set-up for eating. Continual supervision with 1:8 ration, cue and assist as needed. During an interview on 3/5/26 at 10:05 A.M., Certified Nursing Assistant (CNA) #2 said the CNAs are verbally told how much assistance a resident needs and they are not able to see the care plans or Kardex of any resident. CNA #2 said Resident #38 is independent with meals and she had never been told otherwise. During an interview on 3/5/26 at approximately 1:40 A.M., Corporate Nurse #2 and the Regional Director of Operations said that continual supervision means supervision at all times. Both said if a care plan says continual supervision, the nursing staff should follow this care plan intervention During an interview on 3/6/26 at 9:22 A.M., the Nursing Supervisor said continual supervision means at all times. The Nursing Supervisor said if Resident #38's privacy curtain was drawn, supervision could not be provided from the hallway, and staff would have had to be in the room with the Resident while he/she was eating. The Nursing Supervisor said that Resident #38 should have gotten continual supervision with meals if his/her care plan indicated that.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain a homelike environment on 1 of 2 units. Findings include:Review of the facility policy titled Accommodation of Needs and Preferences and Homelike Environment Policy, dated as revised 4/2022, indicated the following:A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of homelike should include the resident's opinion of the living environment. Orderly is defined as an uncluttered physical environment that is neat and well-kept.7. The resident's environment will be maintained in a homelike manner to ensure:-Appropriate housekeeping-Clean linens in good repair-Private closet space for each resident-Adequate and comfortable lighting-Comfortable and safe temperatures-Comfortable sound levels During a tour of the first floor unit on 3/3/26 at 8:27 A.M., the following was observed:Small dining room: the doorway to the room had significant scuff marks and missing paint on the doorway entrance of the room. Along the entire wall there were gouges on the wall with exposed plaster, missing paint on the wall and the radiator had significant dark scuff marks. room [ROOM NUMBER]: there were significant scuff marks and stains on the bottom of the closet door. The wall across from both beds and the wall next to the A bed had had plaster exposed. The wall under the window had significant stains and the radiator had significant scuff marks. room [ROOM NUMBER]: There was a gouge on the wall behind the A bed. The window blinds were broken. There was a black substance on floor, the bulletin board was broken, and the closet doors had a brown stain. The floor was chipped with a piece of the baseboard missing. In the bathroom, there was a loose towel rod, a mirror not attached to the wall resting behind grab bars and the shower did not have a head or handle.room [ROOM NUMBER]: Wallpaper was missing from the wall outside of the room under the number plate. Throughout the interior of the room, the walls had mismatched paint. Outside the bathroom door plaster was exposed on the walls. Stains were observed on the walls above the closet door.The hallway between rooms [ROOM NUMBERS] had plaster exposed and missing wallpaper. room [ROOM NUMBER]: There was a gouge in the wall behind the B bed with plaster exposed. The window blinds were broken. The radiator had significant scuff and stain marks. The hallway between rooms [ROOM NUMBERS] had wallpaper missing from the wall. room [ROOM NUMBER]: There were significant stains on the ceiling above both beds. Plaster was exposed on the wall behind the A bed. The chair across from the A bed was significantly stained and the B bed side table had a missing door to the bottom cabinet. The wallpaper border was peeling from the wall, the walls across from the bed had significant stains, and there was a hole in the wall behind the B bed. The closet doors were broken. Inside the bathroom, there were three small holes in the wall next to the toilet. room [ROOM NUMBER]: The bathroom ceiling had significant yellow and brown stains. There were gouges in the wall behind both walls with drywall exposed. room [ROOM NUMBER]: The bathroom ceiling was stained. The paint in the walls was mismatched. During a tour of the first floor unit on 3/6/26 beginning at 8:07 A.M., the following was observed:room [ROOM NUMBER]: There was dark brown debris covering the walls. A resident in the room said, I already told maintenance about that cause it freaks me out to look at. Additionally, there was paint peeling off the wall by the entryway light switch.room [ROOM NUMBER]: There was paint chipped off the walls and gouges in the walls throughout the room as well as brown stains behind the window bed.room [ROOM NUMBER]: There were gouges of missing paint by the door bed's wall and long dark scuffs/gouges on the bathroom door.room [ROOM NUMBER]: Paint was chipped off the walls and there were gouges in the walls throughout the room. There were long dark scuffs on the bathroom