STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225531	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sudbury Pines Extended Care	642 Boston Post Road Sudbury, MA 01776

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43846 Based on interviews, observations, and policy review, the facility failed to ensure staff treated residents in a dignified manner. Specifically, 1. On the Station 1 and Station 2 Units, the facility failed to provide a dignified dining experience. 2. For Resident #60, the facility failed to ensure staff consistently covered his/her catheter drainage bag. Findings include: Review of the facility policy titled Dignity, dated August 2009, indicated Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Staff shall treat cognitively impaired residents with dignity and sensitivity. 1. On 3/4/25 from 8:30 A.M. to 8:35 A.M., the surveyor observed a Certified Nurse Aide (CNA) was standing while feeding a resident in bed on the Station 2 Unit. On 3/4/25 at 9:58 A.M., a staff member was observed standing over a resident during breakfast while feeding a resident who was in bed on the Station 1 Unit. On 3/4/25 at 12:04 P.M., the surveyor observed a CNA was standing while feeding a resident in the dining room Station 2 Unit. On 3/5/25 at 12:13 P.M., the surveyor observed a CNA was standing while feeding a resident in the dining room Station 2 Unit. On 3/6/25 at 7:57 A.M., the surveyor observed a CNA was standing while feeding a resident in the dining room Station 2 Unit. During an interview on 3/6/25 at 8:31 A.M., CNA #3 said staff should be seated while assisting a resident with their meal. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 7:43 A.M., Unit Manager #2 said staff should be seated while assisting residents with their meals. 49880 During an observation on 3/4/25 at 8:24 A.M., in the Station One dining room the surveyor observed a Certified Nurse's Aide (CNA) walking around the dining room and assisting multiple residents with their meals. The CNA was standing over each resident, providing two to three bites of food, then going to help another resident, each time standing over the resident to provide eating assistance. During an interview on 3/6/25 at 8:57 A.M., the Director of Nurses said that staff should be sitting while assisting residents with meals. During an interview on 3/6/215 at 10:11 A.M., the Director of Nursing said staff should not be standing over residents while assisting them with feeding. 44095 2. Review of the facility policy titled, Quality of Life - Dignity, dated as revised August 2009, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered. Resident #60 was admitted to the facility in September 2022 with diagnoses including neuromuscular dysfunction of the bladder, diabetes, and Parkinson's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/7/25, indicated Resident #60 was dependent on staff for activities of daily living. This MDS indicated Resident #60 required an indwelling catheter. On 3/4/25 at 10:29 A.M., 3/5/25 at 7:48 A.M., 10:07 A.M., and at 1:47 P.M., and on 3/6/25 at 10:58 A.M., the surveyor observed Resident #60 in his/her room from the hallway, Resident #60's urinary drainage bag was exposed without a privacy bag. Resident #60's roommate was present in the room. During an interview on 3/6/25 at 8:41 A.M., Unit Manager #1 said staff should ensure that Resident #60's urinary drainage bag is stored in a privacy bag. During an interview on 3/6/25 at 11:51 A.M., the Director of Nursing (DON) said staff should ensure that Resident #60's urinary drainage bag is stored in a privacy bag.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49880 Based on observations, record review and interview the facility failed to ensure the physician was notified when one Resident (#28), out of a total sample of 26 residents, was not utilizing a Bipap (Bilevel positive airway pressure, a machine used to treat sleep apnea) machine as indicated in the physician's orders. Findings Include: Resident #28 was admitted to the facility in March 2016 with diagnoses that include acute on chronic respiratory failure, obstructive sleep apnea and paranoid schizophrenia. Review of the Minimum Data Set (MDS) assessment, dated 11/26/24 indicated that a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated oxygen use, and did not indicate the use of non-invasive mechanical ventilation (Bipap). Review of Resident #28's physician orders indicated the following orders, dated 2/12/25: -BIPAP: Change BIPAP Device water daily (use sterile or distilled water). [sic] -BIPAP: Apply BIPAP Device at night and as needed (titrate oxygen to maintain SATS (oxygen saturation) greater than 90%) (BIPAP 0= BIPAP Device on, 1=BIPAP Device off. [sic] -On 3/4/25 at 8:06 A.M., Resident #28 was observed sitting up in bed. He/she said that he/she was having a hard time breathing. Resident #28 was on oxygen via nasal cannula at four liters per minute. Resident #28 said that he/she is supposed to use a Bipap machine at night for sleep apnea but that he/she has never used it since receiving it because the staff do not know how to apply it. The Bipap machine was observed on the bedside table with the mask in a bag. -On 3/5/25 at 6:55 A.M., Resident #28 was observed sitting up in his/her bed. Resident #28 said that the Bipap was not applied overnight and that no staff offered to apply Bipap for him/her. The Bipap machine was observed on the bedside table with the mask in a bag in the same position as the previous day. -On 3/6/25 at 7:43 A.M., Resident #28 was observed sitting up in bed. Resident #28 said that staff had not attempted to apply the Bipap machine the night before. The Bipap machine was observed on the bedside table with the mask in a bag in the same position as the previous day. The Bipap machine was observed to be unplugged with the cord wrapped up on the bedside table behind the machine. Review of the February 2024 Treatment Administration Record (TAR) indicated Bipap was not applied seven times and was applied ten times for a total of seventeen opportunities Review of the March 2024 TAR indicated that the Bipap was not applied 3/1 through 3/4 and that it was applied overnight on 3/5. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record failed to indicate that Resident #28 refused the use of Bipap. Further review of the medical record failed to indicate that the physician was notified that the Resident was not utilizing the Bipap machine as ordered at night. Review of a physician's progress note, dated 2/27/25, failed to indicate the non-use of the Bipap machine and indicated Obstructive sleep apnea is followed, and no new hypoxia is noted. During an interview on 3/5/25 at 6:59 A.M., Nurse #4 said that Resident #28 sometimes refuses the Bipap machine. She said that it should be documented in the medical record but isn't sure if the physician is aware. During an interview on 3/5/25 at 1:00 P.M., Nurse #5 said that she works day shift with Resident #28. She said that sometimes Resident #28 refuses the Bipap at night. She said if a resident refuses a treatment then the physician should be notified and it should be documented in the medical record. She is not sure if the physician is aware that Resident #28 is not using the Bipap machine. During an interview on 3/6/25 at 8:21 A.M., Unit Manager #1 said that Resident #28 has had orders for the use of Bipap for about a month. He said the recommendations for use came from the hospital from his/her most recent hospitalization . Unit Manager #1 said that he was not aware that Resident #28 had not been utilizing the Bipap machine. Unit Manager #1 said that if the Resident is not utilizing the Bipap machine then the physician should be notified and it should be documented in the medical record, as it could have negative outcomes for the resident. During an interview on 3/6/25 at 8:46 A.M., the Director of Nursing said she would expect that if the Resident is not utilizing the Bipap machine that the physician would be notified, and it would be documented in the medical record. During a telephone interview on 3/6/25 at 10:47 A.M., Physician #1 said that he was not aware that the Resident was not utilizing the Bipap machine.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44095 Based on record review and interview, the facility failed to provide an accurate estimated cost of services to residents or their representatives, for two out of two resident records reviewed, to ensure they were informed of their potential financial liabilities of the cost of items and services provided. Findings include: The SNF ABN (CMS-10055) notice is administered to a Medicare recipient when the facility determines that the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all of the Medicare benefit days for that episode. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. Review of the notices provided to two residents who came off their Medicare Part-A Benefit, who remained at the facility, were provided Advanced Beneficiary Notices included an estimated cost of services of $400 to $600 for skilled nursing services. During an interview on 3/6/25 at 10:51 A.M., Social Worker #1 said that she delivers the ABN notices to residents who come off their Medicare Part-A Benefit, who remain at the facility, and Social Worker #2 said that there is a range of $400 to $600 which is the daily room and board rate. Social Worker #1 and Social Worker #2 said that they got the $400 to $600 from the Business Office years ago. During an interview on 3/6/25 at 11:27 A.M., the Accounts Receivable Representative (ARR) said there are all different costs for room and board and the ARR was not sure what the cost to pay for therapy services such as physical (PT), occupational (OT), or speech therapy (SLP) services would cost and the surveyor would need to speak with the Director of Rehabilitation (DOR). During an interview on 3/6/25 at 11:35 A.M., the DOR said that she was not aware of the pay rates for PT, OT, of SLP services and she would need to find out from the therapy contract company. During an interview on 3/6/25 at 1:14 P.M., the Administrator said the range of skilled nursing services $400 to $600 includes room and board, pharmaceuticals, and rehabilitation services but did not include the breakdown for the individual services.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43846 Based on observations and interviews, the facility failed to provide a homelike environment during dining on two of two nursing units. Specifically, on the Station 1 and Station 2 Units, residents were observed eating meals on meal trays in the dining rooms. Findings include: Review of the facility policy titled Homelike Environment, dated 3/5/25, indicated To create a more homelike safe environment that offers our residents greater dignity and autonomy, ensuring resident's preferences, needs and values guide decisions and care. On 3/4/25 at 8:09 A.M., the surveyor observed Station 2's dining room, all residents were served their meals on meal trays and staff did not remove the meal trays. On 3/4/25 at 12:01 P.M., the surveyor observed Station 1's dining room, all residents were served their meals on meal trays and staff did not remove the meal trays. On 3/4/25 at 12:05 P.M., the surveyor observed Station 2's dining room, all residents were served their meals on meal trays and staff did not remove the meal trays. On 3/5/25 at 8:30 A.M., the surveyor observed Station 2's dining room, all residents were served their meals on meal trays and staff did not remove the meal trays. On 3/5/25 at 12:20 P.M., the surveyor observed Station 2's dining room, all residents were served their meals on meal trays and staff did not remove the meal trays. During an interview on 3/6/25 at 8:31 A.M., Certified Nurse Aide #3 said staff should remove the resident's meal off the meal tray when eating in the dining room. During an interview on 3/6/25 at 7:43 A.M., Unit Manager #2 said staff should remove the resident's meal off the meal tray when eating in the dining rooms.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 43846 Based on observations, interviews, and record review, the facility failed to accurately assess the use of an alarmed velcro seat belt as a potential restraint for one Resident (#18) out of a total sample of 26 residents. Findings include: Review of the facility policy titled Use of Restraints, dated April 2017, indicated 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which staff applied it given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint. Resident #18 was admitted to the facility in August 2021 with diagnoses that included dementia, dysphagia, repeated falls, and anxiety disorder. Review of Resident #18's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. The MDS further indicated he/she is dependent on staff for activities of daily living, a trunk restraint was not used and a chair that prevents rising was not used. On 3/4/25 at 11:59 A.M., the surveyor observed Resident #18 in the dining room in a reclined position in his/her geri reclining chair with a seat belt in place. On 3/5/25 at 11:17 A.M., the surveyor observed Resident #18 in the dining room in a reclined position in his/her geri reclining chair with a seat belt in place. Review of Resident #18's physician order, dated 7/21/22, indicated: Device- Alarm Seat Belt on wheelchair resident can release device on verbal command 10 out of 10 times or resident cannot walk/transfer and is an extensive assist or physically dependent on staff for locomotion/ambulation; Has consent; Pre-assessment and reviewed quarterly and as needed. Review of Resident #18's fall care plan, dated 1/9/23, indicated I have a (clip belt seat belt) on my (recliner) that does not meet the criteria for a restraint. Review of Resident #18's restraint assessment, dated 2/6/25, indicated the alarmed seat belt is not a restraint. During an interview and observation on 3/5/25 at 11:17 A.M., Certified Nurse Aide (CNA) #3 said she has taken care of Resident #18 many times and he/she cannot self-release his/her seatbelt. CNA #3 said the Resident needs the seatbelt to keep him/her in the chair because he/she tends to lean or slide out of the chair. The Resident was unable to self release the seatbelt during this observation. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/25 at 11:18 A.M., Unit Manager #2 said Resident #18's alarmed seat belt is not a restraint because he/she does not ambulate and he/she has never been able to self release the belt. Unit Manager #2 said Resident #18 is a fall risk and this is a fall intervention to keep the Resident from falling out of their chair. During an interview on 3/6/25 at 9:10 A.M., the Director of Nurses (DON) said Resident #18 could never self-release his/her alarmed velcro belt. The DON said the Resident is a fall risk and this is an intervention to keep this Resident from falling. The DON said the Resident can change his/her position at times and this is why the velcro belt is used.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43846 Based on interview and record review, the facility failed to report a bruise of unknown origin to the State Agency within the mandated time-frame for one Resident (#24) out of a total of 26 sampled residents. Findings include: Review of the facility policy titled Abuse Prohibition, reviewed 10/21/24, indicated It is the policy of the facility to assure an environment free of abuse, neglect, mistreatment and misappropriation of resident property. At risk resident: Resident with the highest risk, i.e., at risk of abuse and neglect include resident who have dementia; residents with no/few visitors; residents who are totally dependent on care; residents with communication disorders. Protection and Notification: Upon receiving an allegation of abuse, supervisors will take necessary steps to protect all residents and then immediately notify the Director of Nursing Services who will notify the Administrator. If the Director of Nursing is unavailable then the report will go directly to the Administrator. The facility will report and investigate all allegations of resident abuse, mistreatment, neglect, involuntary seclusion, and misappropriation of property. A thorough investigation will be completed under the direction of the Director of Nursing Services and/or Administrator. Other personnel (Social Worker, etc.) will be included in the investigation as necessary and appropriate. The results of the investigation will be documented and reviewed with the Administrator. This report and review will be completed within 24 hours of the allegation or within 2 hours of the allegation if the event involved abuse or results in serious injury and the investigation will be ongoing thereafter. The facility Administrator will provide proper notification of administrative staff and all required state and other regulatory agencies. Resident #24 was admitted to the facility in July 2021 with diagnoses that included Alzheimer's disease, dysphagia, anxiety and depression. Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 1/14/25, indicated he/she was assessed by nursing staff to have moderate cognitive impairments. Further review of the MDS indicated he/she is dependent on staff for all Activities of Daily Living (ADLs). On 3/4/25 at 7:40 A.M. , the surveyor observed Resident #24 in bed with a dark purple bruise under his/her left eye that was approximately 3 inches by 1 inch. On 3/4/25 at 11:52 A.M., the surveyor observed Resident #24 in the dining room with a dark purple bruise under his/her left eye. During an interview on 3/6/25 at 7:43 A.M., Unit Manager #2 said Resident #24 has had a bruise under his/her left eye since 2/16/25 which was much bigger then and he/she reported this bruise to the Director of Nursing on 2/16/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 8:52 A.M., the Director of Nursing (DON) said she was aware of the bruise when it happened because staff told her. The DON said she did not report the bruise of unknown origin to the State Agency as potential abuse and said she is not sure if she should have. During an interview on 3/6/25 at 12:00 P.M., the Administrator said a bruise of unknown origin should be reported within two hours from when it was reported to the DON to the State Agency but was not. Review of the State Agency's reporting system from 2/16/25 to 3/5/25 failed to indicate that the facility reported Resident #24's bruise to his/her face of unknown origin.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 43846 Based on record review and interviews, the facility failed to thoroughly investigate an bruise of unknown origin, for one Resident (#24) out of a total sample of 26 residents. Specifically for Resident #24 who on 2/16/25 was found to have a bruise under his/her left eye by a Certified Nurses Aide, the facility staff failed to complete a thorough investigation. Findings include: Review of the facility policy titled Abuse Prohibition, reviewed 10/21/24, indicated It is the policy of the facility to assure an environment free of abuse, neglect, mistreatment and misappropriation of resident property. At risk resident: Resident with the highest risk, i.e., at risk of abuse and neglect include resident who have dementia; residents with no/few visitors; residents who are totally dependent on care; residents with communication disorders. Protection and Notification: Upon receiving an allegation of abuse, supervisors will take necessary steps to protect all residents and then immediately notify the Director of Nursing Services who will notify the Administrator. If the Director of Nursing is unavailable then the report will go directly to the Administrator. The facility will report and investigate all allegations of resident abuse, mistreatment, neglect, involuntary seclusion, and misappropriation of property. A thorough investigation will be completed under the direction of the Director of Nursing Services and/or Administrator. Other personnel (Social Worker, etc.) will be included in the investigation as necessary and appropriate. The results of the investigation will be documented and reviewed with the Administrator. This report and review will be completed within 24 hours of the allegation or within 2 hours of the allegation if the event involved abuse or results in serious injury and the investigation will be ongoing thereafter. The facility Administrator will provide proper notification of administrative staff and all required state and other regulatory agencies. Resident #24 was admitted to the facility in July 2021 with diagnoses that included Alzheimer's disease, dysphagia, anxiety and depression. Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 1/14/25, indicated he/she was assessed by nursing staff to have moderate cognitive impairments. Further review of the MDS indicated he/she is dependent on staff for all Activities of Daily Living (ADLs). On 3/4/25 at 7:40 A.M. , the surveyor observed Resident #24 in bed with a dark purple bruise under his/her left eye that was approximately 3 inches by 1 inch. On 3/4/25 at 11:52 A.M., the surveyor observed Resident #24 in the dining room with a dark purple bruise under his/her left eye. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 7:43 A.M., Unit Manager #2 said Resident #24 has had a bruise under his/her left eye since 2/16/25 which was much bigger then. Unit Manager #2 said the nurse that initiated the incident failed to complete it and did not write a nursing progress note, did not alert the health care proxy (HCP) or the medical doctor (MD). Unit Manager #2 said it is her responsibility to make sure these incident reports are completed and to make sure all statements from staff are gathered but said the only statement that was obtained was from the Certified Nursing Assistant who found the bruise. Unit Manager #2 said there is still not a competed investigation done for his/her bruise nor was there an intervention put into place. During an interview on 3/6/25 at 8:52 A.M., the Director of Nursing (DON) said a nurse initiated a incident report for the bruise found under Resident #24's left eye but never finished it. The DON said the nurse should have gathered more statements, wrote a nursing progress note, alerted the HCP and MD, do a skin check for the newly found bruise and put an intervention into place to keep the resident safe but none of that was done. During an interview on 3/6/25 at 12:00 P.M., the Administrator said she would expect that her staff complete a full and thorough investigation on a bruise of unknown origin but it was not.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 44095 Based on observation, record review, and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for two Residents (#41 and #60), out of 26 sampled residents. Specifically, 1. For Resident #41, the facility failed to ensure the MDS assessment was accurately coded for upper extremity range of motion (ROM, section GG). 2. For Resident #60, the facility failed to ensure the MDS assessment was accurately coded for cognition (section C). Findings include: 1. Resident #41 was admitted to the facility in December 2019 with diagnoses including glaucoma, dementia, and psychosis. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/26/24, indicated that Resident #41 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of the section GG indicated the following: Section GG Upper extremity (shoulder, elbow, wrist, hand), coded as 0, no impairment. On 3/4/25 at 8:14 A.M., and at 9:59 A.M., the surveyor observed Resident #41 without the use of palm protectors, his/her bilateral hands were positioned in tight fists. Resident #41 could not open his/her hands from a fist position. Review of Resident #41's physician's order, dated 10/16/23, indicated: - Bilateral upper extremity (BUE) hand palm protectors, on when in bed during evening shift only, off in the morning for day shift. Skin checks for redness or skin irritation with each application and removal, at bedtime and remove per schedule. Review of Resident #41's physician's order, dated 3/22/24, indicated: - Patient to wear bilateral hand palm protectors 7-3 shift and 11-7 shift, skin checks with each application and removal for skin irritations and hand hygiene, every day and night shift for palm guard. During an interview on 3/6/25 at 6:57 A.M., Certified Nurse Assistant (CNA) #7 said Resident #41's hands have been contracted for like 8 months, and Resident #41 has not been using the palm protectors recently because he/she screams in a lot in pain when staff try to apply the palm guards. CNA #7 said Resident #41 cannot fully open his/her hands. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 3/5/25 at 1:09 P.M., Nurse #5 said Resident #41's hands have been tight for a long time, and Resident #41 wears palm protectors at night for limited range of motion. During an interview on 3/6/25 at 8:43 A.M., Unit Manager #1 said that Resident #41 has had limited range of motion in his/her bilateral hands since the initiation of the palm protectors in 2023. During an interview on 3/6/25 at 11:41 A.M., the Director of Rehabilitation said that Resident #41 has limited ROM in his/her hands. During an interview on 3/6/25 at 11:10 A.M., the MDS Coordinator said that Resident #41's ROM was not coded correctly on his/her most recent MDS. 2. Review of the Resident Assessment Instrument (RAI) manual, dated October 2023, indicated the following for coding C0500: BIMS Summary Score: -Coding Instructions Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15. - If the resident chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the resident chooses not to answer four or more items, then the interview is coded as incomplete and the Staff Assessment for Mental Status is completed. - To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips below for residents who choose not to participate at all. - Code 99, unable to complete interview: if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, or (c) if any but not all of the BIMS items are coded with a dash (-). Resident #60 was admitted to the facility in September 2022 with diagnoses including neuromuscular dysfunction of the bladder, diabetes, and Parkinson's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/7/25, indicated a coding of 99 for the BIMs, indicating Resident #60 was unable to complete the interview. Review of Resident #60's MDS section C, dated as 2/7/25, indicated Social Worker #1 coded the following: C0400. Recall B. Able to recall blue, coded as not assessed, dashed. C0500. BIMS Summary Score (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the resident was unable to complete the interview Review of Resident #60's SECTION Cust. SOCIAL SERVICES-SPEC Brief Interview for Mental Status (3.0 BIMS) assessment, dated 2/7/25, indicated Resident #60 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Which indicated Resident #60 answered all the questions. During the screening on 3/4/25 at 8:01 A.M., Resident #60 was alert and oriented and able to answer screening questions for the surveyor. During an interview on 3/6/25 at 12:59 P.M., Social Worker #1 said that she inaccurately coded Resident #60's most recent BIMs assessment on 2/7/25. During an interview on 3/6/25 at 11:10 A.M., the MDS Coordinator said that Resident #60's BIMs assessment was not coded correctly on his/her most recent MDS.

