STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225516	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eliot Center for Health and Rehabilitation	168 West Central Street Natick, MA 01760

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to issue the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN - notice issued to beneficiaries so they may decide if they wish to continue receiving skilled services that may not be paid for by Medicare and assume financial responsibility), and a paper copy of the Notice of Medicare Non-Coverage (NOMNC - notice issued to beneficiaries before the end of Medicare covered Part A skilled services) for two Residents (#33 and #78) of three applicable residents reviewed for beneficiary notices, out of a total sample of 20 residents.Specifically, the facility failed to:For Resident #33, issue a SNF ABN as required, to the Resident's activated Health Care Proxy (HCP - the person elected to make healthcare decisions for you if you cannot do so for yourself) when the effective date of coverage for skilled services was ending, and provide evidence that a paper copy of the NOMNC was issued to the Resident's activated HCP as required, after telephone notification by the facility of the end of skilled services was conveyed to the activated HCP. 2. For Resident #78, issue a SNF ABN as required, to the Resident's activated HCP when the effective date of coverage for skilled services was ending and provide evidence that a paper copy of the NOMNC was issued to the Resident's activated HCP as required, after facility telephone notification of skilled services ending was conveyed to the activated HCP. Findings include: Review of the Form Instructions for Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN), Form CMS-10055 (2024), required the facility to notify and explain to the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services. Review of the Medicare Claims Processing Manual, Chapter 30 - Financial Liability Protections, indicated the NOMNC should be issued by the facility to the beneficiary at least two days before the end of a Medicare Part A stay.The NOMNC informs the beneficiary of the right to an expedited review by a Quality Improvement Organization (QIO - an independent reviewer authorized by Medicare to review the decision to end these services).Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of notice delivery. The NOMNC may be delivered to a beneficiary's representative. Review of the facility policy, Subject: Medicare Denials - Advance Beneficiary Notice, dated 9/2025, indicated:-Upon coming off Medicare A and remaining in the facility, the MDS Coordinator will issue the Advanced Beneficiary Notice.prior to the last day of coverage. Review of the facility policy, Subject: Notice of Medicare Non-Coverage, dated 2/2025, indicated:-The (Skilled Nursing Facility) SNF (provider) is responsible for delivering the notice in person (preferred) or by other valid means (e.g., phone with documentation, followed by mailing). 1.Resident #33 was admitted to the facility in September 2025 with diagnoses including Alzheimer's Disease, difficulty walking and muscle weakness. Review of Resident #33's clinical record indicated:the Minimum Data Set (MDS) assessment dated [DATE], the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15 possible points.the Resident was not his/her own responsible party and their HCP was activated 8/22/25.the Resident's Medicare Part A Skilled Services started 10/1/25.the Resident's last covered (continued on next page)

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

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day of Part A Skilled Services ended 10/23/25.the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.the Resident remained in the facility.there was no evidence the SNF ABN had been issued to the Resident's activated HCP.the facility staff person telephoned the Resident's activated HCP on 10/21/25 to notify them of the NOMNC, including the last covered day of Part A Skilled Services, and their right to appeal and appeal deadline. There was no evidence in the clinical record that a paper copy of the NOMNC was provided to the Resident #33's activated HCP. 2.Resident #78 was admitted to the facility in January 2026 with diagnoses including Acute Respiratory Failure, Pneumonia, non-displaced fracture of head of radius and unspecified dementia. Review of Resident #78's clinical record indicated:the MDS assessment dated [DATE], the Resident was severely cognitively impaired in both short and long term memory as evidenced by a BIMS score of 99.the Resident was not his/her own responsible party and their HCP was activated 1/25/25.the Resident received Medicare Part A Skilled Services starting 1/23/26.the Resident's last covered day of Part A Skilled Services ended 3/14/26.the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.the Resident remained in the facility.there was no evidence the SNF ABN had been issued to the Resident's activated HCP.the facility staff person telephoned the Resident's activated HCP on 3/12/26 to notify them of the NOMNC, including last covered day of Part A Skilled Services, right to appeal and appeal deadline, but there was no evidence in the clinical record that a paper copy of the NOMNC was provided to the Resident's activated HCP. During an interview on 4/13/26 at 3:18 P.M., MDS Nurse #1 and Social Worker #1 said that the SNF ABN had not been issued to Resident #33 and Resident #78's activated HCPs, but the SNF ABNs should have been issued to the Residents activated HCPs. MDS Nurse #1 and Social Worker #1 also said that they could not provide evidence that a paper copy of the NOMNC was provided to the Residents activated HCPs.