door.The hallway between rooms [ROOM NUMBERS] had a 3-foot (ft) x 1 ft area of missing wallpaper.room [ROOM NUMBER]: There was a long piece of metal falling off underneath the radiator.The hallway beside (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] had peeling wallpaper and three holes in the wall.room [ROOM NUMBER]: An area of 1 ft x 2 ft white paint on the wall, when the room's main color was tan paint. There was also mismatched patches of paint by the window wall.room [ROOM NUMBER]: A long black scuff mark on the walls and brown debris splattered on the walls. There were holes on the bathroom door with missing paint. There were also long dark scuffs on the entryway door. A resident in the room said that it is disgusting and we shouldn't have to live like this. If they hired someone to paint the walls that person would make a killing in this building. room [ROOM NUMBER]: Resident refused access to the surveyor to observe the room.room [ROOM NUMBER]: There were large scuff marks on the walls throughout room and writing in marker all over the closet doors.room [ROOM NUMBER]: There were long black scuff marks on the walls and brown debris on the walls. There were long black scuff marks on bathroom door.room [ROOM NUMBER]: Gouges of paint missing off the wall beside the bathroom door.The hallway between rooms [ROOM NUMBERS], and also between rooms [ROOM NUMBERS] had peeling wallpaper.room [ROOM NUMBER]: Resident refused access to the surveyor to observe the room.room [ROOM NUMBER]: There were large scuff marks on the radiator and gouges in the wall by the door bed.Beside the service elevator there were large pieces of missing wallpaper on the wall.room [ROOM NUMBER]: There were gouges in the bathroom door and paint patches on the walls that are different color than the main wall color of the room.Main dining room: A broken metal plate on the left wall and missing paint on the walls.Outside the main dining room there were large stains on the carpet. During an interview on 3/6/26 at 9:26 A.M., the Maintenance Director said that he tries to do rounding daily to observe the environment and that Thursday is his designated day to do projects and improve on resident rooms. The surveyor shared environmental observations from the 1st floor unit with him and the Corporate Administrator. The Maintenance Director said that he is aware of the mismatched paint on resident walls and that he has brought his concern to the Nursing Home Administrator (NHA). He said that he does not have the paint colors to replace missing paint on the walls in the same color but that the NHA told him to paint with what he has. Additionally, he said that he is aware of the peeling wallpaper in the corridors, but that wallpaper is one of those things you can't just go out and buy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interviews, the facility failed to ensure they reviewed and revised the Comprehensive Care Plan following the completion of his/her scheduled Quarterly Minimum Data Set (MDS) assessment for 1 Resident (#6) out of a total sample of 25 residents Specifically, for Resident #6 the facility failed to ensure a dementia care plan was developed following a Psychiatric assessment adding the diagnosis to the resident record. Review of the facility policy titled Comprehensive Assessments and the Care Delivery Process, dated as revised 2/2025, indicated:-Comprehensive assessments will be conducted to assist in developing person-centered care plans.-Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals. 7. Completed assessments (baseline, comprehensive, MDS, etc.) are maintained in the resident's active record for a minimum of 15 months. These assessments are used to develop, review and revise the resident's comprehensive care plan. Resident #6 was admitted to the facility in October 2025 and has diagnoses that include dementia with psychotic disturbance, Review of the most recent MDS assessment, dated 1/22/26, indicated that on the Brief Interview for Mental Status exam Resident #6 scored a 2 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #6 showed signs and symptoms of delirium, with continuous inattention. Review of the Psychiatric Assessment note dated 1/16/26 indicated Resident #6 has a dx. Unspecified dementia, unspecified severity, with psychotic disturbance. Review of the Psychiatric Assessment note dated 12/18/25 indicated Resident #6 has a dx. Unspecified dementia, unspecified severity, with psychotic disturbance. Review of the Psychiatric Assessment note dated 12/4/25 indicated Resident #6 has a dx. Unspecified dementia, unspecified severity, with psychotic disturbance. Review of Resident #6's Care Plan failed to indicate a care plan for Resident #6's dementia diagnoses, or that one was developed at the time of Resident #6's Comprehensive Quarterly assessment in January 2026. During an interview on 3/06/26 at 8:40 A.M., Certified Nursing Assistant (CNA) #3 said that Resident #6 requires total care. CNA # said that Resident #6 is confused and yells out at times because he/she doesn't know how to ring a call bell or tell the staff