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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** 43846 Based on observation, record reviews and interviews, the facility failed to ensure resident centered care plans were implemented for three Residents (#58, #60 and #50) out of a total sample of 26 residents. Specifically, 1. For Resident #58, the facility failed to implement his/her clothing protector at meal times per the plan of care. 2. For Resident #60, the facility failed to ensure nursing implemented his/her care plan for transfers which indicated he/she required two person assist. 3. For Resident #50, the facility failed to implement oxygen when out of his/her room. Findings include: Review of the facility policy titled Assessments and Care Planning, dated 12/16, indicated the following: The comprehensive care plan will: -Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. -Aid in preventing or reducing decline in the resident's functional status and/or functional level. -The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). -Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 1. Resident #58 was admitted to the facility in August 2020 with diagnoses that included dementia, glaucoma, transient visual loss, and delusional disorders. Review of Resident #58's most recent Minimum Data Set (MDS) assessment, dated 11/28/24, indicated he/she scored a one out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Further review of the MDS indicated he/she requires partial/moderate assistance from staff for eating. On 3/4/25 from 8:14 A.M. to 8:20 A.M., the surveyor observed Resident #58 in the dining room eating from his/her breakfast tray without a clothing protector on. On 3/5/25 from 8:00 A.M. to 8:27 A.M., the surveyor observed Resident #58 in the hallway eating from his/her breakfast tray without a clothing protector on. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 from 8:18 A.M. to 8:34 A.M., the surveyor observed Resident #58 in his/her bed eating from his/her breakfast tray without a clothing protector on. Review of Resident #58's eating care plan, dated 2/19/24, indicated I feel more comfortable and protected when I wear a cloth towel protector at meals. During an interview on 3/6/25 8:30 A.M., Unit Manager #2 said she expects nursing staff to follow each resident's care plan. During an interview on 3/6/25 at 8:59 A.M., the Director of Nurses said she expects staff to follow each resident's care plan and if it says to put a clothing protector on Resident #58 then he/she should have one on at meals. 44095 2. Review of the facility policy titled, Lifting Machine, Using a Mechanical, dated as revised July 2017, indicated the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lift device. It is not a substitute for manufacturer's training or instruction. -General Guidelines: 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 3. Types of lifts that may be available in the facility are: c. Sit-to-stand lift Resident #60 was admitted to the facility in September 2022 with diagnoses including neuromuscular dysfunction of the bladder, diabetes, and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment, dated 12/26/24, indicated that Resident #60 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #60 required dependent (total) assistance for chair/bed-to-chair transfers. Review of Resident #60's plan of care related to toilet transfers, dated 1/21/24, indicated: - I use a Sara lift for transferring for toileting hygiene. Review of Resident #60's plan of care related to mobility and transfers, dated 1/21/24, indicated: - Dependent Sara lift 2 People Required. Review of Resident #60's Fall- Near Fall/ Assisted down or caught, incident report, dated 1/19/25 at 7:52 A. M., indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Incident Description: this writer was at the med cart when the Certified Nursing Assistant (CNA) approached to report the near fall. When I arrived in the room, I found the resident in a supine position. Holding on with his/her right hand of metal on the side of the bed. - Immediate Action Taken: The CNA said the resident was standing on the Sara lift and suddenly he/she slides down, he tried to hold him/her he couldn't, then lower him/her to the floor. - Other Info: Was lowered to the floor during transfer. Resident was weak and legs gave out. Staff Statement: 1/19/25 Resident slide off the Sara lift during transfer from bed to wheelchair. I tried to catch him/her, unsuccessful. I slid him/her to the floor. He/she did not hit her head. [sic] Review of the NURSING - Incident/Accident/Fall Reporting & Intervention Note, dated 1/19/25, indicated: - Fall: The CNA said that the resident was standing on the Sara lift and suddenly he/she slides down, he tried to hold him/her, couldn't then lower him/her to the floor. During an interview on 3/6/25 at 9:16 A.M., CNA #6 said on 1/19/25 he transferred Resident #60 by himself when he/she slid from the Sara lift. On 3/6/25 at 7:18 A.M., the surveyor observed CNA #5 go into Resident #60's room alone with the Sara lift. The surveyor stayed at the door and the surveyor observed the CNA providing care. The surveyor did not leave the door, and the surveyor did not observe any additional staff members entering the room. On 3/6/25 at 7:41 A.M, the surveyor observed CNA #5 transfer Resident #60 alone with the Sara lift. There was a bright pink piece of paper on the Sara lift which indicated THIS LIFT REQUIRES 2 ASSISTS, there were no additional staff members in the room. During an interview on 3/6/25 at 7:47 A.M., CNA #5 said he could use one to two staff members for the Sara lift. CNA #5 said he was alone when he transferred Resident #60 from the bed to the wheelchair. During an interview on 3/6/25 at 11:53 A.M., the Director of Nursing (DON) said that nursing should follow the care plan and use a two person assist. 45343 3. Resident #50 was admitted to the facility in June 2021 with diagnoses including acute respiratory failure with hypoxia, shortness of breath, bacterial pneumonia, and asthma. Review of Resident #50's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she had a Brief Interview for Mental Status (BIMS) exam score of 9 out of a possible 15, indicating he/she has moderate cognitive impairments. Further review of the MDS indicated Resident #50 requires dependent assistance for daily self-care activities and is on oxygen therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #50's physician orders indicated the following: -Oxygen 2-3 liters via nasal cannula to maintain O2 Sats above 88% - document that O2 on by initialing (3 OF 3), every shift, initiated 3/14/24. -Place portable liquid oxygen on when out of room, initiated 4/24/24. Review of Resident #50's oxygen care plan indicated the following: -Oxygen settings: I have O2 (oxygen) via nasal prongs/mask @ (2-3) L (liters) continuously, initiated 3/14/24. -Provide me extension tubing or portable oxygen apparatus if I am out of my room, initiated 3/14/24. On 3/4/25 at 12:15 P.M., and 4:32 P.M., and 3/5/25 at 9:53 A.M., 12:13 P.M., 12:26 P.M., and 5:10 P.M., Resident #50 was observed in the dining room not receiving oxygen and with his/her portable oxygen tank and tubing attached to the handle of his/her wheelchair. Review of Resident #50's nursing documentation failed to indicate Resident #50 refused to wear his/her oxygen when out of his/her room. During an interview on 3/6/25 at 8:41 A.M., Unit Manager #2 said Resident #50 should have his/her oxygen on when he/she is out of their room, but at times he/she takes it off. During an interview on 3/6/25 at 9:10 A.M., the Director of Nursing said Resident #50's oxygen should be on when out of his/her room and documented if the resident refuses.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on observation, record review and interview, the facility failed to ensure the comprehensive care plan was revised by the interdisciplinary team for two Residents (#28 and #70) out of a total sample of 26 residents, after each assessment, including both the comprehensive and quarterly review assessments. Specifically, the facility failed to review and revise the care plan after quarterly assessments were completed to reflect the current status of the Residents. Findings Include: Review of facility policy titled Care Plans, Comprehensive Person- Centered, reviewed 10/21/24, indicated the following: -A comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -The comprehensive person-centered care plan will: -g. Incorporate identified problem areas -h. Incorporate risk factors associated with identified problems 1a. Resident #28 was admitted to the facility in March 2016 with diagnoses that include acute on chronic respiratory failure, obstructive sleep apnea and paranoid schizophrenia. Review of the Minimum Data Set (MDS) assessment, dated 11/26/24 indicated that a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. Review of Resident #28's active care plans indicated the following: - I have BL heel Fractures r/t Fall- care plan from, revised 6/10/2013. -I have been diagnosed with Covid-19, with interventions that included airborne droplet precautions to prevent the spread of the infection, revised 10/19/22. -I have unplanned/unexpected/significant weight gain r/t (related to) Corticosteroid use, overeating, revised 9/29/23. -I am on Antibiotic Therapy r/t COPD, PNA (related to chronic obstructive pulmonary disease and pneumonia), revised 3/13/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record failed to indicate current bilateral heel fractures. Review of the medical record failed to indicate active covid-19 diagnosis. Review of the medical record indicated that between August 2024 and March 2025, Resident #28 had experienced a significant weight loss. Review of the medical record failed to indicate current antibiotic use. 1b. Resident #70 was admitted to the facility in April 2022 with diagnoses that include adjustment disorder with depressed mood, arthritis and glaucoma. Review of Resident #70's most recent MDS, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment. The MDS failed to indicate the use of antibiotics during the look back period. Review of Resident #70's active care plans indicated the following: -I have been diagnosed with covid-19, with interventions for airborne droplet precautions to prevent the spread of infection, dated as revised 5/6/22. Review of the medical record failed to indicate an active covid-19 diagnoses. During an interview on 3/5/25 at 1:25 P.M., the Minimum Data Set (MDS) nurse said that the Director of Nurses reviews each MDS after it is completed and bring forward data to the care plan as needed. She said care plans should be updated and revised after each MDS assessment. She said that when a focus in the care plan is no longer applicable to the Resident it should be resolved from the care plan. During an interview on 3/5/25 at 1:46 P.M., the Director of Nurses said that the comprehensive care plan should include current and up to date information and for Resident #28 and Resident #70, and their care plans did not.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs), for seven Residents (#18, #24, #58, #61, #26, #39, and #9) out of a total sample of 26 residents. Specifically, 1. For Residents #18, #24, #58, #61, #26 and #39, the facility failed to provide assistance and/or supervision with meals as per the plan of care. 2. For Resident #9, the facility failed to provide assistance with grooming. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs), dated March 2018, indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with: d. Dining (meals and snacks). 1a. Resident #18 was admitted to the facility in August 2021 with diagnoses that included dementia, dysphagia, repeated falls, and anxiety disorder. Review of Resident #18's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. The MDS further indicated he/she is dependent on staff for eating. On 3/4/25 from 8:28 A.M. to 8:39 A.M., the surveyor observed Resident #18 awake and in bed, their breakfast tray was left on the nightstand next to him/her not set up for consumption. The surveyor observed multiple staff members walk by the Resident's room. On 3/5/25 from 8:14 A.M. to 8:27 A.M., the surveyor observed Resident #18 awake and in bed, their breakfast tray was left on their over-the-bed table in sight and in reach, not set up for consumption. The surveyor observed multiple staff members walk by the Resident's room. On 3/6/25 from 8:18 A.M. to 8:26 A.M., the surveyor observed Resident #18 awake and in bed, their breakfast tray was left on their dresser in front of his/her bed in sight. The surveyor observed multiple staff members walk by the Resident's room. Review of Resident #18's eating care plan, dated 2/19/24, indicated Eating goals over next 90 days select one: Dependent. Review of Resident #18's active Certified Nurse Aide (CNA) Kardex (form explaining to staff the needs of each Resident), indicated he/she is dependent on staff for eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 8:31 A.M., CNA #3 said there are not enough staff members on this floor to assist all the residents that need assist on this floor. CNA #3 said the tray should not be left for a resident who needs assistance with their meal. During an interview on 3/6/25 8:30 A.M., Unit Manager #2 said they do not have enough staff to feed every resident on this floor. Unit Manager #2 said staff should be following each residents care plan and CNA Kardex. During an interview on 3/6/25 at 8:59 A.M., the Director of Nurses said she expects staff to follow each residents care plan and CNA Kardex. 1b. Resident #24 was admitted to the facility in July 2021 with diagnoses that included Alzheimer's disease, dysphagia, anxiety and depression. Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 1/14/25, indicated he/she was assessed by nursing staff to have moderate cognitive impairments. The MDS further indicated he/she needed partial/moderate assistance from staff for eating. On 3/4/25 at 8:26 A.M., the surveyor observed Resident #24 awake and in bed, their breakfast tray was left on the bedside table next to him/her not set up for consumption. No staff were in the room. On 3/4/25 from 11:52 A.M. to 12:11 P.M., the surveyor observed Resident #24 in the dining room with his/her lunch tray. No staff were observed assisting the Resident with his/her meal. On 3/5/25 from 12:03 P.M. to 12:13 P.M., the surveyor observed Resident #24 in the dining room with his/her lunch tray. Resident #24 was observed to not initiate self feeding. On 3/6/25 from 8:22 A.M. to 8:27 A.M., the surveyor observed Resident #24 awake and in bed, their breakfast tray was partially set up, drinks were left covered. Resident #24 was observed to not initiate self feeding. Review of Resident #24's eating care plan, dated 2/19/24, indicated Eating goals over next 90 days select one: Partial/Moderate Assistance. Review of Resident #24's active Certified Nurse Aide (CNA) Kardex, indicated he/she needs partial/moderate assistance from staff for eating. During an interview on 3/6/25 8:30 A.M., Unit Manager #2 said they do not have enough staff to feed every resident on this floor. Unit Manager #2 said staff should be following each resident's care plan and CNA Kardex. During an interview on 3/6/25 at 8:59 A.M., the Director of Nurses said she expects staff to follow each resident's care plan and CNA Kardex. 