STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225515	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D'Youville Senior Care	981 Varnum Avenue Lowell, MA 01854

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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 - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for four Residents (#175, #139, #93 and #143) out of a total sample of 40 Residents. Specifically,For Resident #175 the facility failed to a). ensure that they obtained physician's orders for the use of CPAP (continuous positive airway pressure, used to treat obstructive sleep apnea) and b). store the CPAP mask and tubing in a bag.For Resident #139, Resident #93, and Resident #143, the facility failed to ensure the respiratory equipment was maintained in a sanitary condition. Specifically, the oxygen concentrators used to administer continuous oxygen had filters covered with a thick layer of dust. Findings include: 1. Review of facility policy titled CPAP, dated as revised 2/26, indicated the following:Procedure: Check MD orderTubing to be labeled with date and time, cleaned daily per manufacturer's instructions and changed weekly. Mask/ tubing to be stored in a bag when not in use.Document Treatment in the ETAR (electronic treatment administration record). a. Resident #175 was admitted to the facility in March 2026 with diagnoses that included osteomyelitis of the right ankle and foot, muscle weakness and obstructive sleep apnea. Review of Resident #175's most recent Minimum Data Set (MDS) assessment, dated 3/9/26 indicated a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. The MDS failed to indicate the use of non-invasive mechanical ventilation (CPAP). On 4/13/26 at 8:12 A.M., the surveyor observed a CPAP machine on the Resident's bedside table. Review of the referring hospital's Discharge summary, dated [DATE], indicated the following: Obstructive Sleep Apnea: History of OSA (Obstructive sleep apnea). At risk for postoperative hypoventilation, especially with opioid use. Resume CPAP at night if available. Monitor oxygen saturation overnight. Review of Resident #175's active physician's orders and active care plans failed to indicate Resident #175's use of CPAP. Review of the clinical progress note dated, 4/6/26, indicated a covid test could not be completed because of CPAP use. Further review of progress notes since admission to the facility failed to indicate any CPAP use. During an interview on 4/14/26 at 7:10 A.M., Nurse #3 said that she works the night shift on Resident #175's unit. She said that Resident #175 wears his/her CPAP every night and is compliant with use. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said she gives the Resident an early morning medication and that is the only time he/she removes the mask. During an interview on 4/14/26 at 11:56 A.M., Resident #175 said he/she uses the CPAP every night since admission to the facility. During an interview and observation on 4/14/26 at 12:19 P.M., the surveyor and Unit Manager #2 observed the CPAP machine in the Resident's room. Unit Manager #2 said that the Resident should have an order for the use of the CPAP machine, including the settings of the machine, so that staff are aware of the usage and can assess the Resident appropriately and ensure compliance. During an interview on 4/14/26 at 2:31 P.M., the Director of Nurses said that there should be a physician's order in place for the use of the CPAP machine. b. On 4/13/26 at 8:12 A.M., 4/14/26 at 6:52 A.M., and 10:15 A.M., the surveyor observed a CPAP machine on the Resident's bedside table. The mask was not stored in bag and was laying out in the open on the bedside table. Review of the medical record failed to indicate physician's orders regarding cleaning and storage of the CPAP mask. During an interview and observation on 4/14/26 at 12:19 P.M., the surveyor and Unit Manager #2 observed the CPAP machine on the Resident's bedside table. The tubing and mask were on the top of the bedside table, uncovered and out in the open. Unit Manager #2 said that it should be stored in a bag. During an interview on 4/14/26 at 2:31 P.M., the Director of Nurses said that the CPAP mask should be stored in a bag and protected from potential bacteria. 2a. Resident #139 was admitted to the facility in May 2025 with diagnoses that included Alzheimer's disease, chronic diastolic heart failure, pulmonary hypertension, and severe persistent asthma. Review of the Minimum Data Set (MDS) assessment, dated 1/15/26, indicated Resident #139 scored 3 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having severe cognitive impairment. The MDS further indicated that the Resident was dependent on staff for care including hygiene, bathing, is on hospice care and is on oxygen therapy. On 4/13/26 at 9:36 A.M., the Surveyor observed Resident #139 resting in bed wearing a nasal canula receiving oxygen at 2 liters per minute (LPM). The oxygen concentrator filter was entirely covered with dust. On 4/13/26 at 12:28 P.M., the Surveyor observed Resident #139 seated in a chair with his/her lunch meal in front of him/her. Resident #139 had a nasal canula receiving oxygen from an oxygen concentrator. The side of the concentrator had a filter that was entirely covered in dust. On 4/13/26 at 2:23 P.M., the Surveyor observed Resident #139 in bed with his/her eyes closed and at this time the nasal canula was on the floor, the concentrator was running and the filter was covered with dust, obscuring the filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/14/26 at 7:23 A.M., the Surveyor observed Resident #139 in bed wearing a nasal cannula receiving oxygen at 2 liters per minute. The filter on the oxygen concentrator was covered with dust. Review of Resident #139's physician's orders indicated: -Oxygen 0.5-2 LPM via nasal cannula to maintain sats above 90-92%. Attempt to titrate down each shift, dated 5/8/25. -Change oxygen tubing every night shift Thursday, dated 5/8/25. Review of Resident #139's physician's orders, and care plans failed to indicate a plan of care to ensure the respiratory equipment was maintained in a clean and sanitary manner. During an interview and observation on 4/15/26 at 7:53 A.M., Nurse #14 said Resident #139 does require continuous oxygen and on occasion he/she will remove the nasal canula. Nurse #14 said the concentrator should be clean and have a clean filter. Nurse #14 said she was not sure how the concentrator filters are cleaned, whether nursing or maintenance does it. Nurse #14 and the surveyor went to Resident #139's room. Nurse #14 removed the filter and began pulling/removing a thick layer of dust covering the entire filter into the nearby trash bin. Nurse #14 said the filter should be clean and that if covered with dust the concentrator may not work as well as it should. During an interview on 4/15/26 at 8:19 A.M., the Director of Nursing (DON) said the oxygen concentrator filter should be kept clean and clear. The DON said the nurses do not have orders to clean the filter, but she would expect the filters to be clean for the administration of oxygen. 2b. Resident #93 was admitted to the facility in September 2025 with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and dependence on supplemental oxygen. Review of the most recent Minimum Data Set (MDS) Assessment, dated 3/12/26, indicated a Brief Interview for Mental Status (BIMS) score 00 out of 15, indicating severe cognitive impairment. On 4/13/26 at 7:36 A.M., the surveyor observed Resident #93 lying in bed with oxygen set on 2 liters via nasal cannula. The filter on the concentrator was covered with a thick layer of dust. On 4/14/2026 at 7:14 A.M., and 4/15/26 at 6:43 A.M., the surveyor observed Resident #93 sleeping in bed with oxygen set on 2 liters via nasal cannula. The filter on the concentrator was covered with a thick layer of dust. Review of Resident #93's physician orders indicated the following: -Oxygen at 2 liters via nasal cannula every shift, dated 9/12/25. -Change oxygen tubing every night shift every Thursday, dated 9/12/25. Review of Resident #93's physician orders failed to indicate maintenance orders to clean or change the oxygen filter. During an interview on 4/15/26 at 6:43 A.M., Nurse #12 said oxygen tubing and filters are changed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	overnight on Thursdays weekly. Nurse #12 said there would be an order to change the tubing and filter and the nurse changing the tubing usually changes the filter. During an observation and interview on 4/15/26 at 6:46 A.M., the surveyor and Nurse #12 reviewed Resident #93's physician orders. Nurse #12 said the Resident had an order to change the tubing but there was no order to change or clean the filter. During an interview on 4/15/26 at 6:49 A.M., Unit Manager #2 said there wouldn't be an order to change or clean the filter because the oxygen company manages the filters and checks on the oxygen tanks weekly. Review of the facility oxygen company contract titled 02 Safe Solutions, dated 4/19/18, failed to indicate maintenance services for the oxygen filters provided by the oxygen company. During an observation and interview on 4/15/26 at 6:52 A.M., the surveyor, Unit Manager #2 and Nurse #12 observed Resident #93's oxygen concentrator filter. The filter on the concentrator was covered with a thick layer of dust. Unit Manger #2 said the filter should've been cleaned and if the filters aren't cleaned then the Resident isn't getting clean oxygen. During an interview on 4/15/26 at 6:57 A.M., the Director of Nursing (DON) said the oxygen company maintains the oxygen tanks and she is not aware of their schedule for switching out the filters. The DON said she has not seen the oxygen filters personally but that the oxygen company was in the facility within the past week. The DON said she would expect the filters to be cleaned and the Resident would have the potential for being exposed to contaminates if the filters aren't cleaned. 2c. Resident #143 was admitted to the facility in March 2024 with diagnoses that included anemia, dementia and obstructive sleep apnea. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/26, indicated a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating severe cognitive impairment. On 4/13/26 at 8:17 A.M., the surveyor observed Resident #143 sleeping in bed with oxygen set on 1 liter via nasal cannula. The filter on the concentrator was covered with a thick layer of dust. On 4/13/26 at 4:03 P.M., the surveyor observed Resident #143 lying in bed with oxygen set on 1 liter via nasal cannula. The filter on the concentrator was covered with a thick layer of dust. On 4/14/26 at 7:17 A.M., and 4/15/26 at 6:42 A.M., the surveyor observed Resident #143 sleeping in bed with oxygen set on 1 liter via nasal cannula. The filter on the concentrator was covered with a thick layer of dust. Review of Resident #143's physician orders indicated the following: -Oxygen at 0.5-1L via nasal canula to maintain sats above 88% every shift, dated 7/30/24. -Change oxygen tubing every night shift every Thursday, dated 3/20/24. Review of Resident #143's physician orders failed to indicate maintenance orders to clean or change the oxygen filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/15/26 at 6:43 A.M., Nurse #12 said oxygen tubing and filters are changed overnight on Thursdays weekly. Nurse #12 said there would be an order to change the tubing and filter and the nurse changing the tubing usually changes the filter. During an observation and interview on 4/15/26 at 6:46 A.M., the surveyor and Nurse #12 reviewed Resident #143's physician orders. Nurse #12 said the Resident had an order to change the tubing but there was no order to change or clean the filter. During an interview on 4/15/26 at 6:49 A.M., Unit Manager #2 said there wouldn't be an order to change or clean the filter because the oxygen company manages the filters and checks on the oxygen tanks weekly. Review of the facility oxygen company contract titled 02 Safe Solutions, dated 4/19/18, failed to indicate maintenance services for the oxygen filters provided by the oxygen company. During an observation and interview on 4/15/26 at 6:54 A.M., the surveyor, Unit Manager #2 and Nurse #12 observed Resident #143's oxygen concentrator filter. The filter on the concentrator was covered with a thick layer of dust. Unit Manger #2 said the filter should've been cleaned and if the filters aren't cleaned then the Resident isn't receiving clean oxygen. During an interview on 4/15/26 at 6:57 A.M., the Director of Nursing (DON) said the oxygen company maintains the oxygen tanks and she is not aware of their schedule for switching out the filters. The DON said she has not seen the oxygen filters personally but that the oxygen company was in the facility within the past week. The DON said she would expect the filters to be cleaned, and the Resident would have the potential for being exposed to contaminates if the filters aren't cleaned.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically,1. For Resident #69 the facility failed to ensure medications were not stored at the bedside. 2. For Resident #175 the facility failed to ensure medications were not stored at the bedside.3a. The facility failed to ensure the treatment cart on the Sweet Land Unit was locked.3b. The facility failed to ensure the medication carts on the Sweet Land Unit, Short Term Rehab Unit and Wannalancit Unit were secured.Findings include: Review of the facility policy titled Medication Storage in the Facility Bedside Medication Storage, dated 2024, indicated All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to given unauthorized medications to the charge nurse for return to the family or responsible party. 1. Resident #69 was admitted to the facility in June 2025 with diagnoses including vascular dementia, cognitive communication deficit, and anxiety disorder. Review of Resident #69's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #69 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15. On 4/13/26 at 8:14 A.M., and 12:59 P.M. the surveyor observed one bottle of Refresh Optive Gel Drops on Resident #69's bedside table. Resident #69 said those were his/her eye drops that he/she needs. On 4/14/26 at 7:14 A.M., the surveyor observed one bottle of Refresh Optive Gel Drops on Resident #69's bedside table. Review of Resident #69's physician orders and care plans failed to indicate the Resident had met criteria to self-administer medications at his/her bedside. Review of the Self-Administration of Medication Informed Consent and assessment dated [DATE] indicated that the Resident did not have medications he/she wants to keep at bedside or wishes to administer his/her own medication. During an observation and interview on 4/14/26 at 7:53 A.M., Nurse #2 said she was not aware of Resident #69's medications being left at the bedside. Nurse #2 and the surveyor observed one bottle of Refresh Optive Gel Drops on Resident #69's bedside table. Nurse #2 said Resident #69 should not have the bottle of eye drops left at the bedside table. Review of Resident #69's physician order dated 2/19/26 indicated the following: Refresh Tears PF Ophthalmic Solution 0.5-0.9 % (Carboxymethylcellulose Glycerin) Instill 1 drop in both eyes every hour for Dry eyes While awake. Review of Resident #69's April 2026 Medication Administration Record indicated that Resident #69's scheduled Refresh Tears PF Ophthalmic Solution was signed off as Resident receiving medication on (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/13/26 and 4/14/26. During an interview on 4/14/26 at 1:17 P.M., Unit Manager #3 said Resident #69 should not have eye drops at his/her bedside and said Resident #69 has not been assessed to self-administer medications. During an interview on 4/14/26 at 3:02 P.M., the Director of Nursing said residents who wish to self-administer medication must have a Self-Administration assessment completed prior to leaving the medications with residents and said Resident #69 should not have the eye drops stored in his/her room as he/she has not been assessed for self-administration. 2. Resident #175 was admitted to the facility in March 2026 with diagnoses that included osteomyelitis of the right ankle and foot, muscle weakness and obstructive sleep apnea. Review of Resident #175's most recent Minimum Data Set (MDS) assessment, dated 3/9/26 indicated a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. On 4/13/26 at 8:12 A.M., the surveyor observed medications stored on the Resident's overbed table. The medications included clotrimazole cream (a topical medication used to treat skin infections caused by fungi) and Hydrocortisone and acetic acid otic solution (a prescription ear drop used to treat outer ear infections and relieve associated inflammation, redness, and itching). On 4/13/26 at 12:27 P.M., the surveyor observed medications stored on the Resident's overbed table. The medications included clotrimazole cream and Hydrocortisone and acetic acid otic solution. In addition to the previously observed medications there was also a tablet of immodium (a medication used to treat diarrhea or loose stool) at the bedside. On 4/14/26 at 6:51 A.M., the surveyor observed medications stored on the Resident's overbed table. The medications included clotrimazole cream and Hydrocortisone and acetic acid otic solution. Review of Resident #175's physician's orders indicated the following: loperimide (immodium) 2 mg every 6 hours as needed for loose stools, dated 3/9/26. Further review of physician's orders failed to indicate orders for Clotrimazole cream or Hydrocortisone and acetic acid otic solution. Review of the medical record failed to indicate that the Resident was assessed to self- administer medications or store medication in his/her room. During an interview on 4/14/26 at 11:59 A.M., Resident #175 said that he/she is not utilizing the medications that are stored on his/her bedside table. During an interview on 4/14/26 at 12:15 P.M., Unit Manger #2 said that there are no residents on the unit who store medications in their rooms. She said medications are kept in the medication cart and locked up. The surveyor and the Unit Manager observed the Resident's room and noted the cream and otic drops on the overbed table. The Unit Manager said that they should not be stored unsecured in the Resident's room. She further said it was a safety concern for other residents on the unit as well as there are residents that like to walkaround the unit and visit other residents in their rooms. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 4/14/26 at 12:24 P.M., Unit Manager #2 said that residents can be assessed for self-administration and storage of medications, but that Resident #175 was not. She said that if any Resident has medications in their rooms, then they need to be locked and secured in a drawer. She said she did not know that Resident #175 had these medications in his/her room. During an interview on 4/14/26 at 2:30 P.M., the Director of Nurses said that Residents should not be storing medications in their rooms. She said that facility staff should have noticed the medications in the room and removed them. 3a. On 4/13/26 at 7:39 A.M., the surveyor observed an unlocked and unsupervised treatment cart in the hallway outside of resident rooms on the Sweet Land Unit. On 4/14/26 from 7:18 A.M. to 7:35 A.M., the surveyor observed an unlocked and unsupervised treatment cart in the hallway outside of resident rooms on the Sweet Land Unit. On 4/15/26 at 7:04 A.M., the surveyor observed an unlocked and unsupervised treatment cart in the hallway outside of resident rooms on the Sweet Land Unit. The surveyor was able to access the cart and observed multiple prescription creams and treatment supplies. During an interview on 4/15/25 at 7:05 A.M., Nurse #1 said if a nurse is not present at the treatment cart, then it should be locked. During an interview on 4/15/26 at 7:07 A.M., the Director of Nurses (DON) said she expects all medication and treatment carts to be locked unless the nurse is present at the cart. The DON said if the carts are left unattended then anyone could access the medications in the carts. 3b. On 4/13/26 at 7:41 A.M., the surveyor observed an unlocked and unsupervised medication cart in the hallway outside of resident rooms on the Sweet Land Unit. On 4/13/26 at 7:47 A.M., the surveyor observed an unlocked and unsupervised medication cart in a resident's room with one resident up in his/her wheelchair on the Sweet Lane Unit. The nurse was no present in the resident's room. On 4/13/26 at 7:55 A.M., the surveyor observed an unlocked and unsupervised medication cart in the hallway outside of resident rooms on the Sweet Land Unit. On 4/14/26 at 8:26 A.M., the surveyor observed an unlocked medication cart on the Wannalancit unit. The surveyor was able to open the medication cart and gain access. The nurse was observed walking away from the medication cart. During an interview on 4/14/26 at 8:28 A.M., Nurse #2 said she should not have left the medication cart unlocked when she pushed a resident down to the dining room. On 4/15/26 at 7:02 A.M., the surveyor observed two of two medication carts were unlocked and unsupervised on the short-term unit. A resident was observed near the carts in the hallway. During an interview and observation on 4/15/26 at 7:03 A.M., Nurse #10 said his medication carts should be locked and they are not. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/15/26 at 7:05 A.M., Nurse #1 said if a nurse is not present at the medication cart, then it should be locked. During an interview on 4/15/26 at 7:07 A.M., the Director of Nurses (DON) said she expects all medication and treatment carts to be locked unless the nurse is present at the cart. The DON said if the carts are left unattended then anyone could access medications in the carts.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically,The facility failed to implement Enhanced Barrier Precautions (EBP) for five residents (#2, #48, #143, #33, and #183) out of a total of 69 residents who required the use of EBP.The facility failed to follow proper infection control practices for shared medical equipment, a). Nursing Staff failed to disinfect the blood pressure cuff between uses on the Sweet Land Unit and [NAME] Unit, and b). Nursing staff failed to disinfect a blood glucometer machine after use on the Wannalancit Lane Unit and c). failed to ensure staff performed hand hygiene while performing blood sugar checks. The facility failed to ensure that staff performed hand hygiene between entering and exiting resident rooms and between glove use. Findings include: 1a. Review of the facility policy titled Infection Control - Enhanced Barrier Precautions, dated as 5/28/25, indicated that it is the policy of this home to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP is defined as an infection control interventions designed to reduce transmission of multidrug-resistant organisms that employees target glove use during high contact resident care activities. 4. High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing Linens f. Changing Briefs or assisting with toileting g. Device care for use: central lines, urinary catheter, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheter, PICC lines, midline catheters. h. Wound Care: any skin opening requiring a dressing. Resident #2 was admitted to the facility in November 2024 with diagnoses including dementia, heart failure, and urinary incontinence. Resident #2's Minimum Data Set assessment, dated 2/3/26, indicated Resident #2 had a severe cognitive impairment as evidence of a BIMs score of 0. This MDS indicated Resident #2 was dependent on staff for activities of daily living, was incontinent of bowel and bladder, and Resident #2 had one unstageable pressure ulcer (severe, full thickness wound where the base is completely obscured by [NAME] or eschar) and he/she required pressure ulcer care. Review of Resident #2's physician's order, dated 1/6/26, indicated: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D'Youville Senior Care	981 Varnum Avenue Lowell, MA 01854