what he/she needs. During the interview there was a loud yell of help from down the hallway and CNA #3 said that that was Resident #6. She explained that yelling out is what Resident #6 does and that the staff then have to try to figure out what he/she wants or needs. During an interview 3/06/26 at 8:46 A.M., the MDS nurse said that Resident #6 should have a dementia care plan in place with individualized interventions but that she must have missed it. The MDS nurse said during the quarterly assessment review period in January 2026 this should have been caught and a dementia care plan developed at that time. During an interview on the 03/05/26 at 1:03 P.M., the Nurse Supervisor said Resident #6 should have dementia care plan in place and if he/she didn't it should have been developed at that time of the quarterly assessment.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide one Resident (#38) with his/her hearing aids to maintain adequate hearing for communication, out of a total sample of 25 residents. Findings include: Review of the policy titled, Ancillary Physician, dated 4/2022, indicated the following:-Direct care staff will assist residents with eyewear and hearing aid care, including removing, cleaning and storage. Resident #38 was admitted to the facility in March 2022 with diagnoses including stroke and right sided hemiplegia. Review of Resident #38's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 00 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #38 uses bilateral hearing aids. On 3/3/26 at 7:55 A.M., Resident #38 was observed lying in bed. The Resident had a difficult time hearing the surveyor's questions and he/she was not wearing hearing aids. On 3/4/26 at approximately 9:15 A.M., Resident #38 was observed lying in bed and not wearing any hearing aids. On 3/5/26 at 8:43 A.M., Resident #38 was observed lying in bed and not wearing any hearing aids. The Resident was able to answer yes/no questions and said he/she hadn't worn his/her hearing aids in a long time and would be agreeable to wear them. On 3/6/26 at 8:12 A.M., Resident #38 was observed lying in bed and not wearing any hearing aids. Review of Resident #38's nursing assessment, dated 2/19/26, indicated the Resident had adequate hearing with the use of bilateral hearing aids. Review of Resident #38's communication care plan indicated the following intervention:-Ensure hearing aid, glasses or other assistive devices are in place, initiated 4/2/24 Review Resident #38's last audiology visit, dated 10/9/24, indicated the following:-Recommendations: Patient requires assistance with insertion and manipulation for hearing aids daily; patient to wear hearing aids daily; continue with current means of communication. Review of Resident #38's medical record for the dates of survey failed to indicate the Resident was offered and refused the use of his/her bilateral hearing aids. During an interview on 3/6/26 at 8:18 A.M., Nurse #7 said Resident #38 has bilateral hearing aids. Nurse #7 said Resident #38 will refuse his/her hearing aids at times, but if he/she were to refuse the nurses need to document the refusal. During an interview on 3/6/26 at 9:22 A.M., the Nursing Supervisor said Resident #38 has bilateral hearing aids and should have been offered them daily in the mornings. The Nursing Supervisor said if Resident #38 refused his/her hearing aids, the nursing would document the refusal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225511	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
NAME OF PROVIDER OR SUPPLIER: Regalcare at Lowell		STREET ADDRESS, CITY, STATE, ZIP CODE: 30 Princeton Boulevard Lowell, MA 01851	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to identify a significant weight loss in a timely manner for one Resident (#46) out of a total sample of 25 residents. Findings include: Review of the facility policy titled ?Weight Management', dated 4/2022, indicated the following but not limited to:-To monitor the resident's weight from time of admission and to provide interdisciplinary support and/or intervention to avert adverse trends.-Weight change is defined as any unplanned weight gain or loss as follows:+/- 5% weight change in 1 month+/- 7.5% weight change 3 months+/- 10% weight change in 6 months-Reweights must be done within 24 hours.-The dietician will assess the resident and will communicate any recommended changes to the DNS and supervisor. Resident #46 was admitted to the facility in October 2025 with diagnoses including cognitive communication deficit and type 2 diabetes mellitus. Review of Resident #46's Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 7 out of a total 15 on the Brief Interview for Mental Status exam indicating severe cognitive impairment. Review of the current Nutritional Status care plan indicated that Resident #46 is at risk for nutritional decline related to therapeutic diet. Review of the Weight and Vitals summary indicated the following:-12/11/25: 117.7 lbs (pounds)-1/16/26: 106.2 lbs-2/6/26: 104 lbs Review of the weights indicated that between 12/11/25 and 1/16/26, Resident #46 lost a total