1c. Resident #58 was admitted to the facility in August 2020 with diagnoses that included dementia, glaucoma, transient visual loss, and delusional disorders. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #58's most recent Minimum Data Set (MDS) assessment, dated 11/28/24, indicated he/she scored a one out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Further review of the MDS indicated he/she requires partial/moderate assistance from staff for eating. On 3/4/25 from 8:14 A.M. to 8:20 A.M., the surveyor observed Resident #58 in the dining room with his/her breakfast tray. Resident #58 was observed to not initiate self-feeding. On 3/4/25 from 12:14 P.M. to 12:16 P.M, the surveyor observed Resident #58 in bed, his/her tray was left of the over the bed table next to the bed not set up for consumption. On 3/5/25 from 8:00 A.M. to 8:27 A.M., the surveyor observed Resident #58 in the hallway with his/her breakfast tray. Resident #58 was observed to not initiate self-feeding. On 3/6/25 from 8:18 A.M. to 8:34 A.M., the surveyor observed Resident #58 in his/her bed with his/her breakfast tray. Resident #58 was observed to not initiate self-feeding. Review of Resident #58's eating care plan, dated 2/19/24, indicated Eating goals over next 90 days select one: Partial/Moderate Assistance. I am easily distracted and need constant coaxing and reminders to finish my meals . will not finish my meal nor really eat without your intervention whether it be verbal cues or physical assistance. Review of Resident #58's active CNA Kardex, indicated Eating: Partial/moderate assist. During an interview on 3/6/25 8:30 A.M., Unit Manager #2 said they do not have enough staff to feed every resident on this floor. Unit Manager #2 said staff should be following each resident's care plan and CNA Kardex. During an interview on 3/6/25 at 8:59 A.M., the Director of Nurses said she expects staff to follow each resident's care plan and CNA Kardex. 1d. Resident #61 was admitted to the facility in August 2021 with diagnoses that included dementia, Alzheimer's disease, anxiety disorder, pressure ulcer of right heel, and major depressive disorder. Review of Resident #61's most recent Minimum Data Set (MDS) assessment, dated 2/13/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Further review of the MDS indicated he/she is dependent on staff for eating. On 3/4/25 from 8:15 A.M. to 8:32 A.M., the surveyor observed Resident #61 in the dining room with his/her breakfast tray in just out of reach of him/her not set up for consumption. On 3/4/25 from 12:06 P.M. to 12:23 P.M., the surveyor observed Resident #61 in the dining room with his/her lunch tray in just out of reach of him/her not set up for consumption. On 3/5/25 from 8:05 A.M. to 8:11 A.M., the surveyor observed Resident #61 in the dining room with his/her breakfast tray in just out of reach of him/her not set up for consumption. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 from 12:13 P.M. to 12:17 P.M., the surveyor observed Resident #61 in the dining room, staff were assisting other residents with their meals. Resident #61 did not have a meal tray or assistance during this time, all other residents had meal trays during this observation period. On 3/6/25 from 7:55 A.M. to 8:02 A.M., the surveyor observed Resident #61 in the dining room with his/her breakfast tray in just out of reach of him/her not set up for consumption. Review of Resident #61's eating care plan, dated 2/19/24, indicated Eating goals over next 90 days select one: Supervision or Touching Assistance. Review of Resident #61's active CNA Kardex, indicated he/she was dependent on staff for eating. During an interview on 3/6/25 8:30 A.M., Unit Manager #2 said they do not have enough staff to feed every resident on this floor. Unit Manager #2 said staff should be following each resident's care plan and CNA Kardex. During an interview on 3/6/25 at 8:59 A.M., the Director of Nurses said she expects staff to follow each resident's care plan and CNA Kardex. 45984 1e. Resident #26 was admitted to the facility in February 2016 with diagnoses including schizophrenia, dysphagia and seizures. Review of Resident #26's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident was unable to complete the Brief Interview for Mental Status exam indicating the resident has severe cognitive impairment. Further review of the MDS indicated that the Resident is dependent on staff for activities of daily living and requires partial/moderate assistance with eating. The surveyor made the following observations: - On 3/4/25 at 12:34 P.M., Resident #26 was eating lunch in the dining room. Resident #26 was feeding him/herself without any staff assistance. The Resident had pureed food remnants around his/her mouth and it was spilling onto his/her chest. - On 3/5/25 at 9:04 A.M., Resident #26 was observed sitting in his/her bed with his/her breakfast in front of him/her on the bedside table. Resident #26 was feeding him/herself with no staff assistance. - On 3/5/25 at 12:24 P.M., Resident #26 was eating lunch in the dining room. Resident #26 was feeding him/herself without any staff assistance, the Resident has spilled coffee and food all over his/her feeding protector. - On 3/6/25 at 8:19 A.M., staff brought in Resident #26's breakfast while he/she was lying in bed. Staff set up the tray and left the room. Resident #26 was observed to have pureed food all over his/her mouth and it was dripping onto his/her chest and was eating very quickly. At 8:34 A.M., Resident #26 was observed to tilt his/her all the way back while swallowing food. At 8:35 A.M., Resident #26 finished his/her entire breakfast with no staff assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's document titled CNA Flow Sheet Worksheet, revised and dated 9/27/23 indicated that Resident #26 requires Partial/moderate assist with all meals. Review of Resident #26's eating care plan dated 10/27/23 indicated the following interventions: - Eating goals over the next 90 days: partial/moderate assistance. - I have dysphagia and I am a real choking hazard waiting to happen. I eat too fast or eat bites that are too large and need to be slowed down and reminded to take small bites with rest periods between so I can thoroughly chew my food and swallow accordingly. - Assist me/feed me with eating when I become fatigued or disinterested or confused or focused elsewhere - I have been known to pocket my food - I need encouragement to eat by my helpers Review of Resident #26's Nutrition care plan related to chewing and swallowing difficulties due to dysphagia, dated 2/4/25, indicated the following interventions: Staff to monitor for s/sx (signs/symptoms) of chewing or swallowing difficulties. Review of Resident #26's Dietary Assessment, dated 2/4/25, completed by the Registered Dietitian, indicated Resident #26 needs to be physically assisted with his/her ability to eat. During an interview on 3/6/25 at 8:58 A.M., Certified Nursing Assistant (CNA) #7 said Resident #26 only requires supervision with meals because he/she has choking concerns and has a history of seizures. During an interview on 3/6/25 at 9:05 A.M., CNA #8 said we use the Resident's flow sheets to know what level of ADL care they need. CNA #8 continued to say Resident #26 only needs supervision with meals due to choking. During an interview on 3/6/25 at 9:38 A.M., Nurse #2 said Resident #26 only needs supervision with his/her meals due to choking and seizures and he was aware the Resident did not get supervision this morning. Nurse #2 was not aware Resident #26 was supposed to have partial/moderate assistance with meals. During an interview on 3/6/25 at 9:52 A.M., Unit Manager #1 said he thought Resident #26 only needed supervision with meals and not staff assistance. During an interview on 3/6/25 at 10:11 A.M., the Director of Nursing (DON) said we check Resident's flow sheets to know what level of ADL assistance a resident needs. The surveyor and DON reviewed Resident #26's flow sheet and the DON said he/she should be receiving partial/moderate assistance with all meals. 45343 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1f. Resident #39 was admitted to the facility in March 2016, with diagnoses including Alzheimer's Disease, dysphagia (difficulty swallowing), and major depressive disorder. Review of Resident #39's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident has severe cognitive deficits. The MDS further indicated Resident #39 requires dependent assistance for eating On 3/4/25 at 8:15 A.M., 8:25 A.M., and 8:30 A.M., the surveyor observed Resident #39 awake lying in bed, with their breakfast tray left on the bedside table next to him/her. There was no staff observed providing assistance with self-feeding. On 3/5/25 at 8:04 A.M., 8:12 A.M., and 8:25 A.M., the surveyor observed Resident #39 awake lying in bed with their breakfast tray left on his/her dresser next to his/her bed. There was no staff observed providing assistance with self-feeding. On 3/6/25 at 8:04 A.M., 8:15 A.M., and 8:28 A.M., the surveyor observed Resident #39 awake lying in bed, with their breakfast tray left on the bedside table next to him/her. There was no staff observed providing assistance with self-feeding. Review of Resident #39's eating care plan, dated 10/25/23, indicated EATING GOALS OVER NEXT 90 DAYS SELECT ONE: DEPENDENT. Further review of Resident #39's Kardex (a form indicating level of assistance a resident requires) dated as of 3/13/24 indicated he/she is dependent on staff for eating. During an interview on 3/6/25 at 8:31 A.M., CNA #3 said there are not enough staff members on this floor to assist all the residents that need assist on this floor. CNA #3 said the tray should not be left for a resident who needs assistance with their meal. During an interview on 3/6/25 at 8:30 A.M., Unit Manager #2 said they do not have enough staff to feed every resident on this floor. Unit Manager #2 said staff should be following each resident's care plan and CNA Kardex. During an interview on 3/6/25 at 8:59 A.M., the Director of Nurses said she expects staff to follow each resident's care plan and CNA Kardex. 2. Resident #9 was admitted to the facility in December 2020, with diagnoses including Peripheral vascular disease, Type 1 Diabetes Mellitus, schizoaffective disorder, and major depressive disorder. Review of Resident #9's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15, indicating he/she has severe cognitive impairments. The MDS also indicated Resident #9 requires substantial/maximal assistance for all self-care activities. On 3/4/25 at 7:40 A.M., 8:30 A.M., and 12:15 P.M.; 3/5/25 at 7:00 A.M., 8:16 A.M. and 12:05 P.M.; 3/6/25 at 8:59 A.M., and 3/6/25 at 7:55 A.M., Resident #9 was observed with upper lip hair. Resident #9 said he/she normally does not have facial hair, and staff normally remove his/her facial hair on their shower day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the unit shower schedule on 3/6/25 at 7:58 A.M., indicated Resident #9's shower day is Mondays (P.M.). Review of Resident #9's nursing notes failed to indicate he/she refused care. During an interview on 3/6/25 at 10:10 A.M., Unit Manager #2 said we normally shave Residents during morning care with their permission. Unit Manager #2 said if a resident refuses care, the Certified Nursing Assistant will notify her and they will reattempt care. Unit Manager #2 said she was not notified Resident #9 was refusing care. During an interview on 3/6/25 at 9:01 A.M., the Director of Nursing said she would expect facial hair to be removed with the resident's permission during routine care and any refusals should be documented in the medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43846 Based on observation, record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for one Resident (#24), out of a total sample of 26 residents. Specifically, the facility failed to assess the Resident who is dependent on staff for care was found with a bruise under his/her left eye. Findings include: Resident #24 was admitted to the facility in July 2021 with diagnoses that included Alzheimer's disease, dysphagia, anxiety and depression. Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 1/14/25, indicated he/she was assessed by nursing staff to have moderate cognitive impairments. The MDS further indicated he/she needed partial/moderate assistance from staff for eating. On 3/4/25 at 7:40 A.M. , the surveyor observed Resident #24 in bed with a dark purple bruise under his/her left eye. On 3/4/25 at 11:52 A.M., the surveyor observed Resident #24 in the dining room with a dark purple bruise under his/her left eye. Review of Resident #24's weekly skin check, dated 2/18/25, indicated Resident's skin is dry, warm and intact. No bruise was noted on the skin check. Review of Resident #24's weekly skin check, dated 2/25/25, indicated Resident's skin is dry, warm and intact. No bruise was noted on the skin check. Review of Resident #24's weekly skin check, dated 3/4/25, indicated All skin areas with no discoloration, dry and with no open areas. No skin issues. No bruise was noted on the skin check. Review of Resident #24's nursing progress notes from 1/14/25 to 3/4/25 failed to indicate the Resident had a bruise under his/her left eye, or that the Medical Doctor and Health Care Proxy was aware. Review of Resident #24's physician orders failed to indicate he/she was on an anticoagulant medication (a medication that makes someone more at risk for bruising). During an interview on 3/6/25 at 7:43 A.M., Unit Manager #2 said Resident #24 has had a bruise under his/her left eye since 2/16/25 which was much bigger then. Unit Manager #2 said the nurse that initiated the incident failed to complete it and did not write a nursing progress note, did not alert the health care proxy (HCP) or the medical doctor (MD). Unit Manager #2 said there should have been a nursing note written and a full assessment completed for this Resident but it was not done. Unit Manager #2 said this Resident is dependent on staff for care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 8:52 A.M., the Director of Nursing (DON) said a nurse initiated a incident report for the bruise found under Resident #24's left eye but never finished it. The DON said the nurse should have gathered more statements, wrote a nursing progress note, alerted the HCP and MD, do a skin check for the newly found bruise and put an intervention into place to keep the resident safe but none of that was done. The DON said she would expect a full assessment done on a Resident who had a new large bruise found on their face.