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Maintain Enhanced Barrier Precautions due to wounds, may discontinue precautions when wounds heal, every shift. Review of Resident #2's physician's order, dated 3/4/26, indicated: - Coccyx: Cleanse wound with Vashe (wound cleaner), pat dry with gauze. Apply nickel-thick amount of Santyl (prescription medication) to wound bed. Then, cover wound bed with Calcium Alginate (wound dressing), followed by Silicone Absorbent Border form every day shift for wound healing and as needed for if soiled or not intact. On 4/13/26 at 11:07 A.M., the surveyor observed signage outside Resident #2's door a sign that indicated the following EBP, providers and staff must wear gloves and gown for the following high-contact resident care activities. Dressing, Providing Hygiene, changing briefs or assisting with toileting., The surveyor entered Resident #2's room and observed two Certified Nursing Assistants (CNA) providing direct care (incontinence care) to Resident #2 neither CNA was wearing a gown. The surveyor observed a dressing on Resident #2's coccyx that was peeling off and the wound was exposed, the CNA offered to fully remove the dressing so the surveyor could see it (the wound). During an interview on 4/14/26 at 4:22 P.M., the DON said CNA should be wearing PPE while providing direct care for Residents who require EHB, and the DON said the reason for EBP is to prevent further infection. 1b. During an observation on the Belvidere Unit on 4/13/26 at 9:17 A.M., the surveyor observed two staff members transfer a resident with a total lift. A sign on the Resident #48's door indicated the need for Enhanced Barrier Precautions during transfers. The two staff members assisting with the transfer utilized only gloves and no gowns. 1c. During an observation on the Belvidere Unit on 4/13/26 at 12:32 P.M., the surveyor observed two staff members enter a resident's room and provide care for Resident #143. There was a sign on the Resident's doorway to indicate the need for Enhanced Barrier Precautions. The two staff members utilized gloves only and did not use gowns when providing care to the Resident. During an interview on 4/15/26 at 9:44 A.M., Nurse #15 said that for any resident who requires Enhanced Barrier Precautions staff must wear a gown and gloves for high contact care which includes the use of a total lift, transfers, activities of daily living care or any care pertaining to a wound, Intravenous line or catheter. During an interview on 4/15/26 at 9:45 A.M., Unit Manager #2 said that staff should be utilizing gown and gloves for all residents on EBP who require high contact care. Unit Manager #2 said that gowns and gloves should be worn for transfers, activities of daily living, and for any care involving an intravenous line, foley catheter or wound when the resident is indicated to be on EBP. 1d. On 4/13/26 at 7:41 A.M., the surveyor observed signage outside Resident #33's door a sign that indicated the following EBP, providers and staff must wear gloves and gown for the following high-contact resident care activities. The surveyor then observed Nurse #1 providing wound care to Resident #33 without wearing a gown. 1e. On 4/14/26 at 9:08 A.M., the surveyor and Unit Manager #1 observed three staff members providing wound care to Resident #183 without PPE on. The Unit Manager said the Resident has a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound and the staff members should have PPE on while providing wound care but do not. During an interview on 4/15/26 at 7:07 A.M., the Director of Nurses (DON) said when a nurse is providing wound care it is expected they wear a gown and gloves following the EBP signage. The DON said the purpose of wearing PPE is to protect the resident from infection. 2a. Review of the facility policy titled Infection Control – Cleaning and Disinfection of Resident Care Equipment, dated 11/28/24, indicated but was not limited to the following: Resident care equipment can be a source of indirect transmission of pathogens. Reusable resident care equipment will be cleaned and disinfected in accordance with the current CDC (Centers for Disease Control) recommendations in order to break the chain of infection. 3. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines include: d. Multiple resident use equipment shall be cleaned and disinfected after each use. h. Use only EPA registered disinfectants that kill claims for the common organisms found in the home. If the equipment is exposed to residents and transmission based precautions verify the disinfectant are registered for use with relevant organisms. i. Verify the disinfectant is compatible with the equipment. j. Follow manufacturer recommendations for cleaning equipment. On 4/13/26 at 7:44 A.M., the surveyor observed Nurse #1 on the Sweet Land Unit obtain vitals with the vital sign machine on a Resident and then did not disinfect the vitals machine. Nurse #1 then entered another resident's room to obtain vitals with the contaminated vitals machine. On 4/14/26 at 7:43 A.M., the surveyor observed Nurse #1 on the Sweet Land Unit obtain vitals with the vital sign machine on a Resident and then did not disinfect the vitals machine. Nurse #1 then entered another resident's room to obtain vitals with the contaminated vitals machine. On 4/14/26 at 7:57 A.M., the surveyor observed Nurse #1 on the Sweet Land Unit obtain vitals with the same contaminated vital sign machine on a Resident and then did not disinfect the vitals machine. During an interview on 4/15/26 at 7:07 A.M., the Director of Nurses said she expects the vitals machine to be cleaned after each use to protect the residents from infection. 2b. The surveyor made the following observations on the [NAME] Unit on 4/14/26 at 7:47 A.M.: Nurse #7 was observed putting on a blood pressure cuff and taking vitals on a Resident who was sitting in the common room area. Nurse #7 removed the blood pressure cuff and did not sanitize the equipment. Nurse #7 then put the blood pressure cuff on a second resident in the common room area and took vitals. Nurse #7 removed the blood pressure cuff from the second Resident did not sanitize it. Nurse #7 then put the blood pressure cuff on a third resident in the common room area and took vitals. Nurse #7 removed the blood pressure cuff from the third Resident did not sanitize it. During an interview on 4/14/26 at 7:58 A.M., Nurse #7 said she should have cleaned and sanitized the blood pressure cuff in between residents and acknowledged that the blood pressure cuff could have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been contaminated after each use and it should have been cleaned. 2c. The following observations were made on the Wannalancit Lane Unit: a. On 4/13/26 at 8:13 A.M., the surveyor observed Nurse #2, remove a glucometer (machine used to obtain a blood sugar level), from inside the medication cart, along with glucometer test strips, lancets, gauze and alcohol swab, and brought the items into a resident room. -Nurse #2 placed the glucometer directly on the Resident's bedside table, which had papers, cups of water, and crumbs visible on top. -Nurse #2 took out the test strip, a lancet, gauze and an alcohol swab and placed these items directly on the bedside table. -Nurse #2 obtained the Resident's blood sugar, removed the test strip from the glucometer, and with the same hand that she had just removed the bloody test strip, Nurse #2 then placed the glucometer and used tests strip back onto the Residents bedside table, and removed her contaminated gloves. Without using hand sanitizer, Nurse #2 picked up the glucometer and used test strip with her bare hand and returned to the medication cart. -Nurse #2 then placed the glucometer directly on top of the medication cart. -Nurse #2 then donned a new pair of gloves to her contaminated hands and removed a white and red container from inside the medication cart. -Nurse #2 removed a Sani-Cloth Plus wipe from the container and wiped down the glucometer machine and immediately placed it directly back on top of the medication cart. -Nurse #2 removed her contaminated gloves and with her bare contaminated hand she picked up the glucometer machine and placed it back into the medication cart. Nurse #2 did not perform hand hygiene during the observation. Review of the Sani-Cloth Plus Germicidal Disposable wipes manufactures instructions indicated the following: All blood and other bodily fluids must be thoroughly cleaned from surface objects before disinfection by the germicidal wipe. Open, unfold first germicidal cloth to remove visible soil. Contact Time: Use second germicidal cloth to thoroughly wet surface. Allow surface to remain visibly wet for two (2) minutes, let air dry. During an interview on 4/13/26 at 9:02 A.M., Nurse #2 said she should not have placed the items on the bedside table and said she uses the wipes in the cart to clean the glucometer after use but did not wait the appropriate time for cleaning and said she should have sanitized her hands between glove use. During an interview on 4/13/26, at 1:13 A.M., Unit Manager #2 said staff must use approved bleach wipes to clean the glucometer machines after each use and said they must follow the guidelines for disinfecting equipment. Unit Manager #3 said nurses must wash their hands before and after glove use and not touch contaminated equipment with their bare hands. 2d. On 4/14/26 at 8:27 A.M., the surveyor observed Nurse #2, removed a glucometer machine from (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inside the medication cart, along with glucometer test strips, lancets, gauze and alcohol swabs, and placed them directly on top of the medication cart. -Nurse #2 obtained the Resident's blood sugar, removed the test strip from the glucometer, with the same hand that she had just removed the bloody test strip, Nurse #2 then placed the glucometer and used tests strip back on top of the medication cart, and removed her contaminated gloves. Without using hand sanitizer, Nurse #2 picked up the glucometer and used test strip with her bare hand and moved the items to a different location on top of the medication cart. -Nurse #2 did not disinfect the glucometer machine and it remained on top of the medication cart. -Nurse #2 did not perform hand hygiene and was observed pushing the Resident in a wheelchair down to the dining room. During an interview on 4/14/26 at 8:29 A.M., Nurse #2 said she should not have placed the contaminated items on top of the medication cart and said she should have performed hand hygiene. During an interview on 4/14/26 at 3:02 P.M., the Director of Nursing (DON) said glucometers must be disinfected with approved bleach wipes and cleaning must be done after each use and stored appropriately. The DON said staff must wash their hands before and after glove use and not touch contaminated equipment. 