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation and interview, the facility failed to provide an ongoing program of group activities designed to meet the interests of and support the physical, mental, and psychological well-being of residents on two Units (3 and 4) out of three units.Finding include: Review of the Activities Calendar posted on the bulletin board indicated the following activities were scheduled on 4/9/26:-9:00 A.M. - Morning Greeting-10:00 A.M. - Coffee Social-10:30 A.M. - Scattergories-11:00 A.M. - Seated Stretch-2:00 P.M. - Balloon Pants Game On 4/9/26 from 10:20 A.M. to 10:58 A.M., on Unit #4, the surveyor observed the following:-The scheduled activity programs (Coffee Social and Scattergories) were not occurring on the unit.-Activity Staff #1 was distributing the Daily Chronicle in resident rooms.-Six Residents were seated in wheelchairs parked against a wall and another resident was wandering in the hallway.-No staff were engaging with the seven residents. During an interview on 4/9/26 at 10:58 A.M., the surveyor observed a resident seated alone in the dining room on Unit 4 holding a Daily Chronicle sheet. The resident said, There was nothing interesting in [the Daily Chronicle], there were no activities happening, and there was usually nothing to do. The resident further said that it had been like that for a while, and they do not have enough staff. On 4/9/26 at 11:07 A.M. in the main dining/activity room, the surveyor observed five residents sitting at tables and the scheduled activity Seated Stretch did not occur. On 4/9/26 at 2:45 P.M. in the main dining/activity room, the surveyor observed five residents sitting at tables with one activity staff present. The scheduled Balloon Pants Game did not occur. Review of the Activities Calendar posted on the bulletin board indicated the following activities were scheduled on 4/10/26:>9:00 A.M. - Morning Greeting>10:00 A.M. - Coffee Social>10:30 A.M. - Name 5>11:00 A.M. - Group Exercise>2:00 P.M. - Create your own puzzle>3:00 P.M. - Rhyme, Rhyme, Wrong! During a continuous observation on 4/10/26 from 8:05 A.M. to 10:37 A.M on Unit 3, the surveyor observed the following:-9:24 A.M. - Five residents ambulating in the hallway, including one resident attempting to access the elevator requiring staff to redirect him/her and another resident asking about flights out of Boston. No staff were redirecting the residents or engaging them in any group activity.-10:00 A.M.- Two of the five residents continued to wander on the unit.-the scheduled activity programs, (Morning Greeting, Coffee Social, and Name 5) were not occurring on the unit.-Resident #2 was seated in small dining room at a table and facing the wall and was loudly calling out, with no engagement in activity.-Resident #74 was wandering on the unit and stating, What do I do? and There is nothing to do. No engagement in group activity was observed. During an interview on 4/10/26 at 10:25 A.M., Activity Staff #1 said that she is a new staff member who started 13 days prior and had been on her own in the Activity Department until the current Activity Director started 3 days prior. Activity Staff #1 said that she and another CNA were trying to coordinate activities, but they were unable to execute the activity programs on the schedule. She said the facility will offer a large group program around 10:15/10:30 each morning and at 2:00 P.M. in the large dining and activity room downstairs. Activity Staff #1 said that there are not enough staff in the activities department to do activity programs on each of the units. During an interview on 4/13/26 at 10:37 A.M., Resident #96 and Member of the Resident Council, said the facility went awhile without activities because there was no one working in the activity department. The Resident said that there are no activities on the weekend and the Resident Council has discussed wanting more varied activities because it gets boring doing the same things. During an interview on 4/13/26 at 2:24 P.M., the Administrator and the Activities Director reported the Activity Director began employment on 4/8/26 and Activity Staff #1 began on 3/17/26. The Administrator said there was staff turnover in the previous Activity Department over the course of a few months and one CNA was facilitating activities during that time. The Administrator said currently there are no activity programs occurring on the Units and the only activities offered on the Units are one to one visits, nail care, room visits, and music therapy due to staffing challenges.