of 11.5 lbs., which is a 9.7% clinically significant weight loss. Review of the clinical record failed to indicate that Resident #46 had been assessed by the Dietitian after this weight loss or that the weight loss had been reviewed. Review of the nutrition progress note, dated 2/12/26, indicated that Resident #46 had weight loss from admission and the plan was for weekly weights x 4 weeks and add assorted snack 2x (two times) per day. During an interview on 3/6/26 at 9:12 A.M., Nurse #6 said he was not aware of Resident #46's weight loss. He said if there is a discrepancy in the resident's weight then a reweight would occur the following day and the dietician would be notified. During an Interview on 3/6/26 at 9:18 A.M., Certified Nursing Assistant (CNA) #4 said if a resident was weighed and there is a weight loss they would reweigh the resident and then notify the nurse. CNA #4 said Resident #46 likes foods brought to him/her from home. During an interview on 3/6/26 at 11:10 A.M., the Dietician said she runs the weight reports monthly and that the facility has a weekly risk meeting where they discuss weights. The dietician said that Resident #46 had a significant weight loss, and she believed it was because the Resident had moved floors and was weighed on a different scale. She further said the Resident should have been reweighed to confirm the weight loss and interventions should have been put in place sooner. During an interview on 3/6/26 at 11:30 A.M., the Director of Nursing said residents with weight loss should be reweighed the next day and if it confirms weight loss, it should be reported to the physician and dietician.

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NAME OF PROVIDER OR SUPPLIER Regalcare at Lowell		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Princeton Boulevard Lowell, MA 01851	

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observations, record review and interviews, the facility failed to ensure that for 1 Resident (#6), who was diagnosed with dementia, appropriate treatment and services were provided to attain his/her highest practical physical, mental and psychosocial well-being, and that person centered interventions were implemented, out of a total sample of 25 residents. Findings include:Review of the facility policy titled Dementia CP, dated as revised 3/33, indicated:Treatment and ManagementFor the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life. The IDT (interdisciplinary team) will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses' notes and documentation tools). Progressive or persistent worsening of symptoms and increased need of staff support will be reported to the IDT. Resident #6 was admitted to the facility in October 2025 and has diagnoses that include dementia with psychotic disturbance, Review of the most recent MDS assessment, dated 1/22/26, indicated that on the Brief Interview for Mental Status exam Resident #6 scored a 2 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #6 showed signs and symptoms of delirium, with continuous inattention. Review of the most recent Psychiatric assessment notes indicate the following visit notes: 1.) 2/18/26, Diagnostic assessment: Resident #6 continues to be disruptive, yell out and is difficult to redirect. Since he/she is on low dose of Depakote (a mood stabilizer), will recommend increasing this and adding prn (as needed) Trazadone (as antidepressant) for the time being. 2.) 1/16/26, Diagnostic assessment: Resident #6 with psychosis: continue to yell out through the day and is very anxious and disruptive.Recommendations: start Haldol (an antipsychotic) .5 milligrams (mg) BID (two times a day). Review of the Psychiatric Assessment note dated 12/4/25 indicated Resident #6 has a dx. Unspecified dementia, unspecified severity, with psychotic disturbance. Review of Resident #6's Care Plan failed to indicate a care plan for Resident #6's dementia diagnoses with person centered interventions. During an observation on 3/3/26 at 8:51 A.M., Resident #6 was observed in bed yelling out, I want music, why can't I just get music. The yelling could be heard 30-35 feet away at the nurse's station, and several staff were in the vicinity, however no one responded to the yelling or provided the resident with music. During an observation on 3/4/26 between approximately 1:30 P.M., and 1:50 P.M., the surveyors could here screaming from the floor up above. Upon arriving on the unit, it was the determined that the yelling was Resident #6. He/she was observed in bed, and a Certified Nursing Assistant (CNA) was in the room speaking to the resident. After a few moments, the resident did not respond to the CNA and the CNA left the room. Resident #6 remained alone in the room yelling. During an interview on 3/6/26 at 8:40 A.M., CNA #3 said that Resident #6 requires total care. CNA #3 said that Resident #6 is confused and yells out at times because he/she doesn't know how to ring a call bell or tell the staff what he/she needs. During the interview there was a loud yell of help from down the hallway and CNA #3 said that that was Resident #6. She explained that Resident #6 frequently yells out and that staff then have to try to figure out what he/she wants or needs. CNA #3 could not say interventions that were utilized to support Resident #6 at the time these behaviors presented. During an interview 3/6/26 at 8:46 A.M., the MDS nurse said that Resident #6 should have a dementia care plan in place with individualized interventions in place to address his/her status and care needs. During an interview on the 3/5/26 at 1:03 P.M., the Nurse Supervisor said Resident #6 should have dementia care plan in place with resident specific interventions to address his/her mood and behavior and care needs, as he/she cannot express them him/herself due to dementia.