3. Review of the facility policy titled Hand washing, dated as revised 2/26, indicated the following:-Purpose: to prevent the spread of infection.-You should always wash your hands in the following instances: after handling soiled linen, dirty utensils or soiled dressings, after removing gloves. During an observation on 4/14/26 at 7:52 A.M., on the Belvidere Unit, the surveyor observed a housekeeping staff member enter a resident room on the unit. The housekeeping staff member put on gloves, emptied the trash in the room and bathroom then cleaned the bathroom and mopped the floor. At 8:01 A.M., the housekeeping staff exited the room, removed her gloves and put up a wet floor sign. She then pushed her housekeeping cart and a trash barrel down the hall. Without performing hand hygiene, she put on a new pair of gloves and then mopped the end of the hallway. The housekeeping staff member then removed her gloves and without performing hand hygiene, pushed her cart and barrel down the hallway outside of another resident's room. At 8:05 A.M., without performing hand hygiene, the housekeeping staff member then put on another pair of gloves and entered the resident room to clean and empty trash. During an interview on 4/15/26 at 9:42 A.M., the Director of Nurses said that all staff should be performing hand hygiene between glove changes and in between entering and exiting resident rooms. During an interview on 4/15/26 at 9:59 A.M., The Infection Preventionist said that she would expect that hand hygiene is performed between glove changes and when coming in and out of a resident's room.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure staff treated residents in a dignified manner for two Resident (#73 and #4) out of a total sample of 40 Residents. Specifically,1. For Resident #73 the facility failed to ensure the Physician did not dictate a history and physical at the nursing station in the presence of 14 residents, a laundry aide, a housekeeper, and a nurse. 2. For Resident #4 the facility failed to ensure the Hospice Nurse did not assess the Resident in a common area. Findings include: Review of the facility policy titled, Residents Rights - Promoting and Maintaining Resident Dignity, dated as revised 4/26/23, indicated that it is the practice of this home to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 12. Maintain resident privacy. 1. Resident #73 was admitted to the facility in March 2026 with diagnoses including urinary tract infection, hypotension, and dementia. Review of the Minimum Data Set assessment, dated 3/4/26, indicated Resident #73 had a severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 2 out of a possible 15. On 4/13/26 between 10:53 A.M., through 11:02 A.M., the surveyor observed Physician #1 at the [NAME] nursing station, dictating Resident #73's history and physical loudly in the open at the nursing station in the presence of 14 residents, a laundry aide, a housekeeper, and a nurse. During an interview on 4/14/26 at 9:25 A.M., Nurse #5 said that Physician #1 always dictates his notes at the nursing station. During an interview on 4/14/26 at 11:43 A.M., Resident #73's Family Member #1 said that she and her sisters find it important to protect Resident #73's health information and she would like health concerns discussed privately and not in an open area. During an interview on 4/14/26 at 4:24 P.M., the Director of Nursing (DON) said that Physician #1 should not be dictating history and physicals at the nursing station in front of other residents and non-essential staff. The DON said that when Physician #1 is dictating notes at the nursing station the nursing staff on the unit should request Physician #1 go out back into the office to maintain Resident #73's dignity. During an interview on 4/15/26 at 8:51 A.M., the Medical Director said that Physician #1 should have dictated the Resident's history and physical in a private area. The Medical Director said that dignity and privacy should be protected for all Residents. 2. Resident #4 was admitted to the facility in July 2024 with diagnoses including dementia, anxiety, and post-traumatic stress disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/12/26, indicated that Resident #4 had a severe cognitive impairment as evidenced by a BIMS score of 3 out of a possible 15.Review of Resident #2's plan of care related to hospice, dated as revised on 2/23/26, included the following goal: I will appear at peace, be treated with dignity and comfortable daily by review date. The surveyor made continuous observations on 4/14/26 from 11:46 A.M. through 11:50 A.M. of the Hospice Nurse perform an assessment of Resident #4 in a common area on the [NAME] Unit. The Hospice Nurse obtained vital signs, listened to Resident #4's lungs and heart, and checked Resident #4's feet for edema. During this observation there were nine residents in the vicinity, two licensed nurses, and a family member who walked by during the Hospice Nurse's assessment. During an interview on 4/14/26 at 12:02 P.M., Nurse #5 said the Hospice Nurse typically does her assessment in common areas, but she shouldn't. During an interview on 4/14/26 at 12:27 P.M., the Hospice Nurse said that she assessed Resident #4 in a common area, and she said she should have brought Resident #4 back to his/her room to do the assessment, but she did not. During an interview on 4/14/26 at 4:19 P.M., the DON said that the Hospice Nurse should have assessed Resident #4 in a private location to maintain his/her dignity. The DON said that direct care staff could have asked the Hospice Nurse to assess Resident #4 in a private location.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record review and interview, the facility failed to develop and implement individualized care plans related to pacemakers for two Residents (#130 and #172) out of a total of 40 sampled Residents and 13 total residents with cardiac pacemakers.Findings include: Review of the American Heart Association article titled Living with your Pacemaker, dated 10/29/24 indicated: Before you leave the hospital, your health care team will talk to you about problems to watch out for and things to avoid. You'll also receive a card with information about your pacemaker, when it was placed, its settings, your health care professional and the hospital. You should always carry this card with you. Make sure you understand your pacemaker's programmed lower and upper heart rate. Talk to your health care professional about the maximum acceptable heart rate above your pacemaker rate. Review of the facility's policy titled Use of Pacemaker policy dated 3/25/24 indicated:All residents with a pacemaker will be monitored according to standard protocol and plan of care. All documentation about the pacemaker will be placed in the residents' chart and part of their permanent record. Pacemaker checks will be performed as ordered by the physician. 1. Resident #172 was admitted to the facility in June 2025 with diagnoses including legal blindness, macular degeneration and presence of cardiac pacemaker. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #172 was cognitively intact as evidenced by a score of 15 out a possible 15 on the Brief Interview for Mental Status exam. During an interview on 4/15/26 at 7:12 A.M., Resident #130 said that he/she has a pacemaker and that the staff monitor his/her vitals. Resident #130 said that his/her family member keeps his/her pacemaker transmitter and brings it in on a set schedule made by the cardiologist to transmit the pacemaker signal to their office. Review of Resident #172's physician orders failed to include information related to Resident #172's pacemaker. Review of Resident #172's care plans indicated: Focus: The resident has a pacemaker, 6/11/25Interventions: Monitor/document/report PRN (as needed) any s/sx (signs symptoms) of infection at incision site: redness, drainage, warmth. The care plan included only one intervention and failed to include individualized information related to Resident #172's pacemaker including make, model, and pulse rate. During an interview on 4/14/26 at 9:47 A.M., Nurse #6 said that for residents with pacemakers, nurses check their heartrates and if it seems irregular or elevated, they alert the physician. Nurse #6 said that he/she wasn't sure about pacemaker settings and where that information would be documented. During an interview on 4/15/26 at 7:21 A.M., Unit Manager #3 said that residents with pacemakers have care plans identifying they have pacers including information related to the pacemaker make and model. Unit Manager #3 said that nurses monitor pulse rates, but the set rate of the pacemaker is monitored by the resident's cardiologist. During an interview on 4/15/26 at 7:28 A.M., the Director of Nursing (DON) said that the facility usually does not get information related to settings for residents with pacemakers. The DON said that staff would monitor pulse rates and if it's out of a normal range then nursing would notify the physician. The DON said that residents with pacemakers should have care plans in place that are individualized with information related to the resident's pacemaker. 2. Resident #130 was admitted to the facility in January 2025 with diagnoses including atrial fibrillation, epilepsy and presence of cardiac pacemaker. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #130 was cognitively intact as evidenced by a score of 15 out of a possible 15.Review of Resident #130's physician orders failed to indicate orders related to monitoring Resident #130's pacemaker or pulse setting.Review of Resident #130's care plans indicated: Focus, 1/20/25: The resident has a pacemaker r/t (related to) Atrial fibrillation. Interventions: Follow up with cardiology. Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of altered cardiac output or pacemaker malfunction: dizziness, syncope, difficulty breathing. Pacemaker checks as ordered per house protocol and document in (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chart: heart rate, rhythm, battery check.The care plan failed to include individualized information related to the make, model and pulse setting for Resident #130's pacemaker. During an interview on 4/15/26 at 7:21 A.M., Unit Manager #3 said that residents with pacemakers have care plans identifying that they have pacers including information related to the pacemaker make and model. Unit Manager #3 said that nurses monitor pulse rates, but the set rate of the pacemaker is monitored by the resident's cardiologist. During an interview on 4/15/26 at 7:28 A.M., the Director of Nursing (DON) said that the facility usually does not get information related to settings for residents with pacemakers. The DON said that staff would monitor pulse rates and if it's out of a normal range then nursing would notify the physician. The DON said that residents with pacemakers should have care plans in place that are individualized with information related to the resident's pacemaker.