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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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, record review and interviews, the facility failed to ensure residents at risk for developing pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to prevent new ulcers from developing for four Residents (#61, #60, #69, and #78) out of a total of 26 sampled residents. Specifically, 1. For Resident #61 who has a pressure ulcer, the facility failed to ensure that his/her air mattress had a physician's order in place and failed to set it to the Resident's weight. 2. For Resident #60 who has a pressure ulcer, the facility failed to ensure that his/her air mattress was set to the physician's orders. 3. For Resident #69 who has a pressure ulcer, the facility failed to follow the wound doctor's recommendation for sitting up in a wheelchair for no more than one hour each day. 4. For Resident #78, who has a pressure ulcer, the facility failed to ensure that his/her air mattress had a physician's order in place and failed to implement physician's orders for heel lifters and blanket lifters while in bed. Findings include: Review of Facility policy titled Policy for Bed Air Mattress, dated as updated 12/29/22, indicated the following: -A Bed Air Mattress can be utilized to provide pressure relief surface for Residents exhibiting tissue loss or residents with loss of mobility and potential for tissue loss. [sic] -Doctors order is obtained for residents without contradictions; an air mattress may be unsuitable for residents with spinal orthopedic fractures or whose body habitus does not meet the size limits as per manufacturer guidelines. -Air mattress use is documented in nursing and CNA care plans and the resident is required/ documented to have assist of 2 for bed mobility and transfers with air mattress in place. -Resident is weighed weekly and air mattress is calibrated with internal pressure of Air Mattress. Accurate weight is documented in the physician's order. Review of Facility policy titled Pressure Ulcers/ Skin Breakdown- Clinical Protocol, dated as revised April 2018, indicated the following: -The physician will order pertinent wound treatments, including reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and the application of topical agents. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #61 was admitted to the facility in August 2021 with diagnoses that included dementia, Alzheimer's disease, anxiety disorder, pressure ulcer of right heel, and major depressive disorder. Review of Resident #61's most recent Minimum Data Set (MDS) assessment, dated 2/13/25, indicated he/she was assessed by nursing staff to have severe cognitive impairment. Further review of the MDS indicated he/she is at risk for developing pressure ulcers and has one stage 2 unhealed pressure ulcer over a boney prominence. On 3/5/25 at 6:53 A.M., the surveyor observed Resident #61 in bed on an air mattress, the air mattress was set to 180 lbs (pounds). Review of Resident #61's weights indicated: - 3/6/25 weight 111.2 lbs. - 3/3/25 weight 111.2 lbs. Review of Resident #61's Braden (Scale for predicting pressure sore risk) score, dated 2/12/25, indicated a score of 10 indicating he/she is at high risk for developing pressure ulcers. Review of Resident #61's active physician orders failed to indicate an order was in place for his/her air mattress. During an interview on 3/6/25 at 7:42 A.M., Unit Manager #2 said Resident #61 is on an air mattress and that the Resident does have a pressure ulcer on their foot. Unit Manager #2 said the air mattress should be set to the Resident's weight and there should be a physician's order in place. During an interview on 3/6/25 at 8:58 A.M., the Director of Nursing said if a resident is on an air mattress nursing should have put in a physicians order and the air mattress should be set to weight. 44095 2. Resident #60 was admitted to the facility in September 2022 with diagnoses including neuromuscular dysfunction of the bladder, diabetes, and Parkinson's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/7/25, indicated Resident #60 was dependent on staff for activities of daily living. This MDS indicated Resident #60 was assessed as at risk for developing pressure ulcers and he/she had one unhealed pressure ulcer/injury. Review of Resident #60's physician's order, dated 2/21/25, indicated: - Right buttock stage 2 pressure ulcer: wash area with vashe, pat dry, apply calcium alginate and cover with optifoam daily and as needed, every day shift. Review of Resident #60's physician's order, dated 1/31/25, indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Air Mattress - Dial - Monitor - setting every shift to confirm correct internal pressure setting based on the resident's current weight - choices are 65, 115, 155, 200, 240, 285, 325 pounds - weights less than 10 pounds difference before next level will be pushed to next highest level over that. Review of Resident #60's plan of care related to impaired skin integrity, dated 2/3/25, indicated: - Air Mattress- Digital/Dial - Monitor setting on residents current weight - change setting if weight setting does not match current weight accordingly - scales vary on different machines - settings should be next highest level (example 135 pounds would register at 150 mark) - If weight is 10 pounds less than next highest category than setting should allow for clothing, fluid, and food (example 140 pounds would be set not at 150 but 200 pounds). Review of Resident #60's weights indicated he/she weighed the following: - On 3/4/25 and 3/5/25 172.3 pounds, and - On 3/6/25 169.4 pounds. On 3/4/25 at 10:29 A.M., 1:11 P.M., and at 4:13 PM, on 3/5/25 at 6:39 A.M., 7:48 A.M., 11:37 A.M., 1:47 P.M. , and at 3:17 P.M., and on 3/6/25 at 6:46 A.M., and at 7:18 A.M., the surveyor observed Resident #60 in bed, his/her air mattress dial was set between 320 and 350 pounds. The dial on Resident #60's air mattress included the following numbers 80, 120, 150, 180, 210, 250, 280, 320, and 350 pounds. Comparative review of the physician's order failed to include numbers that coincided with Resident #60's air mattress. During an interview on 3/6/25 at 7:48 A.M., Certified Nurse Assistant (CNA) #5 said he just completed care for Resident #60, and he does not adjust air mattress settings. During an interview on 3/6/25 at 7:53 A.M., Nurse #6 said that air mattress settings are checked every shift based on the physician's order. Nurse #6 said that Resident #60's air mattress should be set to his/her weight. During an interview on 3/6/25 at 8:38 A.M., Unit Manager #1 said that Resident #60 has an air mattress for his/her pressure ulcer. Unit Manager #1 said that nurses should check air mattress settings during their medication pass and document according to the physician's order. During an interview on 3/6/25 at 11:47 A.M., the Director of Nursing (DON) said Resident #60 has a pressure ulcer and his/her air mattress should be set to his/her weight to help heal his/her pressure ulcer. 45984 3. Resident #69 was admitted to the facility in December 2024 with diagnoses including pressure ulcer of sacral region, anxiety disorder, bipolar disorder and bronchitis. (continued on next page)

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Sudbury Pines Extended Care	642 Boston Post Road Sudbury, MA 01776

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #69's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 13 out of 15 indicating intact cognition. Further review of the MDS indicated that the Resident is dependent on staff for ADLs including transferring from a bed to chair and has a stage 4 pressure ulcer. The surveyor made the following observations: - On 3/4/25 at 12:17 P.M., Resident #69 was sitting in his/her wheelchair in his/her room. At 2:06 P.M., Resident #69 was still sitting in his/her wheelchair in his/her room. Resident #69 told the surveyor that his/her butt hurt and he/she has been sitting in his/her wheelchair since lunch at noontime. Resident #69 continued to say that staff will eventually get to him/her to put him/her in bed. At 2:41 P.M., Resident #69 was still sitting in his/her wheelchair in his/her room. Resident #69 was sitting in his/her wheelchair for two hours and twenty-four minutes. - On 3/5/25 at 12:01 P.M., Resident #69 was sitting in his/her wheelchair in his/her room. At 12:36 P.M., Resident #69 told the surveyor that his/her butt hurts when he/she sits in his/her wheelchair for too long. At 1:27 P.M., Resident #69 was still sitting in his/her wheelchair in his/her room. Resident #69 was sitting in his/her wheelchair for one hour and twenty-six minutes. Review of Resident #69's weekly Wound Care Specialist Physician Follow up Visit notes dated 12/27/24, 1/3/25, 1/10/25, 2/7/25, 2/14/24, 2/21/25 and 2/28/25 indicated the following: - Plan: Emphasized the importance of limiting time to chair to <1 hr/day (less than one hour per day) to prevent further deterioration (of sacral wound). Review of Resident #69's physician's orders failed to indicate an order to limit the amount of time Resident #69 sits down in his/her wheelchair due to his/her sacral wound. Review of Resident #69's Mobility/Transfer - Chair/Bed to - chair transfer care plan indicated the following interventions dated 12/30/24: Dependent; Hoyer 2+ person, I am not safe transferring myself from bed to chair and need helpers to provide physical assistance during the transfer. Review of Resident #69's Certified Nursing Assistant (CNA) flow sheet indicated that the Resident is dependent on staff for transferring from chair/bed to chair. Review of Resident #69's impaired functional mobility due to a sacral wound care plan indicated the following intervention dated 1/31/25: Please follow wound team guidelines of patient being OOB (out of bed) in chair for no more than 45 minutes per day to facilitate wound healing. Review of Resident #69's document titled Braden Scale for Predicting Pressure Sore Risk dated 1/28/25 indicated that the Resident was a high risk for developing pressure ulcer sores. During an interview on 3/6/25 at 8:58 A.M., CNA #7 said Resident #69 requires a Hoyer lift to get out of bed and the Resident will tell staff when he/she wants to go back to bed from his/her chair. CNA #7 then said the Resident has the worst pressure ulcer in the building right now. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, with a translator on 3/6/25 at 9:07 A.M., CNA #5 said Resident #69 is dependent on staff and she usually stays in his/her wheelchair for 2-3 hours each day. CNA #5 then said Resident #69 has pain on his/her backside if he/she sits for too long and he/she tells us when he/she wants to go back to bed. During an interview on 3/6/25 at 9:38 A.M., Nurse #2 said Resident #69 is up in his/her wheelchair for meal times. Nurse #2 then said the facility has a wound team that comes in weekly and the Unit Manager and Director of Nursing (DON) will round with them to document any recommendations they make for each resident. Nurse #2 said these recommendations almost always get implemented by the facility. During an interview on 3/6/25 at 10:11 A.M., Unit Manager #1 said he does rounds with the wound team when they come to the building and he will receive recommendations. Unit Manager #1 then said he will let the Nurse Practitioner or DON know, he then said he has never seen the facility not accept recommendations made by the wound team. Unit Manager #1 then said Resident #69 usually goes into his/her wheelchair by 10:30 A.M., and will stay in it for a couple of hours. During an interview on 3/6/25 at 10:11 A.M., the DON said herself and the Unit Manager will round with the wound team and implement any recommendations they make. The DON said Resident #69 is usually in his/her wheelchair for an hour to two hours depending on how much he/she can handle. The DON said the facility should be implementing the recommendations from the wound team to limit Resident #69 from being in his/her wheelchair for no more than an hour and there should be a physician's order so staff know. 49880 4. Resident #78 was admitted to the facility in March 2024 with diagnoses that included metabolic encephalopathy, moderate protein calorie malnutrition and diabetes. Review of Resident #78's MDS, dated [DATE], indicated a Brief Interview for Mental Status score of 6 out of 15, indicating severe cognitive impairment. The MDS further indicated that the Resident did not have any pressure ulcers. Review of the Braden Score for Predicting Pressure Sore Risk Assessment, dated 12/2/24, indicated that Resident #78 was at high risk for development of pressure ulcers with a score of 10. Review of Resident #78's most recent wound consult note, dated 2/28/25, indicated the following: -Stage 3 pressure ulcer (full thickness wound) is located on the sacrum. -Wound size is 1.5 cm (centimeters) length, 1.0 cm width and 0.1 cm depth. -Assessment: Not improved stage 3 pressure ulcer. -Off loading discussed: suggest mattress upgrade. Review of Resident #78's active care plan, dated 5/10/24, indicated, I have pressure ulcer or potential for pressure ulcer development [related to history] of ulcers, immobility. [sic] (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4a. On 3/4/25 at 