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure that one Resident (#39) was free of significant medication errors out of a total sample of 24 residents. Specifically, the nurse substituted and attempted to administer furosemide (a diuretic- used for removing excess fluids from the body) medication without a physician order.Findings include: Review of the facility policy titled Oral Medication Administration, dated 4/22, indicated the following but not limited to:-Verify that there is a physician's medication order for this procedure.-Check the label on the medication and confirm the medication name and does with the MAR (medication administration record).-Check the medication dose. Re-check to confirm proper does. Resident #39 was admitted to the facility in January 2026 with diagnoses including acute heart failure and coronary artery disease. Review of Resident #39's Minimum Data Set (MDS), dated [DATE] indicated the Resident scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. During a medication observation pass on 3/4/26 at 9:03 A.M., Nurse #3 pulled a blister pack containing one tablet out of the medication cart, the nurse said to the surveyor that the order for Torsemide 20 mg (milligram) (a diuretic) had changed, and the resident was now receiving 40 mg (milligram). Nurse #3 said that she was going to the pyxis machine (an automated locked medication dispensing cabinet used to securely store, manage and dispense medication), to access another dose of torsemide. Nurse #3 walked away and then shortly returned saying she had sent another nurse to bring her the medication. Nurse #2 returned with two pills in a pack and handed it to Nurse #3. Nurse #3 poured the medication into a medication cup then handed the empty packet to the surveyor. The surveyor noted the packet stated Furosemide 20mg tablets. She then proceeded to enter the Resident's room to administer the medication, at this point the surveyor asked Nurse #3 to step out of the room, prior to administering the incorrect medication. During an interview on 3/4/26 at 9:49 A.M., Nurse #3 said she asked Nurse #2 to bring her Lasix (furosemide) form the pyxis. Nurse #3 said that she thought Torsemide and furosemide are the same medication. Nurse #3 said she did not have a physician order to substitute medication, and she should have administered what was ordered which was Torsemide. Review of Resident #39's current physician's order indicated the following order:-Torsemide oral tablet 40 mg give one tablet by mouth one time a day for edema (swelling caused by excess fluid trapped in body tissue, commonly occurring in legs, feet, and ankles). Review of the physician order failed to indicate an order for Furosemide. During an interview on 3/5/26 at 8:07 A.M., Nurse #2 said that Nurse #3 had asked her to retrieve Lasix (Furosemide) 40 mg from the pyxis. She said it was the nurse's responsibility to double-check the medication against the order to ensure she had the right medication. During an interview on 3/4/26 at 2:00 P.M., the Director of Nursing (DON) said the nurses should be doing the five checks when performing medication administration. She further said all medications require a physician order to administer. During an Interview on 3/6/26 at 12:24 P.M., Nurse Practitioner #1 said medication should never be given without a physician order. She said the difference between furosemide and torsemide is that they are metabolized differently.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to provide dental services to one Resident (#9) out of a total sample of 25 residents. Specifically, the facility failed to refer Resident #9 to the dentist to repair or replace his/her broken dentures. Findings include:Resident #9 was admitted to the facility in November 2025 with diagnoses including Wernicke's encephalopathy. Review of Resident #9's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 00 out of a possible 15 on the Brief Interview for Mental Status exam which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #9 required assistance from staff for all functional tasks. On 3/3/26 at 7:58 A.M., Resident #9 was observed lying in bed. The Resident was observed to have a missing front tooth from his/her upper dentures and did not have lower dentures. Resident #9 could not be interviewed due to cognition. On 3/4/26 at 9:43 A.M., Nurse #2 and the surveyor