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide care in accordance with professional standards of practice for two Residents (#96, #78) out of a total of 40 sampled residents. Specifically:1.For Resident #96 the facility failed to a. implement physician's orders for booties to bilateral lower extremities while in bed and b. implement orders for bilateral fall mats on the floor while the Resident was in bed.2. For Resident #78 the facility failed to administer medications in accordance with professional standards. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019 indicated the following: - The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1a. Resident #96 was admitted to the facility in April 2022 with diagnoses that included senile degeneration of the brain, major depressive disorder, dysphagia and low back pain. Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating severe cognitive impairment. The MDS failed to indicate that rejection of care was exhibited by the Resident. The MDS further indicated that the Resident was dependent on staff for assistance with activities of daily living. Review of physician's orders indicated the following: Booties while in bed at all times, dated 5/22/24. Review of the Braden Assessment for Predicting Pressure Ulcer Risk Assessment, dated 3/20/26, indicated a score of 11, indicating moderate risk for skin breakdown and pressure ulcer development. On 4/13/26 at 7:40 A.M., the surveyor observed the Resident sleeping in bed. The Resident's bilateral heels were in direct contact with the mattress. The residents' booties were observed in a chair across the room. On 4/14/26 at 6:48 A.M., 7:58 A.M., 9:01 A.M. and 10:03 A.M., the surveyor observed the Resident sleeping in bed. The Resident's bilateral heels were in direct contact with the mattress. The surveyor observed two booties across the room on the floor. Review of the April 2026 Treatment Administration Record indicated that the booties had been in place since 4/1/26 every shift as ordered. The TAR failed to indicate any refusals to wear booties while in bed. Review of Nursing progress notes since 4/1/26 failed to indicate any refusals to utilize booties while (continued on next page)

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	225515	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D'Youville Senior Care	981 Varnum Avenue Lowell, MA 01854

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in bed. During an interview on 4/14/26 at 1:44 P.M., Unit Manager #2 said that booties should be in place and staff should be implementing physician's orders as indicated. She said she does not know if Resident #96 to refuse care, but if he/she did then it should be documented in the medical record. During an interview on 4/14/26 at 1:50 P.M., Certified Nurse Aide (CNA) #8 said that when she got the Resident up this morning he/she did not have booties on but maybe the night shift took them off to change the Resident and forgot to put them back on. She further said that the Resident should be wearing the booties if he/she is in bed. During an interview on 4/14/26 at 2:32 P.M., the Director of Nurses (DON) said that she would expect that staff are following physician's orders as written. She said that staff should not sign off something that they did not do and that if a resident refused any treatment, then it should be documented in the medical record. b. Review of physician's orders indicated the following: Floor mats to both sides of bed at all times in bed, dated 8/16/23. On 4/13/26 at 7:40 A.M., the surveyor observed the Resident sleeping in bed. There was a fall mat to the right side of the Resident's bed. No fall mat was seen on the left side of the bed or anywhere in the Resident's room. On 4/14/26 at 6:48 A.M., 8:08 A.M. and 10:03 A.M., the surveyor observed the Resident sleeping in bed. There was a fall mat to the right side of the Resident's bed. No fall mat was seen on the left side of the bed or anywhere in the Resident's room. Review of the April 2026 Treatment Administration Record (TAR) indicated every shift since 4/1/26 bilateral fall mats were in place. During an interview on 4/14/26 at 1:44 P.M., Unit Manager #2 said that bilateral fall mats should be in place and staff should be implementing physician's orders as indicated. She said staff should not be documenting it was implemented in the medical record if it was not. During an interview on 4/14/26 at 1:50 P.M., CNA #8 said that the Resident only uses one fall mat on the right side of his/her bed and that he/she does not have a second mat in the room. During an interview on 4/14/26 at 2:32 P.M., the DON said that she would expect that staff are following physician's orders as written. She said that staff should not sign off something that they did not do and if a resident refused any treatment, then it should be documented in the medical record. 2. For Resident #78 the facility failed to ensure medications were administered in accordance with standards of nursing practice. Resident #78 was admitted to the facility in June 2026 and has diagnoses that include but are not limited to type 2 diabetes with diabetic chronic kidney disease, and dependence on renal dialysis. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #78 scored 15 out of 15 on the Brief Interview for Mental Status which indicated the Resident is cognitively intact. Further, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the MDS indicated the Resident is on dialysis. During an observation and interview on 4/13/26 at 9:44 A.M., Nurse #4 was standing at the medication cart outside of Resident #78's room. Resident #78 was observed in his/her room, in bed, holding a medication cup with three pills inside. Resident #78 said 'I take them (medications) one at time, until these last three small pills, I take them at once'. As Resident #78 took the medication there was no nursing staff in or near the vicinity of Resident #78. Review of Resident #78's active physician's orders failed to indicate Resident #78 has an order to administer his/her own medication. Review of Resident #78's Care Plans failed to indicate Resident #78 had a care plan to self-administer his/her own medications. During an interview on 4/14/26 at 12:34 P.M., Nurse #4 said when a nurse administers medication to a resident they are to stay and make sure the resident takes the medication as ordered. Nurse #4 said medication should not be left with a resident unless they have an order and are assessed to self-administer. Nurse #4 said she prepared and administered Resident #78's medication on 4/13/26 and should not have left the Resident until he/she finished taking all his/her medication. During an interview on 4/14/26 at 5:08 P.M., the Director of Nursing said the nurses are not to leave a resident with medications but could monitor from the doorway. The DON said it is not policy for the nurse to leave a resident before they finish taking all their medications, The DON said the nurse should stay with the Resident to ensure they take the medications entirely.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure standards of quality of care for the treatment of a pressure ulcer for one Resident (#124), who has a pressure ulcer, out of a total sample of 40 residents. Specifically, the nursing staff failed to ensure the intervention of the air mattress on Resident #124's bed was implemented in accordance with Resident #124's weight to assist with prevention and healing of the pressure ulcer. Findings include: Review of the manufacturer's operation manual titled, Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System, not dated indicated the following: Indications, the Med Aire Melody Alternating Pressure and Low Air Loss Mattress Replacement System, is indicated for the prevention and treatment of any and all stage pressure ulcers management program. Operating Instructions Step 6 Determine the patient's weight and set the control knob to that weight setting on the control unit. Resident #124 was admitted to the facility in October 2025 and has diagnoses that include atrial fibrillation, adult failure to thrive, peripheral vascular disease, moderate protein calorie malnutrition, and unspecified dementia and pressure ulcer of sacral region. Review of the most recent Minimum Data Set (MDS), dated [DATE] indicated Resident #124 scored 0 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as severely cognitive impaired. Further, the MDS indicated Resident #124 is at high risk for developing pressure ulcer/injuries and has 1 unstageable ulcer/injury. During the survey the surveyor made the following observations: -On 4/13/26 at 8:01 A.M., Resident #124 was in bed. An air mattress control unit was affixed to the footboard and was set to above 350 lbs. (pounds), firm. A piece of tape on the unit read ?keep setting here with the arrow pointing between the 120 lbs. and 150 lbs. Resident #124's eyes closed and did not participate in an interview and was observed to be frail and slight in stature. -On 4/13/26 at 11:03 A.M., and 1:08 P.M., Resident #124 had his/her eyes closed and resting on an air mattress with the control unit set above 350 lbs. -On 4/14/26 at 8:04 A.M., and 10:37 A.M., Resident #124 was in bed resting on an air mattress with the dial set at over 350 lbs. Resident #124's eyes were closed and he/she was unable to participate in an interview. During an interview on 4/14/26 at 10:38 A.M., Nurse #4 said Resident #124 is now on IV (intravenous) antibiotics for a wound infection and that she was in the Resident's room a short time ago to hang the IV medication. On 4/14/26 at 10:56 A.M., Two surveyors observed Resident #124 resting in bed with his/her eyes closed. The control unit of the air mattress was set to above 350 lbs. Review of Resident 124's clinical record indicated Resident #124 weighed 120.0 pounds dated 4/3/26. This weight is not consistent with the setting of the air mattress control unit observed multiple times. Review of Resident #124's physician's orders indicated the following: -COCCYX/SACRAL WOUND: cleanse wound with wound cleanser apply Santyl to wound bed and lightly pack undermining and wound bed with calcium alginate using a q tip and cover with border foam dressing every day shift 3/31/26-Air mattress with bolsters check placement and functions every shift dated 12/19/25. Review of the Treatment Administration Record for April 2026 indicated the nursing staff documented by signing off on the TAR the following: Air Mattress with Bolsters, Check placement and function every shift start date 12/19/25. On 4/13/26 all three shifts and 4/14/26 for 1 shift. During an interview and observation on 4/14/26 at 3:32 P.M., Nurse #4 said Resident #124 does not get up which could contribute to his/her risk for developing pressure ulcers. Nurse #4 said she did not know how long Resident #124 had a wound on his/her sacrum. Nurse #4 said interventions to prevent and treat pressure ulcers include repositioning, providing the treatment as ordered, diet including vitamin protocol and the use of the air mattress. Nurse #4 said the air mattress should be set to the Resident's weight and is used to assist with the healing of the wound. Nurse #4 and the surveyor went to Resident #124's room and observed the air mattress control unit set to over 350 lbs. Nurse #4 said the air mattress should be set at Resident #124's weight and not be set at 350 lbs., and that Resident #124 is not 350 lbs. and is small. During an interview and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 4/14/2026 3:40 P.M. Unit Manager #2 and the surveyor went to Resident #124's room. Unit Manager #2 said the air mattress in use is to be set to the Resident's weight and not at set 350 lbs. Unit Manager #2 said the mattress is too firm and would put more pressure on Resident #124's pressure ulcer which could impact healing. During an interview and observation on 4/14/26 at 3:50 P.M., the Director of Nursing said it is not policy to put a sticker on the air mattress and said the air mattress should be set to a resident's weight. The DON said having the air mattress too firm at 350 lbs., for Resident #124 could impact the healing of the pressure ulcer. The DON said Resident #124 is unable to say how the air mattress would feel.