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review and interview, the facility failed to ensure it was free of a medication error rate of five percent or greater when one of two nurses observed, made two errors out of 34 opportunities, for a medication error rate total of 5.88%, affecting one Resident (#30) out of three residents observed.Specifically, for Resident #30, the facility failed to: -ensure that a blood pressure reading was obtained per Physician order, prior to administering Amlodipine (medication to treat high blood pressure) medication, putting the Resident at risk for hypotension (extremely low blood pressure) and related complications.-ensure that MiraLAX (medication to treat constipation) medication was administered as ordered, when the medication was not given, by signed off as given by staff, putting the Resident at risk for constipation. Findings include: Review of the facility policy titled Administering Medications, undated, indicated:-The following is checked/verified for each resident prior to administering medications: >vital signs, if necessary.-Medications are administered in accordance with prescriber orders, including any required time frame. Resident #30 was admitted to the facility in September 2025, with diagnoses including Hypertension, Anxiety, and Adult Failure to Thrive. Review of Resident #30's April 2026 Physician orders indicated:-Amlodipine 10 mg tablets - give one tablet my mouth one time a day for Hypertension (high blood pressure), hold for systolic blood pressure (SBP) less than 100.-MiraLAX Powder 17 grams (gm), give one scoop by mouth one time a day for constipation, mix in 6-8 ounces of water or juice, hold for loose stools. On 4/9/26 at 7:48 A.M., the surveyor observed the following during medication administration for Resident #30 by Nurse #1:*Nurse #1 prepared and administered the following medication:-Amlodipine 10 milligram (mg) tablet, 1 tablet.-Nurse #1 did not obtain a blood pressure reading prior to administering the Amlodipine medication.-did not administer MiraLAX medication to the Resident. Review of Resident #30's April 2026 Medication Administration Record (MAR), indicated:*Nurse #1 had electronically signed that she administered the following medications on 4/9/26:- Amlodipine 10 mg tablet.-MiraLAX Powder 17 grams. During an interview on 4/9/26 at 8:28 A.M., Nurse #1 said she did not obtain Resident #30's blood pressure reading before administering the Amlodipine medication because the previous shift usually obtains the Residents' vital signs. Nurse #1 said the computer did not alert her to enter a blood pressure reading. Nurse #1 said if there was no blood pressure documented the computer would not have allowed her to move on to another resident. Nurse #1 said she had no blood pressure reading for Resident #30. Nurse #1 further said she should have obtained Resident #30's blood pressure before administering the Amlodipine medication but she did not. Nurse #1 also said there was no MiraLAX medication available to be administered in her medication cart, but she needed to sign the MAR to indicate that she had administered the MiraLAX medication so she could continue to the next resident. Nurse #1 said she should not have electronically signed that the MiraLAX medication was administered when she had not administered it. During an interview on 4/9/26 at 8:55 A.M., the Assistant Director of Nursing (ADON) said Nurse #1 should have followed the Physician's order to obtain Resident #30's blood pressure reading before administering the Amlodipine medication. The ADON further said Nurse #1 should not have signed off the MiraLAX medication as administered when the medication was not available in the medication cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interviews, the facility failed to adhere to infection control standards of practice, for one Resident (#14) out of a total sample of 20 residents, and on one Unit (Fourth Floor) out of three units observed. Specifically, the facility failed to:1. ensure that Resident #14's foley catheter drainage bag remained off the floor to prevent contamination putting the Resident at risk for catheter associated infections.2. ensure that ice in an ice chest was distributed to the residents on the Fourth Floor Unit under sanitary conditions.3. ensure the housekeeping staff adhered to appropriate infection control practices when cleaning consecutive rooms which included a room with contact precautions on the Fourth Floor Unit. Findings include:1. Review of the facility policy titled Catheter Care, Urinary, undated, indicated: -Infection Control: be sure the (urinary) catheter tubing and drainage bag are kept off the floor. Resident #14 was admitted to the facility in April 2024 with diagnoses including hydronephrosis with renal and ureteral calculus obstruction, retention of urine, and Acute Kidney Failure, Unspecified. Review of Resident #14's Physician's orders for April 2026 indicated the Resident had Physician's orders for the following treatments: -Foley catheter care every shift monitor for hematuria and placement, dated 11/18/25. Review of the April 2026 Treatment Administration Record (TAR) indicated Resident #14 was receiving foley catheter care as ordered by the Physician. On 4/8/26 at 10:50 A.M., the Resident #14's foley catheter drainage bag was observed on the floor next to the Resident's bed. During an interview at the time, Resident #14 said he/she was unaware the urinary drainage bag was on the floor. On 4/9/26 at 8:59 A.M., the surveyor observed Resident #14 asleep in bed and the urinary drainage bag was laying on the floor next to the Resident's bed. On 4/9/26 at 10:34 A.M., the surveyor observed a Nurse entering Resident #14's room and closing the door. The Nurse was then observed exiting Resident #14's room and the surveyor observed the urinary drainage bag laying on the floor next to the Resident's bed as the Nurse exited the room. During an interview on 4/9/26 at 10:45 A.M., with the District Coordinator of Education, Resident #14's foley catheter bag was observed laying on the floor next to the Resident's bed. The District Coordinator of Education said the Nurse (who was in the room) should have noticed the urinary catheter bag on the floor and should have picked up and positioned the urinary drainage bag off the floor. The District Coordinator of Education said urinary catheter drainage bags should always be off the floor to prevent the spread of infection. During an interview 4/14/26 at 10:00 A.M., the Director of Nursing (DON) said Resident #14's urinary catheter bag should never be on the floor because it was an infection control issue. 2. On 4/9/26 at 8:44 A.M. the surveyor observed the following on the Fourth Floor Unit: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A resident was walking behind the nursing station holding two cups. The resident placed the two cups on an ice cart stored behind the nursing station. -The resident opened the ice chest and took the scoop from the holder with his/her bare right hand and began banging on the ice with the scoop. -The resident then took a scoop of ice from the chest, removed the ice from the scoop with his/her bare left hand and put the ice in the two cups. The resident dropped some of the ice directly on top of the ice cart and picked up the ice off the cart and put it in the two cups. -The resident proceeded to bang on the ice with the scoop and remove ice from the scoop with his/her bare hands two more times while picking up ice that was dropped on the top of the ice cart and placing it in the two cups. -During the same time the resident was accessing the ice chest, two staff members went behind the nursing station and walked by the resident as he/she was accessing the ice chest and did not redirect the resident away from the ice chest or attempt to assist the resident. -The resident was then observed putting the scoop back in its holder and walking back down the hall with the two cups. The resident was not observed sanitizing his/her hands at any time during the observation. During an interview on 4/9/26 at 9:24 A.M., the Assistant Director of Nursing (ADNS) said the residents should not be behind the nursing station accessing the ice. The ADNS said if staff sees the residents accessing the ice they should be redirecting the resident away from the ice chest and assisting residents with getting the ice from the ice chest. The ADNS said the residents accessing the ice chest on their own is an infection control issue and can cause the spread of infection to other residents. During an interview on 4/14/26 at 10:16 A.M., the Director of Nursing (DON) said residents should not be behind the nursing station accessing the ice chest on their own. The DON said residents accessing the ice chest on their own creates an infection control issue. 3. On 4/14/26 at 9:45 A.M., the surveyor observed housekeeping staff (HSK) #2 mop a resident's room (414) with a Contact Precaution sign outside of the door indicating that anyone entering the room should wear a gown and gloves. HSK #2 was not observed wearing a gown. HSK #2 completed mopping room [ROOM NUMBER] and then moved onto to room [ROOM NUMBER]. HSK #2 was observed mopping the floor of room [ROOM NUMBER] with the same water used in room [ROOM NUMBER] and continued to the other side of the hallway with the same water and mopped room [ROOM NUMBER] that was not identified as a precaution room. During an interview on 4/14/26 at 10:00 A.M., HSK #2 said she cleaned three rooms and changed the water. HSK #2 said she was aware room [ROOM NUMBER] was a Contact Precaution room. During an interview on 4/14/26 at 10:15 A.M., the Infection Preventionist (IP) said the Contact Precaution room [ROOM NUMBER] was a resident who had been diagnosed with Clostridium Difficile (C-DIFF – bacterial infection causing severe loose stools that is contagious). The IP said HSK #2 should have worn a gown before cleaning the room and should have cleaned the contaminated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room last. The IP said HSK #2 should not have cleaned another room with the same water. During an interview on 4/14/26 at 10:30 A.M., the Housekeeping Manager said the requirement is for the housekeeping staff to clean the contaminated room last and not to clean another room with the same water.