observed Resident #9's broken dentures. Nurse #2 said she was unaware the Resident's dentures were broken and did not know if the dentist had been notified for them to be fixed. Review of Resident #9's admission nursing assessment, dated 11/26/25, failed to indicate the Resident had broken dentures on admission. Review of Resident #9's nursing notes from time of admission to present failed to indicate any documentation of when or how the dentures broke as well as any referral to the dentist to have the denture repaired or replaced. During an interview on 3/5/26 at 10:00 A.M., Certified Nursing Assistant (CNA) #1 said Resident #9's dentures were not broken when admitted and this must have happened at some time during the Resident's stay at the facility. CNA #1 said he was unaware if the facility had contacted the dentist to have the dentures fixed. During an interview on 3/6/26 at 9:20 A.M., the day Nursing Supervisor said she was unaware that Resident #9's dentures were broken. The Nursing Supervisor said the Resident was not admitted with broken dentures and they must have broken at some time since admission. The Nursing Supervisor said the facility refers anyone with broken dentures to the dentist to have the dentures fixed and the facility had not done this for Resident #9. During an interview on 3/6/26 at 7:48 A.M., the Director of Nursing said she was unaware prior to survey that Resident #9's dentures were broken. The Director of Nursing said when a denture breaks, the resident should be referred out to the dentist and this did not occur for Resident #9 and should have. During an interview on 3/5/26 at 10:32 A.M., Resident #9's Legal Guardian said she was unaware Resident #9's dentures were broken and if she had known, she would have wanted them fixed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interviews and record review, the facility failed to ensure a hospice care plan was present in the medical record and coordinated between facility staff and the hospice agency for one Resident (#48) out of a total sample of 24 residents. Findings include: Review of the facility policy titled Hospice Care, revised April 2022, indicated but was not limited to the following: -In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including: -Determining the appropriate hospice plan of care. -Our facility staff will coordinate care provided to the resident with the hospice staff. He or she is responsible for the following: -Obtaining the following information from the hospice: -The most recent hospice plan of care specific to each resident. -Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident #48 was admitted to the facility in June 2022 with diagnoses including vascular dementia. Review of Resident #48's Minimum Data Set (MDS) assessment, dated 1/22/26, indicated the Resident scored a 10 out of a possible 15 on the Brief Interview for Mental Status, indicating he/she had moderate cognitive impairment. Review of Resident #48's medical record indicated the following: -A physician's order, dated 2/12/26: may do hospice evaluation and treat and admit as indicated. -A facility care plan: [Resident #48] is receiving the following care: hospice related to end-stage dementia, initiated 2/12/26. -A Hospice Election Form indicating the Resident was admitted to hospice on 2/19/26. Review of the medical record failed to indicate the hospice agency's plan of care was available to the staff at the facility; furthermore, the medical record failed to indicate appropriate coordination between the facility and hospice agency to create a plan of care that includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. During an interview on 3/4/26 at 8:27 A.M., Nurse #6 said all hospice residents are supposed to have a binder that includes the hospice plan of care. Nurse #6 said Resident #48 started hospice recently and he/she does not currently have a binder with the hospice plan of care; he said if there is no binder with the hospice plan of care, the Resident is at risk of not receiving the care he/she needs and the facility staff would be unable to follow the hospice care plan. During an interview on 3/4/26 at 1:25 P.M., Day Supervisor #1 said the hospice plan of care is sent from the hospice agency to the facility and uploaded into the Electronic Health Record. Day Supervisor #1 said the facility had not received the hospice plan of care for Resident #48. During an interview on 3/4/26 at 1:49 P.M., the Director of Nursing (DON) said the nursing staff are responsible for coordinating hospice care at the facility. The DON said she would expect a hospice plan of care to be available within one to two weeks of a resident being admitted to hospice, and that Resident #48 should have already had a hospice plan of care available. During an interview on 3/4/26 at 2:23 P.M., Hospice Nurse #1 said all hospice residents have a binder that should include a plan of care at the facility. Hospice Nurse #1 said Resident #48 was recently admitted to hospice, but she was out sick the previous week and was unable to provide the facility with the plan of care timely.