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to provide foot care and treatment in accordance with professional standards of practice for one Resident (#189) out of a total sample of 40 residents. Specifically, the facility failed to ensure Resident #189 was scheduled to be seen by the podiatrist since admission to the facility resulting in thickened, yellow, long-curling toenails.Findings include:Review of the facility policy titled Diabetic Foot Care, dated and revised April 2016, indicated the following: - It is the policy of the facility of the facility to provide appropriate foot care to all diabetic residents/patients.- Do not cut toenails of any Resident/patient. Notify Podiatry if immediate intervention needed. Resident #189 was admitted to the facility in October 2025 with diagnoses including unspecified dementia and type 2 diabetes mellitus with diabetic polyneuropathy.Review of Resident #189's most recent Minimum Data Set Assessment, dated 1/29/26, indicated that the Resident was unable to complete the Brief Interview for Mental Status exam indicating severe cognitive impairment. Further review of the MDS indicated that the Resident does not reject evaluation or care and has diabetes mellitus.During an interview on 4/13/26 at 10:58 A.M., Resident #189's Resident Representative (RR) told the surveyor that the facility has not taken care of Resident #189's toenails and they are very long. Resident #189's RR then said she has asked the facility multiple times for the Resident's toenails to be cut because Resident #189 has diabetes and she does not want the Resident to get an infection. Resident #189's RR then removed the Resident's socks revealing the Resident's toenails to be thickened and yellow in appearance as well as multiple toenails being roughly half an inch in length and starting to curl inwards towards the bottom of the feet.Review of Resident #189's physician's order, dated 10/28/25, indicated the following: Consultation Services: Audiology, Dental, Ophthalmology, Podiatry and Psych.Review of Resident #189's care plans failed to indicate a care plan relating to podiatry services or toenail care.During an interview on 4/14/26 at 11:45 A.M., another RR for Resident #189 said his/her family have been trying to request podiatry to come cut his/her nails for months and they have not come in.During an interview on 4/14/26 at 11:55 A.M., Unit Manager #4 said when a Resident needs an outside service such as Podiatry, the facility will fax over a consent form to the consultation service upon admission to the facility so the Resident can be scheduled to be seen. Unit Manager #4 said she faxed over a Podiatry request form yesterday because she said she heard the family member requesting Podiatry services to the surveyor. Unit Manager #4 said she believed she faxed over a request form in the past, but she heard no response and she said she should have followed up with them. Unit Manager #4 then showed the surveyor a chart of Residents needing outside Consultation service and under the podiatry section was Resident #189, Unit Manager #4 then confirmed he/she has not been seen. Unit Manager #4 said she was not aware of how long and thick Resident #189's toenails were and it could be an infection risk since the Resident has type 2 diabetes. Unit Manager #4 said the Certified Nursing Assistants (CNAs) should be telling nursing staff when they notice long toenails and then the nursing staff should be telling her so she can follow up.During an interview on 4/14/26 at 12:11 P.M., Nurse #8 said if a Resident needs podiatry services, then the facility will fax a cover sheet to the doctor's office and then they will be scheduled to be seen. Nurse #8 then said if CNAs notice long toenails while performing care they should be telling a nurse. Nurse #8 said she has never been made aware of Resident #189's long toenails.During an observation on 4/14/26 at 12:18 P.M., Resident #189's RR, Unit Manager #4, Nurse #8 and CNAs #1 and #2 observed Resident #189's toenails with the surveyor. Unit Manager #4 and Nurse #8 said Resident #189's toenails are curling and very long and they were not aware. CNA's #1 and #2 said they would have told a nurse if they realized how long the Resident's toenails were, they both said they were not aware. Resident #189's RR said when she takes off Resident #189's socks that fabric always sticks to the nails and she has to clean them.During an interview on 4/14/26 at 1:17 P.M., Nurse Practitioner #1 said Resident #189 should have been seen by Podiatry services since he/she has diabetes and is at risk of infection. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Practitioner #1 said she was not made aware that Resident #189's toenails were very long and curling.During an interview on 4/14/26 at 1:45 P.M., the Director of Nursing (DON) said Resident #189 was scheduled for Podiatry services as of yesterday but was unaware that the resident had not been since admission. The DON then provided the surveyor the podiatry request form for Resident #189 dated 4/13/26.

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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 observation, record review and interview, the facility failed for one Resident (#9), out of a total sample of 40 residents, to ensure acceptable perimeters of nutritional standards of practice were implemented when Resident #9 experienced a significant weight loss. Specifically, the facility failed to ensure Resident #9, who is assessed as being at risk of malnutrition and experienced a significant weight loss of 5.1% in less than a month, had the weight verified to determine/verify the significant weight loss, and when the reweigh occurred Resident #9 had continued weight loss of a total body weight loss of 6.44 % in less than 30 days, resulting in a delay to intervene to abate further weight loss. Findings include: Review of the facility's policy, titled Weight Monitoring, with an effective date of 11/27/24 indicated the following: Based on the resident's comprehensive assessment, the home will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Compliance Guidelines: 5. A weight monitoring schedule will be developed upon admission for all residents: a. weights should be recorded at the time obtained. Mathematical rounding should be utilized, b. newly admitted residents-monitor weight weekly, c. Residents with weight loss-monitor weights weekly, d. If clinically indicated-monitor weight daily, e. all others-monitor weight monthly. 6. Weight analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a 5% change in weight in 1 month (30 days) b 7.5% in weight in 3 months (90 days) c 10% change in weight in 6 months (180 days) Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. e. The Registered Dietician or Dietary Manager should be consulted to assist with intervention; actions are recorded in the nutritional progress notes. ˆ Resident #9 was admitted to the facility in March 2025 and has diagnoses that include spinal stenosis, type 2 diabetes mellitus, and dysphagia.ˆ Review of the most recent comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 scored 15 out of 15 on the Brief Interview for Mental Status indicating he/she as having intact cognition. Further, the MDS indicated Resident #9 is 72 inches (6 feet) in height and weighs 126 pounds, requires set-up and clean-up assist with eating. Review of the Care Area Assessment of the MDS indicated Resident #9 triggered for nutritional considerations and to proceed to care plan to avoid complications and minimize risks related to nutritional status. ˆ During an observation and interview on 4/13/26 at 9:17 A.M., the surveyor observed Resident #9 to be frail and slight in stature. Resident #9 said he/she just had his/her breakfast. Resident #9 said when he/she first came (to the facility) just over a year ago he/she was weighed weekly and then monthly and never varied more or less than a fraction of a pound. Resident #9 said that last week he/she was weighed on the 8th (April) and lost 7 pounds and he/she has no idea why and thinks something is wrong. ˆ Review of Resident #9's weights in the clinical record indicated the following: -3/4/26 125.6 lbs (pounds).-3/19/25 125.6 lbs. -4/9/26 119.2 lbs. ˆ No weights dated after 4/9/26 were in the clinical record. ˆ On 3/4/26, Resident #9 weighed 125.6 lbs. On 4/9/26, Resident #9 weighed 119.2 lbs. which is a -5.1% loss and meets the criteria of a significant weight loss. ˆ Review of Resident #9's physician's orders indicated the following: -No added salt (3-4 gram) House consistent carb diet, ground texture, thin consistency, allow bacon dated 7/25/25. -House supplement- diabetic 2 times a day dated 7/28/25 prefers chocolate flavor. -At risk for Malnutrition d/t (due to) BMI (body mass index) underweight dated 3/17/25. ˆ ˆReview of Resident #9's care plan focus, Nutritional Status: I have nutritional problem or potential problem due to: -At risk for malnutrition 2/2 (due to) underweight BMI, DM (diabetes mellitus). ˆ -Underweight BMI 04/2026 5% significant weight loss revision on 4/14/26, after the surveyor brought Resident #9's weight loss to the attention of facility staff. Goal: I will maintain adequate nutritional status by showing no signs or symptoms of malnutrition: and I will consume at (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	least 50% of at least 2 of my meals daily until my next review date initiated 3/14/25. ˆ Review of the Mini Nutrition Assessment Summary note dated 3/16/26 indicated the following: Resident (#9) has no decrease in food intake in the last 3 months. Weight loss between 1 and 3 kg (2.2 and 6.6 lbs.) in the last 3 months. Able to get out of bed/chair but does not go out. Has not suffered psychological stress or acute disease in the past 3 months. Resident has no psychological problems. Resident BMI is less than 19. Mini Nutritional Score: the score is 9.0 (at risk of malnutrition) 12-14 points: Normal nutritional status 8-11 points: At risk of malnutrition 0-7 points: Malnourished ˆ Review of the Nutrition Comprehensive Assessment, V 1.0 dated 3/16/26 indicated: most recent weight 3/4/26 125, 72 inches. Previous weights 10/9/25 127.6 (Pounds), 12/4/25 124.4, 2/5/26 127.2, 3/4/26 125.6. BMI: 17.0 Goal weight/UBW (usual body weight) was blank. Nutrition summary: Resident presents for annual review. Continues to tolerate diet a/o (as ordered). Appetite remains unchanged. Weight stable, free of sig (significant) changes. Continues on house supplement-diabetic 2x a day b/t (between meals) Nutritional Diagnosis at risk for malnutrition,ˆexplanation of risk for malnutrition underweight, DM (diabetes). During an observation and interview on 4/14/26 at 12:29 P.M., Resident #9 was in his/her bed and appeared frail and with a slight, thin stature. Resident #9 said he/she has not talked with anyone (staff) about his/her 7-pound weight loss and said he/she is concerned about it. ˆ ˆ During an interview on 4/14/26 at 3:10 P.M., Nurse #15 said if a resident has a weight change up or down a reweigh is obtained to verify the weight. Nurse #15 said the reweight is verified by the Certified Nursing Assistant (CNA) and Nurse together, and the reweigh should be done as soon as possible after the weight change. ˆ During an interview on 4/14/26 at 3:13 P.M., CNA #9 said Resident #9 is weighed monthly and the weight is put on paper then the Unit Manager enters the weight into the computer.