7:59 A.M., Resident #78 was observed lying in bed on his/her back. There was an air mattress on the bed set to 270 pounds. Resident #78 said that he/she has a wound on their bottom. -On 3/5/25 at 6:58 A.M., Resident #78 was observed lying in bed on his/her back. There was an air mattress on the bed set to 270 pounds. -On 3/5/25 at 9:26 A.M., and 12:57 P.M., Resident #78 was observed lying in bed on his/her back. There was an air mattress on the bed set to 330 pounds. -On 3/6/25 at 7:42 A.M., Resident #78 was observed sleeping in bed on his/her back. There was an air mattress on the bed set to 330 pounds. Review of Resident #78's medical record indicated a current weight of 141.9 pounds on 3/4/25. Review of Resident #78's active physician's orders failed to indicate an order for the use of an air mattress. During an interview on 3/5/24 at 1:00 P.M. Nurse #5 said that air mattress settings are determined by the resident's weight. She said that residents who use an air mattress should have a physician's order for use that includes the settings. Nurses check the settings every shift. During an interview on 3/6/25 at 8:27 A.M., Unit Manager #1 said that air mattress settings are based on the resident's weight. He said that there should be a physician's order for use of an air mattress with the settings included in the order. He said that if the setting of an air mattress is too high, it would be too hard and defeat the purpose of using an air mattress and a wound could potentially worsen. During an interview on 3/6/25 at 8:40 A.M., the Director of Nurses said that an air mattress should be set to the resident's weight, or the closes possible weight based on the air mattress. She said that there should be a physician's order in place indicating the setting for the air mattress and nurses should be ensuring the correct settings every shift. The Director of Nurses said that an air mattress set at a weight too high for a resident would defeat the purpose of using an air mattress. 4b. Review of Resident #78's physician's orders indicated the following: -Sacrum pressure ulcer: wash area with vashe (or similar antibacterial wound cleanser) pat try, apply calcium alginate and cover with optifoam daily and as needed, dated 3/1/25. [sic] -Blanket lifter for feet at all times when in bed every shift for wound care, dated 5/10/24. -Heel lifters while in bed every shift, dated 4/11/24. -On 3/4/25 at 7:59 A.M., Resident #78 was observed lying in bed on his/her back. An air mattress was in place. The Resident's bilateral heels were directly on the mattress, and blankets were directly over his /her feet. No blanket lift or heel lifters were in use. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/5/25 at 6:58 A.M., 9:26 A.M., and 12:57 A.M., Resident #78 was observed lying in bed on his/her back. An air mattress was in place. The Resident's bilateral heels were directly on the mattress, and blankets were directly over his/her feet. No blanket lift or heel lifters were in use. -On 3/6/25 at 7:42 A.M., Resident #78 was observed sleeping in bed on his/her back. An air mattress was in place. The Resident's bilateral heels were directly on the mattress and blankets were directly over his/her feet. No Blanket lift or heel lifters were in use. Review of the March 2025 Treatment Administration Record (TAR) indicated that Resident #78's blanket lifter and heel lifters were applied as indicated in the physician's orders. During an interview on 3/6/25 at 8:27 A.M., Unit Manager #1 said that Resident #78 is accepting of care and does not refuse care. He said that staff should be implementing heel and blanket lifters as indicated in the physician's orders. He said that the Resident is at risk for skin breakdown. During an interview on 3/6/24 at 8:40 A.M., the Director of Nurses said that staff should be implementing physician's orders for a blanket lift and heel elevation. She said that if a resident refuses, it should be documented as refused.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on observation, record review, and interview, the facility failed to ensure it provided an environment free of potential safety hazards for three Residents (#60, #17, and #41) out of a total sample of 26 residents. Specifically: 1. For Resident #60, the facility failed to ensure nursing provided two-person assistance with a lift (Sara lift, a sit-to-stand style lift). 2. For Resident #17, the facility failed to ensure he/she was consistently provided with a smoking apron while smoking. 3. For Resident #41, the facility failed to ensure nursing provided a bed and chair alarm as ordered by the physician and plan of care. Findings include: 1. Review of the facility policy titled, Lifting Machine, Using a Mechanical, dated as revised July 2017, indicated the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lift device. It is not a substitute for manufacturer's training or instruction. -General Guidelines: 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 3. Types of lifts that may be available in the facility are: c. Sit-to-stand lift 1. Resident #60 was admitted to the facility in September 2022 with diagnoses including neuromuscular dysfunction of the bladder, diabetes, and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment, dated 12/26/24, indicated that Resident #60 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #60 required dependent (total) assistance for chair/bed-to-chair transfers. Review of Resident #60's plan of care related to toilet transfers, dated 1/21/24, indicated: - I use a Sara lift for transferring for toileting hygiene. Review of Resident #60's plan of care related to mobility and transfers, dated 1/21/24, indicated: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dependent Sara lift 2 People Required. Review of Resident #60's Fall- Near Fall/ Assisted down or caught, incident report, dated 1/19/25 at 7:52 A. M., indicated the following: - Incident Description: this writer was at the med cart when the Certified Nursing Assistant (CNA) approached to report the near fall. When I arrived in the room, I found the resident in a supine position. Holding on with his/her right hand of metal on the side of the bed. - Immediate Action Taken: The CNA said the resident was standing on the Sara lift and suddenly he/she slides down, he tried to hold him/her he couldn't, then lower him/her to the floor. CNA said the resident did not hit his/her head. The resident as well said he/she didn't hit his/her head. - Other Info: Was lowered to the floor during transfer. Resident was weak and legs gave out. Staff Statement: 1/19/25 Resident slide off the Sara lift during transfer from bed to wheelchair. I tried to catch him/her, unsuccessful. I slid him/her to the floor. He/she did not hit her head. [sic] Review of the NURSING - Incident/Accident/Fall Reporting & Intervention Note, dated as 1/19/25, indicated: - Fall: The CNA said that the resident was standing on the Sara lift and suddenly he/she slides down, he tried to hold him/her, couldn't then lower him/her to the floor. During an interview on 3/6/25 at 9:16 A.M., CNA #6 said on 1/19/25 he transferred Resident #60 by himself when he/she slid from the Sara lift. On 3/6/25 at 7:18 A.M., the surveyor observed CNA #5 go into Resident #60's room alone with the Sara lift. The surveyor stayed at the door and the surveyor observed the CNA providing care. The surveyor did not leave the door, and the surveyor did not observe any additional staff members entering the room. On 3/6/25 at 7:41 A.M, the surveyor observed CNA #5 transfer Resident #60 alone with the Sara lift. There was a bright pink piece of paper on the Sara lift which indicated THIS LIFT REQUIRES 2 ASSISTS, there were no additional staff members in the room. During an interview on 3/6/25 at 7:47 A.M., CNA #5 said he could use one to two staff members for the Sara lift. CNA #5 said he was alone when he transferred Resident #60. During an interview on 3/6/25 at 11:53 A.M., the Director of Nursing (DON) said on 1/19/25 Resident #60 slid from the Sara lift. The DON said that CNA #6 did not use a second person when transferring Resident #60 and he should have. The DON said that after Resident #60's fall on 1/19/25 the facility educated all staff on using two assists with the Sara lift and even added bright pink paper on the lifts that indicated 2 assists. The surveyor made the DON aware of the observation on 3/6/25 at 7:41 A.M., the DON said that CNA #5 should have used a second staff member for the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility policy titled, Smoking Policy - Residents, dated as revised 6/12/23, indicated the Facility shall establish and maintain safe resident smoking practices according to local, state, and federal regulations. -Policy and Procedure The facility allows smoking for residents, visitors, and staff but only in specific areas outside and for the residents under direct supervision at specific time frames. The facility prohibits any smoking inside the building. The facility screens the residents for their ability to smoke and adhere to the rules. It someone is non-compliant with the rules and conditions, then they are at risk of losing their ability to smoke, Smoking ability can be restricted or denied if staff determine there is a safety concern. 9. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine any restrictions on a resident's smoking privileges. If the resident elects to pursue smoking cessation medication or strategies, then the MD/PA/NP will be notified for an evaluation. 10. Residents are assessed on admission for smoking safety and assessed as needed. Safety aprons are recommended for individual needs and if resident cannot stand up immediately from a seated position for safety. Aprons can also be requested by any resident for a safer smoking experience 11. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 12. The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. Resident #17 was admitted to the facility in September 2015 with diagnoses including impulsiveness, age related cataracts, hearing loss, and chronic obstructive pulmonary disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/19/24, indicated that Resident #17 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS indicated Resident #17 required supervision or touching assistance with eating and required assistance with dressing. Review of the facility provided form titled Smoking Residents/ Smoking Apron, dated as revised 1/22/25, indicated Resident #17 required a smoking apron while in wheel chair. Review of Resident #17's physician's order, dated 6/9/22, indicated: - Resident will be allowed to Smoke cigarettes outside under facility supervision as long as Facility Smoking Policy is followed - Smoking is a Privilege and NOT a Right - Smoking can be restricted for violating the facility smoking policy Review of Resident #17's plan of care related to smoking, dated 10/16/15, indicated: - I will wear smoking apron if warranted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Smoking to be suspended if I become very demanding and create an outburst/scene around smoking or I am in violation of facility smoking policy. - I will be assessed for ability to smoke safely. - I will be considered a Smoking Risk and therefore be subject to smoking privileges being denied for giving cigarettes and other smoking materials and lighter to other residents. - I believe and will tell others I am exempt from following the smoking policy. I feel entitled and can smoke where I like. I have been educated and reminded on multiple occasions by staff and Administrator of smoking policy. I have been educated regarding the smoking policy with other smokers in a group and also privately. I continue to feel entitled, I continue to remain defiant regarding following policy and when staff re-educate and remind me I claim they are picking on me, being mean to me, yelling at me. Review of Resident #17's NURSING-SPEC Smoking Assessment (ADMISSION/PRN) dated 9/19/24, indicated: Resident need for adaptive equipment 7a. Smoking apron- (considerations for use of a Smoking Apron could be obesity, unable to move lower extremities, decreased sensation, poor communication, or cognitive deficit making the presence of a burning ember unnoticed or unable to alleviate situation/move or understand danger or sensations relative to burning flesh): this was checked off. On 3/4/25 at 9:31 A.M., on 3/5/25 at 11:25 A.M., and on 3/5/25 at 4:31 P.M., the surveyor observed Resident #17 in his/her wheelchair outside smoking without a smoking apron. During an interview on 3/5/25 at 11:30 A.M., Resident #17 said he/she just finished smoking, and he/she did not have a smoking apron on. Resident #17 said he/he is supposed to wear a smoking apron, but staff do not always put the apron on him/her. During an interview on 3/6/25 at 8:42 A.M., Unit Manager #1 said Resident #17 should wear a smoking apron, and he/she sometimes doesn't want to wear them, and when he/she doesn't want to wear the smoking apron staff need to get involved to ensure he/she wears the smoking apron. During an interview on 3/6/25 at 11:39 A.M., the Director of Nursing (DON) Resident #17 should wear a smoking apron, if he/she refuses the apron staff should encourage him/her to wear the apron. 3. Review of the facility policy titled, Falls and Fall Risk, Managing, dated as revised March 2018, indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 8. Position change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines if the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #41 was admitted to the facility in December 2019 with diagnoses including glaucoma, dementia, and psychosis. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/26/24, indicated that Resident #41 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #41 was dependent on staff for activities of daily living Review of Resident #41's physician's order, dated 12/5/22, indicated: - Personal Alarm while in bed (alarm 0= alarm on and working, 1= alarm not on, 2=not in bed), Please double [NAME] all resident with personal alarms while in bed, every shift. Review of Resident #41's physician's order, dated 9/5/24, indicated: - Chair alarm pad while in chair or wheelchair (alarm 0=alarm on, 1=alarm off, 2= not in chair or wheel chair), every shift. Review of Resident #41's plan of care related to high risk for falls, most recently reviewed on 11/19/24, indicated: - Personal Alarm in Bed, dated as initiated 12/5/22. - I use chair pad alarm, electronic alarm. Ensure the device is in place as needed, dated as initiated 9/6/24. Review of Resident #41's current care card, dated as revised 11/8/23, indicated: - bed alarm in bed. On 3/4/25 at 8:14 A.M., 9:59 A.M., 3:28 P.M., and at 4:11 PM the surveyor observed Resident #41 in bed without the use of a bed alarm. On 3/4/25 at 11:58 A.M., and at 4:39 P.M., the surveyor observed Resident #41 out of bed in his/her wheelchair without the use of a chair alarm. On 3/5/25 at 6:38 A.M., 9:32 A.M., and 1:19 P.M., the surveyor observed Resident #41 in bed without the use of a bed alarm. On 3/5/25 at 1:00 P.M., the surveyor observed Resident #41 out of bed in his/her wheelchair without the use of a chair alarm. During an interview on 3/5/25 at 1:07 P.M., Certified Nurse Assistant (CNA) #7 said that he routinely cares for Resident #41, CNA #7 said that Resident #41 has not used a bed alarm for about 2 years. CNA #7 said he was not aware that Resident #41 required a chair alarm. There was no chair alarm on Resident #41. During an interview on 3/5/25 at 1:10 P.M., Nurse #5 said that Resident #41 is a fall risk, and he/she uses bed and chair alarms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 11:41 A.M., the Director of Nursing (DON) said Resident #41 has a history of falls and nursing should implement the bed and chair alarms.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44095 Based on observation, record review, and interview, the facility failed to provide treatment and services related to an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body), for one Resident (#60) out of a total sample of 26 residents. Specifically for Resident #60, the facility staff failed to a.) implement the physician's orders related to the correct the indwelling catheter balloon size and b.) change the urinary drainage bag as ordered by the physician, increasing the Resident's risk for indwelling urinary catheter complications. Findings include: Review of the facility policy titled, Catheter Care, Urinary, dates as revised September 2014, indicated the purpose of this procedure is to prevent catheter-associated urinary tract infections. 1. Review the resident's care plan to assess for any special needs of the resident. Resident #60 was admitted to the facility in September 2022 with diagnoses including neuromuscular dysfunction of the bladder, diabetes, and Parkinson's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/7/25, indicated Resident #60 was dependent on staff for activities of daily living. This MDS indicated Resident #60 required an indwelling catheter. a.) On 3/5/25 at 10:08 A.M., the surveyor observed Resident #60's indwelling urinary catheter as size 18 French with a 30 milliliter (mL) balloon. Review of Resident #60's physician's order, dated 12/24/24, indicated: - Change Suprapubic Catheter 18 French 10 milliliter (mL) every 21 days (per Urologist). May utilize 3-way catheter Review of Resident #60's Medication Administration Record (MAR), dated 2/25/25, indicated Nurse #3 changed Resident #60's indwelling catheter. Review of Resident #60's physician's order, dated 2/1/23, indicated: - Change Suprapubic Catheter 18 French 10 mL every 24 hours as needed, every 24 hours as needed, for treatment due to leaking, increase sedimentation, not voiding. Review of Resident #60's Treatment Administration Record (TAR), dated 3/6/25 at 2:31 A.M., indicated Nurse #6 changed Resident #60's indwelling catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 8:13 A.M., Nurse #6 said that he had to change Resident #60's catheter this morning because Resident #60 was complaining of suprapubic pain and the urinary drainage bag had very little output. Nurse #6 said he changed the catheter based on the physician's order and he filled the balloon up to 30 mL because that is what he had. During an interview on 3/6/25 at 8:42 A.M., Unit Manager #1 that nursing should only use a 10 mL balloon for Resident #60's urinary catheter. Unit Manager #1 said that if the balloon is too big it will cause problems like added pressure in the bladder and problems with the urine draining. During an interview on 3/6/25 at 11:50 A.M., the Director of Nursing (DON) said that nursing should insert the correct size catheter into Resident #60's bladder. b.) On 3/5/25 at 7:48 A.M., the surveyor observed Resident #60's catheter drainage bag dated as 2/18. There were no other catheter drainage bags stored in Resident #60's room. Review of Resident #60's physician's order, dated 9/29/22, indicated: -Urinary Drainage Bag: Change every 2 weeks on Mondays 11-7. Review of Resident #60's Treatment Administration Record (TAR), dated 2/27/25, indicated nursing changed the urinary drainage bag on 2/27/25. However, based on the surveyor's observation this was not changed on 2/27/25. During an interview on 3/6/25 at 8:40 A.M., Unit Manager #1 said nurses should change the urinary drainage bags as ordered and dispose of the old urinary drainage bags. During an interview on 3/6/25 at 11:49 A.M., the Director of Nursing (DON) said that nursing should change catheter bags as ordered by the physician and that old urinary drainage bags should be disposed of.

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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** 44095 Based on observations, interview, and record review, the facility failed to ensure that respiratory care and services consistent with professional standards of practice were provided for three Residents (#34, #50, and #69) out of sample of 26 residents. Specifically, 1. For Resident #34, the facility failed to ensure that nursing changed Resident #34's oxygen tubing as ordered by the physician. 2. For Resident #50, the facility failed to routinely change and date nebulizer tubing. 3. For Resident #69, the facility failed to ensure oxygen was being administered per the physician's order. Findings Include: Review of the facility policy titled Oxygen Administration, undated, indicated the following: Purpose -The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation -Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. -Review the resident's care plan to assess for any special needs of the resident. 1. Resident #34 was admitted to the facility in December 2019 with diagnoses including chronic obstructive pulmonary disease, hematuria, and obesity. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/26/24, indicated that Resident #34 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #34 required oxygen therapy. On 3/4/25 at 7:53 A.M., and at 8:25 A.M., the surveyor observed Resident #34 receiving oxygen via nasal cannula. The nasal cannula tubing was dated 11/28. Resident #34 said he/she was not sure when his/her oxygen tubing was last changed by nursing and Resident #34 said he/she would allow the tubing to be changed. Review of Resident #34's physician's order, dated 8/6/20, indicated: - Oxygen - Oxygen (O2) 2 liters via nasal cannula to maintain O2 saturation above 88% - document that O2 on by initialing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #34's physician's order, dated 3/28/24, indicated: - Change Oxygen tubing & Humidifier every Wednesday on 11-7, every night shift, every Wednesday, change tubing and humidifier date tubing please. Review of Resident #34's Treatment Administration Record (TAR), dated February 2025, indicated nursing changed the tubing as ordered by the physician most recently on 2/26/25. On 3/4/25 at 12:19 P.M., the surveyor observed Resident #34's nasal cannula tubing dated as 3/4/25. The surveyor asked Resident #34 about the new tubing. Resident #34 laughed and said, someone came in and woke me up to change the tubing about an hour ago. During an interview on 3/5/25 at 10:13 A.M., Unit Manager #1 said oxygen tubing should be changed weekly according to the physician's orders. Unit Manager #1 reviewed Resident #34's TAR and he said that Resident #34's oxygen tubing was last changed on 2/26/25 by Nurse #3. The surveyor shared the observation of the tubing that was dated as 11/28 on 3/4/25 at 7:53 A.M. During an interview on 3/5/25 at 10:21 A.M., Nurse #3 said oxygen supplies are stored in the medication room, and when there is an order to change the oxygen tubing nursing is required to label and date the tubing with tape and a permanent marker, Nurse #3 removed a permanent marker and tape from the medication cart to show the surveyor what she would use to label and date oxygen tubing. Nurse #3 said that she could not recall ever changing Resident #34's oxygen tubing. During an interview on 3/6/25 at 11:42 A.M., the Director of Nursing (DON) said nursing should change oxygen tubing according to the physician's orders. 45343 2. Resident #50 was admitted to the facility in June 2021 with diagnoses including acute respiratory failure with hypoxia, shortness of breath, bacterial pneumonia, and asthma. Review of Resident #50's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she had a Brief Interview for Mental Status (BIMS) exam score of 9 out of a possible 15, indicating he/she has moderate cognitive impairments. Further review of the MDS indicated Resident #50 requires dependent assistance for daily self-care activities and is on oxygen therapy. Review of Resident #50's physician orders indicated the following: - Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol), 3 ml inhale orally every 6 hours for Shortness of Breath or Trouble Breathing, initiated 2/2/24. -Nebulizer-change nebulizer administration setup every week on Wednesday 3-11 shift, every evening shift, every Wednesday, initiated 4/24/24. On 3/4/25 at 8:05 A.M., and 4:09 P.M., 3/5/25 at 9:53 A.M., and 5:10 P.M., and 3/6/24 at 7:50 A.M., the surveyor observed Resident #50's nebulizer machine and tubing on his/her nightstand with the tubing dated 1/8/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January and February Treatment Administration Record (TAR) indicated that the tubing was changed 1/15/25, 1/22/25, 2/5/25, 2/12/25, 2/19/25, and 2/26/25. During an interview on 3/6/25 at 8:41 A.M., Unit Manager #2 said the nebulizer tubing should be changed weekly and labeled with the date it was changed. During an interview on 3/6/25 at 9:10 A.M., the Director of Nursing said any resident on oxygen or a nebulizer should have the tubing changed and labeled weekly on 11 P.M. to 7 A.M. shift. 45984 Resident #69 was admitted to the facility in December 2024 with diagnoses including pressure ulcer of sacral region, anxiety disorder, bipolar disorder and bronchitis. Review of Resident #69's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 13 out of 15 indicating intact cognition. Further review of the MDS indicated that the Resident is dependent on staff for ADLs and requires oxygen therapy. The surveyor made the following observations: - On 3/4/25 at 9:20 A.M. and 12:25 P.M., Resident #69 was awake in bed not receiving any supplemental oxygen. Resident #69 said he/she believes he/she only needs to wear it at nighttime. - On 3/5/25 at 7:26 A.M., 12:03 P.M. and 12:36 P.M., Resident #69 was in his/her room, not receiving any supplemental oxygen. - On 3/6/25 at 7:11 A.M., Resident #69 was sleeping in bed not receiving any supplemental oxygen. Review of Resident #69's physician's order dated 2/28/25: Oxygen - Oxygen 2 liters via nasal cannula to maintain O2 sats (saturation) above 88% - document that O2 (oxygen) was on by initialing, every shift. Review of Resident #69's Oxygen Therapy Care Plan indicated the following intervention dated 12/30/24: Oxygen Settings: I have O2 via nasal prongs/mask @ (2) L (liters) continuously. During an interview on 3/6/25 at 9:52 A.M., Unit Manager #1 reviewed Resident #69's care plan with the surveyor and he said it needs to be updated as he believes the Resident only needs oxygen at nighttime. Unit Manager #1 said Resident #69's physician's order implies he/she should be receiving supplemental oxygen each nursing shift. During an interview on 3/6/25 at 10:11 A.M., the Director of Nursing (DON) said Resident #69's physician's order and oxygen care plan need to be updated.