ˆ ˆ During an interview on 4/14/26 at 3:20 P.M., Unit Manager #2 said she enters the weights that are obtained by the CNAs, usually by Wednesdays, into the medical record. Unit Manager #2 said she compares the weights and will request a reweigh if there is a weight change of about 5 lbs. or looks funny from the previous weight. Unit Manager #2 said she was not aware of Resident 9's weight loss/change and reviewed the weight record and said he/she has lost about 6-7 pounds. Unit Manager #2 said there was no warning on the weight record and reviewed the progress notes and said there was no note indicating Resident 9's significant weight loss. Unit Manager #2 said she missed the weight loss, and she would get a reweigh now and would inform the NP (nurse practitioner) of the over 5% weight loss. ˆ ˆ On 4/14/26 at 3:24 P.M., the surveyor observed Unit Manager #2 walking Resident #9 to the scale. At 3:28 P.M., Resident #9 and Unit Manager #2 were observed walking back from the scale. Resident #9 said to the surveyor apparently, I am now 117 lbs., I have lost more weight. Unit Manager #2 said Resident #9 weighed 117. 6 lbs. ˆ Review of Resident #9's weights indicated that on 4/9/26, Resident #9 weighed 119.2 lbs. On 4/14/26, Resident #9 weighed 117.6 lbs. which is a -1.34% loss. Resident #9 experienced a significant total body weight loss of 6.40 %, in 27 days.ˆ ˆ During an interview on 4/14/26 at 4:53 P.M., the Director of Nursing (DON) said typically it is the Unit Mangers that review the weights on a weekly basis and are to report any significant weight loss, so the resident can be reviewed by the team at the client at-risk meeting. The DON said they attempt to obtain monthly weights by Wednesday so if reweights are needed they can be obtained to verify a weight change. The DON said the reweight should be competed the next day. She said the floor nurses are not reviewing weights and that a reweight should have been obtained the next day, but the Unit Manager was off on Friday 4/10/26, and it was not obtained on Monday 4/13/26. The DON said any significant weight changes are to be reported to the provider and the team including the dietician could collaborate on a plan. The DON said she would need to review Resident #9's specific weight changes. Review of Resident #9's progress notes dated 4/9/26 through 4/13/26 failed to indicate any notes regarding Resident #9's significant weight loss. Review of the progress note dated 4/14/26 at 18:50 22 (6:50 P.M.) indicated weight loss reported to NP. New orders to increase diabetic supplements to TID (three times a day) and check CBCWD CMP TSH free T4 on 4/25/25 (laboratory blood tests). This note was entered after the surveyor brought Resident #9's (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	significant weight loss to Unit Manager #2's attention. During an interview on 4/15/26 at 9:48 A.M., Registered Dietician #1 said resident weights are obtained according to the physician's order and nutritional assessment. RD #1 said if there is a weight difference of 3 pounds the nurse should do a reweigh. The RD said the reweigh should be obtained as soon as possible to ensure the weight is accurate and so the NP/MD (doctor) RD, and resident or health care proxy are notified, and the plan of care plan can be reviewed and updated. The RD reviewed Resident #9's recorded weights and said he/she had a significant weight loss and is at risk of malnutrition. The RD said it is clinical practice to verify and assess significant weight loss in a resident who is at risk of malnutrition. The RD said the reweigh was not timely and said the Resident had continued trending unplanned weigh loss.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Midline Catheter (A midline catheter is an IV longer than 3 inches and it is inserted into the upper arm through the basilic, brachial or cephalic vein, with the catheter tip located at the or near the level of the axilla), consistent with professional standards of practice for one Resident (#124), out of three reviewed Resident's with an IV catheter. Specifically, for Resident #124, the facility failed to ensure that the midline insertion site was able to be visualized.Findings include:Resident #124 was admitted to the facility in December 2023 with diagnoses that included adult failure to thrive, peripheral vascular disease, dementia, stage three pressure of the sacral region. Review of Resident #124's most recent Minimum Data Set (MDS) assessment, dated 3/20/26, indicated he/she was assessed to have severe cognitive impairments. Review of Resident #124's physician ordered dated, 3/12/26, indicated Midline catheter Monitor IV insertion site every shift (Signing indicates: no s/sx (signs/symptoms) of any IV complications present; dressing is c/d/i (clean/dry/intact); catheter, tubing, and needleless connectors properly present; and secured, no s/sx of infection If complication found, document in progress note. Notify provider. Review of Resident #124's April 2026 Treatment Administration Record (TAR) indicated from 4/9/26 through 4/13/26 indicated nursing signed off the Monitor IV insertion site every shift order as administered. On 4/14/26 at 11:54 A.M., the surveyor observed a midline IV in the Resident's right arm receiving IV antibiotics. The insertion site of the IV was covered with gauze unable to be visualized, blood could be seen around the gauze. The midline dressing was dated 4/9/26. During an interview and observation on 4/14/26 at 11:55 A.M., Unit Manager #2 said Resident #124 has a midline because he/she is on IV antibiotics for a wound infection. The surveyor said the nurses cannot visualize the site for signs and symptoms for infection if the site is covered in gauze. During an interview and observation on 4/14/26 at 11:57 A.M., Nurse #4 said Resident #124's midline insertion site is unable to be visualized and nursing staff would not be able to assess if there was an infection at the insertion site. During an interview on 4/15/25 at 7:07 A.M., the Director of Nurses (DON) said nurses should not cover the insertion site of a midline with gauze. The DON said the site would not be able to be assessed if it is covered in gauze and then nursing could not tell if there was an issue at the site.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to implement standards of care related to dialysis for the 1 Resident (#78), out of 2 residents reviewed for dialysis, out of a total sample of 40 residents. Specifically, for Resident #78 the staff failed to ensure the dialysis order was signed off in accordance with the dialysis treatment schedule. (Hemodialysis is a machine that removes blood from the body, filters it through a dialyzer (artificial kidney) and returns the clean blood to the body). Findings include: Review of the facility policy titled Dialysis, revision date 4/2021 indicated this home will provide necessary care and treatment, consistent with professional standards of practice, physician's orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of resident receiving hemodialysis.14, The home will ensure that the physician's orders for dialysis include: b. The dialysis schedule. Resident #78 was admitted to the facility in June 2026 and has diagnoses that include but are not limited to type 2 diabetes with diabetic chronic kidney disease, and dependence on renal dialysis. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #78 scored 15 out of 15 on the Brief Interview for Mental Status which indicates the Resident is cognitively intact. Further, the MDS indicated Resident #78 is on dialysis. During an observation and interview on 4/13/26 at 9:44 A.M., Resident #78 said he/she goes out to dialysis on Tuesdays, Thursdays and Saturdays, and pulled down the front of his/her shirt revealing a covered catheter with 2 lumens below the dressing, and then pointed to his/her left arm and said I just got this, referring to a left arm fistula. Review of Resident #78's physician's orders indicated the following: Patient on dialysis at (provider's name) M (Monday) W (Wednesday) F (Friday), transport by (provider's name) pick up at 6 A.M., this is a temporary schedule expected to change mid-March, date 2/22/26. Review of the March 2026, Medication Administration Record (MAR) indicated the nurses signed off and documented on the following order (Patient on dialysis at (provider) on Monday, Wednesday and Friday, transport by (provider) pick up at 6am. every shift (this is a temporary schedule expected to change mid/March, start date 2/22/26. Review of the April 2026 MAR indicated the nurses signed off and documented on the following order (Patient on dialysis at (named Provider) on Monday, Wednesday and Friday, transport by (named provider) pick up at (6am) every shift (this is a temporary schedule expected to change mid/March, start date 2/22/26. Review of the communication book that accompanies Resident #78 to dialysis and Resident #78's dialysis calendar indicated Resident #78 resumed a Tuesday, Thursday, Saturday, dialysis treatment schedule on March 17, 2026. The physician's order therefore failed to have the appropriate dialysis treatment schedule for Resident #78, which continued to be documented and signed off on by the nursing staff. During an interview on 4/13/26 at 2:29 P.M. Resident #78 said he/she goes out to dialysis Tuesdays, Thursdays and Saturdays, but went Monday, Wednesday and Saturdays for a few weeks and it has been back to Tuesday, Thursday and Saturday now for a few weeks now. Nurse #13 who was in Resident #78's room, said the dialysis schedule is in the physician's orders and should be Tuesdays, Thursdays and Saturdays. During an observation and interview on 4/13/26 2:46 P.M., Nurse #13 reviewed the physician's orders and said the order is not consistent with the Resident's dialysis schedule and it should be. Unit Manager #2 said the physician's order and the actual treatment should be the same. Unit Manager #2 said nurses are to read and verify orders and should have identified the orders were not in accordance with the dialysis schedule and should not have just been signed off.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one Resident (#28) out of a total sample of 40 residents, was seen by the Physician at least every 30 days for the first 90 days after admission and at least every 60 days thereafter, with alternate visits by a Nurse Practitioner (NP) as indicated. Findings include:Resident #28 was admitted to the facility in March 2025 with diagnoses that included dementia and major depressive disorder. Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status score of 00 out of 15, indicating severe cognitive impairment.Review of the medical record indicated Physician visit notes (from Physician #3), dated 3/17/25, 10/11/25 and 2/27/26.On 4/14/26 at 12:55 P.M., the surveyor requested all of Resident #28's physician and nurse practitioner progress notes since admission to the facility from the Director of Nurses (DON). The DON said that the Physician #3 typically hand writes his progress notes and places them in the chart for the facility staff to upload into the electronic medical record (EMR). She further said that the Physician does not typically have a nurse practitioner see his residents at the facility. Review of the paper record indicated two physician visit notes (that were also uploaded and observed in the EMR) dated:-10/11/25-2/27/26 Review of the medical record failed to indicate that the Resident was seen by the Physician at least every 30 days for the first 90 days after admission and at least every 60 days thereafter, with alternate visits by a Nurse Practitioner (NP) as required. During an interview on 4/14/26 at 1:46 P.M., Unit Manager #2 said that Physician #3 usually comes into the facility after his office hours. She said he hand writes notes and places them into the medical record. She also said that sometimes his notes are dictated and entered into another electronic medical record (not utilized by the facility). She said that nurses at the facility do not have access to this EMR but that she and all of the Unit Managers do have access. During a follow up interview on 4/14/26 at 1:52 P.M., Unit Manager #2 said the Physician did not have any visit notes in Resident #28's alternate EMR. During an interview on 4/14/26 at 2:38 P.M. the DON said that she too had checked the alternate EMR and did not find any other visit notes for Resident #28. She said that the physician is not in the facility as much as he should be but is generally responsive by phone or a secure texting system they have. She said she expects the Physician to see his residents as per the regulations require, but in this case, he did not. On 4/14/26 at 2:06 P.M., the surveyor placed a call to Physician #3, Resident #28's attending physician in the facility and requested a call back. As of 4/15/26 at 11:15 P.M., at the time of exit from the facility, the physician had not called back.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, record review and interview, the facility failed to ensure dental service recommendations were provided for one Resident (#130) out of a total of 40 sampled Residents. Specifically, the facility failed to obtain a consent form to begin denture fabrication for Resident #130. Findings include: Resident #130 was admitted to the facility in January 2025 with diagnoses including atrial fibrillation, epilepsy and peripheral vascular disease. Review of the Minimum Data Set Assessment, dated 1/15/26, indicated Resident #130 was cognitively intact as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated that Resident had no natural teeth. During an interview on 4/13/26 at 8:12 A.M., Resident #130 said, I don't have any teeth and I need dentures. Resident #130 said that he/she had been seen by a dentist who recommended he/she get dentures, but it had been awhile and wasn't sure what the status was. Review of Resident #130's dental visit dated 2/26/26 indicated: Initial ExamPatient is edentulous. Patient reports he/she had extractions and temporary dentures made right after, but they did not fit. He/she was planned for a new set but was unable to follow up with his/her dentist. Discussed limitation of retention of lower dentures. Patient requesting new set. Upper and lower dentures recommended to improve patient's ability to eat if approved. Recommend annual exam 1X per year if approved. NV (next visit): Denture Step 1 (initial impressions) if approved. Action required by nursing home staff: Continue daily oral care. Please have responsible party sign consent for dentures form. Review of the clinical record indicated that Resident #130's health care proxy was activated on 3/11/26; approximately 13 days after Resident #120 had been seen by the dentist. Review of the clinical record failed to indicate that Resident #130 or his/her activated health care proxy signed a consent form for dentures. During an interview on 4/14/26 9:37 A.M., Resident #130 said that he/she had not been asked to sign a consent form to obtain dentures.During an interview on 4/14/26 at 9:39 A.M., Family Member #2 said that the health care proxy had activated recently, and she had not been asked to sign a consent form for Resident #130's denture fabrication.During an interview on 4/14/26 at 9:49 A.M., Unit Manager #3 said that dental recommendations are uploaded into the resident record and also emailed to the facility. Unit Manager #2 said that it did not look like a consent form for Resident #130 had been completed and that it should have been addressed.During an interview on 4/14/26 at 1:19 P.M., the Director of Nursing (DON) said that she expects dental recommendations to be reviewed timely.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interview the facility failed to ensure for one Resident (#75), out of a total sample of 40 residents, that he/she was provided with food items that were on his/her diet slip. Specifically, staff failed to follow the diet slip, resulting in food items not being provided to Resident #75 for three observed meals. Findings include:Resident #75 was admitted to the facility in July 2025 and has diagnoses that include unspecified dementia, anemia, type 2 diabetes mellitus, osteoarthritis, and gastro-esophageal reflux. Review of the most recent Minimum Data Set assessment, dated 3/17/26, indicated Resident #75 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS) exam signifying he/she as having moderate cognitive impairment, required setup or clean-up assistance for meals and is on a therapeutic diet. During an observation and interview on 4/13/26 at 9:55 A.M., Resident #75 was sitting up in a wheelchair with his/her breakfast tray in front of him/her. Resident #75 said he/she did not get all the food on his/her breakfast tray and said, I did not get margarine, I did not get hot cereal, I did not get my V-8. Review of the diet slip with Resident #75's name revealed, Monday Breakfast, 4/13/26 with the following food item listed on the diet slip, 6 oz (ounces) of oatmeal, 8 oz V8 Juice, both of which were underlined, and 1 Pc (piece) of Margarine. These items were not present on his/her meal tray.During an observation and interview on 4/13/26 at 2:19 P.M., Resident #75 was in his/her room, eating his/her lunch. Resident #75 said he/she just started eating his/her lunch. Resident #75 said he/she did not get his/her yogurt. Review of the diet slip on the tray, included Resident #75's name, Monday lunch dated 4/13/26, 4 oz yogurt which was underlined on the diet slip.During an observation on 4/14/26 at approximately 12:30 P.M., of the point of service meal distribution on the B unit where Resident #75 resides, the Nurse was observed reading off the diet slips to the dietary staff to make up the lunch meal to be served.During an observation and interview on 4/14/26 at 12:49 P.M., Resident #75 was eating his/her lunch in the dining room. Review of the diet slip indicated Resident #75's name, Tuesday lunch, 4/14/26. 4 oz yogurt, which was underlined. The 4 oz, yogurt was not present. Resident #75 said he/she likes to eat yogurt.Review of Resident #75's physician's orders indicated, Consistent Carbohydrate Diet, reg (regular) texture, thin liquid consistency, allow brown sugar, start date 4/28/25.Review of Resident #75's Nutritional Status, care plan with a revision date of 1/19/26 indicated I have a nutritional problem or potential nutritional problem due to: At risk for malnutrition r/t (related to) dementia, HLD (hyperlipemia), DM (diabetes mellitus) and hx (history) of weight gain, altered nutrition related to lab values r/t DM AEB (as evidenced by) A1C (a blood test that measure blood sugars over a period of time) greater than 10 percent.During an interview on 4/14/26 at 12:53 P.M., the Food Service Director (FSD) was present in the B unit dining room. The FSD said the nursing staff and the dietary staff are to make sure a diet slip is followed, so a resident gets the items on the diet slip per a resident's preference and diet order. The FSD said it is a double check system. The FSD reviewed Resident #75's diet slip and said the yogurt was not present. Resident #75 said he/she did not want the yogurt now. The FSD said the diet slip is generated from the diet or and all items should be provided.During an interview on 4/14/26 at 5:02 P.M., the Director of Nursing (DON) said typically a resident should receive the food items that are listed on the diet slip. The DON said residents can change their minds and make choices, but the diet order should be followed and that any food items underlined on the diet slip need to be on the meal tray or served.

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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** Based on observation, record review and interview, the facility failed to accurately document in the medical record for one Resident (#86) out of a total sample of 40 residents. Specifically, for Resident #86 the facility documented that oxygen therapy was administered when it was not. Findings include:ˆ Resident #86 was admitted to the facility in December 2024 with diagnoses including essential primary hypertension, chronic kidney disease and dementia.ˆ Review of Resident #86's's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #86 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15.ˆ On 4/13/26 at 8:15 A.M., the surveyor observedˆResident #86 in bed, and he/she was not wearing oxygen. The oxygen concentrator, respiratory tubing and equipment were next to the bed. On 4/13/26 at 12:56 P.M., the surveyor observedˆResident #86 sitting in the dining room eating lunch. Resident #86 was not wearing a nasal canula and no oxygen was being administered. Resident #86 said he/she has not been using the oxygen today and said, I don't know if I need it or not. On 4/13/26 at 4:17 P.M., the surveyor observed Resident #86 sitting outside his/her room in the hall socializing with other residents. Resident #86 was not wearing a nasal canula and no oxygen was being administered. On 4/14/26 at 8:17 A.M., the surveyor observedˆResident #86 sitting in the dining room eating breakfast. Resident #86 was not wearing a nasal canula and no oxygen was being administered. On 4/14/26 at 12:16 P.M., the surveyor observedˆResident #86 sitting in the dining room eating lunch. Resident #86 was not wearing a nasal canula and no oxygen was being administered. Review of Resident #86's active physician orders indicated the following: O2 (oxygen) at 2l (2Liters) via nasal cannula to keep sats (saturation) above 90 every shift for hypoxia (low level of oxygen in blood). Start Date 3/30/26, every shift. Review of the Medication Administration Record dated March 2026 indicated that the nurse documented the oxygen as administered per the physician order on 4/13/26 and 4/14/26. During an interview on 4/14/26 at 7:52 A.M., Nurse #2 said Resident #86 has an order for oxygen because he/she had an upper respiratory illness. Nurse #2 said she did not administer the oxygen because his/her oxygen was 93%. Nurse # 2 said she should not document oxygen that was administered when it was not. During an interview on 4/14/26 at 1:18 P.M., Unit Manager #3 said nurses should not be documenting that oxygen was administered when it was not. ˆDuring an interview on 4/14/26 at 3:03 P.M., the Director of Nursing said that the nurses are to follow physician orders and said that nurses should not document that the oxygen was administered when it was not.