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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. 44095 Based on record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#35) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 26 residents. Specifically, for Resident #35 the facility failed to ensure nursing did not obtain blood pressures from his/her arm with the AV (arteriovenous fistula, is when an artery and vein connect directly, allowing blood to flow) fistula. Findings include: Review of the facility policy titled, Pre-Dialysis and Post Dialysis Treatment, dated 9/26/24, indicated the purpose of this policy is to ensure safe monitoring guidelines to assess dialysis patients before and after treatment to identify complication for early intervention. Resident #35 was admitted to the facility in October 2017 with diagnoses including end stage renal disease, diabetes, and glaucoma. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/28/24, indicated that Resident #35 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #35 required dialysis. Review of Resident #35's plan of care related to hemodialysis, dated 10/13/17, indicated: - Alert all personnel to avoid using the extremity with vascular access site (or non-dominant arm, if long term access has not been established) for blood pressure or venipuncture. These procedures may damage vessels and lead to failure of the AV Fistula. - Do not draw blood or take blood pressure in arm with graft. Review of Resident #35's physician's order, dated 1/15/24, indicated: - Dialysis on Monday, Wednesday, and Friday. Review of Resident #35's physician's order, dated 8/25/17: - HEMODIALYSIS - NO LAB DRAWS OR BLOOD PRESSURES IN AV FISTULA ARM (left arm), avoid left arm venipuncture on the red area, every shift Review of Resident #35's physician's order, dated 9/5/23, indicated: - HEMODIALYSIS - CHECK BRUIT/THRILL OF RIGHT FOREARM AV FISTULA EVERY SHIFT AND AS NEEEDED. Review of Resident #35 weights and vitals tab in the electronic health record dated 12/2/24 through 3/1/25 indicated nursing obtained Resident #35 blood pressure 21 times from his/her left arm and obtained blood pressure 15 times from his/her right arm in 36 opportunities. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/25 at 2:14 P.M., Nurse #3 said that blood pressures cannot be obtained on Resident #35's arm with the AV Fistula. Nurse #3 said she would know what arm to obtain blood pressures from based on the physician's orders. Record review indicated Nurse #3 had obtained blood pressure from Resident #35's left arm and Resident #35's right arm on several occasions. During an interview on 3/6/25 at 8:34 A.M., Unit Manager #1 said that Resident #35 has a fistula in his/her right arm. Unit Manager #1 said that nursing should be only obtaining blood pressures from Resident #35's left arm. Unit Manager #1 continues to say Resident #35 no longer had a fistula in his/her left arm and the fistula stopped working in the summer of 2023 when he/she had an episode uncontrollable bleeding and needed a new AV fistula. Record review indicated Unit Manager #1 had obtained blood pressures from Resident #35's left arm and Resident #35's right arm on several occasions. During an interview on 3/6/25 at 11:34 A.M., the Director of Nursing (DON) said that nursing should obtain blood pressures based on the physician's order. The DON said that if Resident #35 has orders for no blood pressures with the arm with the fistula then nursing should obtain blood pressures from his/her legs.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 45343 Based on record review and interview, the facility failed to ensure a comprehensive plan of care was developed for Trauma Informed Care for one Resident (#3) who had a history of trauma out of a total sample of 26 residents. Specifically, for Resident #3, the facility failed to develop a comprehensive trauma care plan, with individualized triggers. Findings Include: Review of the facility policy titled Behavioral Assessment, Intervention and Monitoring, dated 12/16, indicated the following: Policy Statement -Behavioral symptoms will be identified using facility approved behavioral screening tools and the comprehensive assessment. Policy Interpretation and Implementation -Interventions and approaches will be based on a detailed assessment of physical, psychosocial and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: -A description of the behavioral symptoms, including frequency, intensity, duration, outcomes, location, environment, and precipitating factors or situations. Resident #3 admitted to the facility in April 2022 with diagnoses that included Post-Traumatic Stress Disorder (PTSD), anxiety, and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/9/25, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #3 has an active diagnosis of PTSD. Review of Resident #3's medical record failed to indicate a plan of care for PTSD with identified triggers. During an interview on 3/6/35 at 8:45 A.M., Unit Manager #2 said the social workers complete the trauma assessments and develop the PTSD care plans, and she would expect triggers to be identified to better care for the residents. During an interview on 3/6/25 at 9:05 A.M., the Director of Nurses said a PTSD assessment should be completed on admission and a care plan developed with identified triggers. During an interview on 3/6/35 at 1:01 P.M., Social Worker #2 said a personalized PTSD care plan should be developed with identified triggers.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observation, record review and interview, the facility failed to ensure that three Residents (#61, #39 and #62), who are diagnosed with dementia, received appropriate treatment and services to attain his/her highest practical physical, mental and psychosocial well-being, out of a total sample of 26 residents. Specifically the facility failed to ensure a dignified dining experience for residents with dementia or Alzheimer's disease when staff pushed their meals away from them so that they could not reach them. Findings include: Review of the policy titled Dementia Clinical Protocol, dated 10/21/24, indicated Direct care staff will support the resident in initiating and completing activities and tasks of daily living. a. Bathing, dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed. 1. Resident #61 was admitted to the facility in August 2021 with diagnoses that included dementia, Alzheimer's disease, anxiety disorder, pressure ulcer of right heel, and major depressive disorder. Review of Resident #61's most recent Minimum Data Set (MDS) assessment, dated 2/13/25, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Further review of the MDS indicated he/she is dependent on staff for eating. On 3/4/25 from 8:15 A.M. to 8:32 A.M., the surveyor observed Resident #61 in the dining room with his/her breakfast tray just out of reach of him/her not set up for consumption, the two other tablemates were eating and being assisted by staff members. Resident #61 was observed to grab at his/her breakfast tray and his/her tablemates. Staff were observed to push away Resident #61's meal tray out of reach. On 3/4/25 from 12:06 P.M. to 12:23 P.M., the surveyor observed Resident #61 in the dining room with his/her lunch tray just out of reach of him/her not set up for consumption. Resident #61 was observed to get agitated and grind his/her teeth, the three other tablemates had their trays and were receiving assistance from staff members. Resident #61 was observed to bang his/her spoon on the table and reach out for his/her tablemates meal trays. On 3/5/25 from 8:05 A.M. to 8:11 A.M., the surveyor observed Resident #61 in the dining room with his/her breakfast tray in just out of reach of him/her not set up for consumption, the two other tablemates were eating and being assisted by staff members. On 3/5/25 from 12:13 P.M. to 12:17 P.M., the surveyor observed Resident #61 in the dining room, staff were assisting other residents with their meals. Resident #61 did not have a meal tray or assistance during this time, all other residents had meal trays during this observation period. The two other tablemates were receiving assistance from staff members who had their backs to the Resident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/25 from 7:55 A.M. to 8:02 A.M., the surveyor observed Resident #61 in the dining room with his/her breakfast tray just out of reach of him/her not set up for consumption. Resident #61 was observed to grab at his/her breakfast tray and his/her tablemates. Staff were observed to push away Resident #61's meal tray out of reach. During an interview on 3/6/25 at 8:31 A.M., Certified Nurse Aide (CNA) #3 said there are not enough staff members on this floor to assist all the residents that need assist on this floor. CNA #3 said the tray should not be left for a resident who needs assistance with their meal. During an interview on 3/6/25 at 8:30 A.M., Unit Manager #2 said they do not have enough staff to feed every resident on this floor. Unit Manager #2 said staff should be following each resident's care plan and CNA Kardex. During an interview on 3/6/25 at 8:49 A.M., the Director of Nursing said that she would expect residents are assisted by staff as the meal is delivered to them and the resident is not left with the tray in front of them with nothing set up. If the resident needs assistance with meals, she would expect to at least have the drinks set up for consumption. She said staff should not be putting a meal in front of a resident and then pushing it away from them and telling them to wait. 45343 2. Resident #39 was admitted to the facility in March 2016, with diagnoses including Alzheimer's Disease, dysphagia (difficulty swallowing), and major depressive disorder. Review of Resident #39's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident has severe cognitive deficits. The MDS further indicated Resident #39 requires dependent assistance for eating On 3/4/25 from 12:06 P.M. to 12:24 P.M., the surveyor observed Resident #39 seated in the dining room with their lunch tray set in front of him/her at the table. Resident #39 was observed attempting to reach for food items on his/her lunch tray. There was no staff observed providing assistance with self-feeding. On 3/5/25 from 12:06 P.M. to 12:24 P.M., the surveyor observed Resident #39 seated in the dining room with their lunch tray set in front of him/her at the table. Resident #39 was observed attempting to reach for food items on his/her lunch tray. There was no staff observed providing assistance with self-feeding. On 3/6/25 from 8:04 A.M. to 8:28 A.M., the surveyor observed Resident #39 awake lying in bed with their breakfast tray left on the bedside table next to him/her. Resident #39 was observed attempting to reach for rood items on his/her breakfast tray. There was no staff observed providing assistance with self-feeding. Review of Resident #39's eating and nutrition care plan indicated the following: -EATING GOALS OVER NEXT 90 DAYS SELECT ONE: DEPENDENT, initiated 10/25/23. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nutrition: Fed by staff utilizing cueing and encouragement to complete meals, needs fluids to swallow, initiated 12/18/24. Review of Resident #39 cognitive care plan indicated the following: - As my dementia progresses, I may become malnourished, dehydrated and behavioral because I have: difficulty noticing food and getting snacks - I do not feel as hungry/thirsty as before; I have a change in my sense of smell or taste; an inability to use eating utensils properly due to physical dexterity limitations as well as level of confusion; difficulty communicating my needs; swallowing problems; level of frustration with my lack of abilities update my MD, initiated 1/5/25. Further review of Resident #39"s Kardex (a form indicating level of assistance a resident requires) dated as of 3/13/24 indicated he/she is dependent on staff for eating. During an interview on 3/6/25 at 8:31 A.M., CNA #3 said there are not enough staff members on this floor to assist all the residents that need assist on this floor. CNA #3 said the tray should not be left for a resident who needs assistance with their meal. During an interview on 3/6/25 at 8:30 A.M., Unit Manager #2 said they do not have enough staff to feed every resident on this floor. Unit Manager #2 said staff should be following each resident's care plan and CNA Kardex. During an interview on 3/6/25 at 8:49 A.M., the Director of Nursing said that she would expect residents are assisted by staff as the meal is delivered to them and the resident is not left with the tray in front of them with nothing set up. If the resident needs assistance with meals, she would expect to at least have the drinks set up for consumption. She said staff should not be putting a meal in front of a resident and then pushing it away from them and telling them to wait. 49880 3. Resident #62 was admitted to the facility in November 2021 with diagnoses that included Alzheimer's disease. Review of Resident #62's Minimum Data Set (MDS) Assessment, dated 1/23/25, indicated a Brief Interview for Mental Status score of 0 out of 15, indicating severe cognitive impairment. The MDS further indicated the Resident is dependent for activities of daily living including eating and that the Resident complains of pain or difficulty with swallowing. Review of Resident #62's active eating assistance care plan, dated as revised 2/1/23, indicated, I have been known to try to grab out at others food. I do not know what to do with my utensils, so I need to be fed. I also have been known to take my napkin and put it in my food, my dementia has been progressing. The care plan also indicated, eating goals over the next 90 days: dependent [sic] Review of Resident #62's active cognitive function care plan, revised 9/2/23, indicated I have impaired cognitive function/dementia or impaired thought processes r/t [related to] Alzheimer's with behavioral disturbance, Vascular Dementia, Paranoia, disorganized thought, visual hallucinations, delusions, cognitive deficits, major neurocognitive disorder, altered mental status, depression. [sic] (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/4/25 at 12:01 P.M., in the Station One dining room, Resident #62 had a meal tray in front of him/her on the table. the plate was covered, and all the drinks were covered. At 12:12 P.M., the tray remained in front of Resident #62, and he/she was trying to pull off the cover. No staff had attempted to sit with or assist the Resident. The Resident was able to partially uncover the meal, and a staff member came over, recovered the meal, pushed it further away from the resident and told him/her to wait a few more minutes. There were five other residents at the same table, all eating their meals or being assisted by staff with their meals during this time. At 12:17 P.M., a staff member sat with Resident #62 and began to assist him/her with their meal. During an interview on 3/6/25 at 8:49 A.M., the Director of Nursing said that she would expect residents are assisted by staff as the meal is delivered to them and the resident is not left with the tray in front of them with nothing set up. If the resident needs assistance with meals, she would expect to at least have the drinks set up for consumption. She said staff should not be putting a meal in front of a resident and then pushing it away from them and telling them to wait.

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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. 43846 Based on observations, interviews and policy review, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, 1. The facility failed to ensure treatment carts and medication rooms were locked while a nurse was not present. 2. The facility failed to ensure drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the medication room and medication carts on two of two units. 3. The facility failed to ensure that medications were dated once opened, according to manufacturer's guidelines. Further, the facility failed to ensure that medications with shortened expiration dates were removed from the medication cart when expired and were not available for administration in two of two medication carts observed. Findings include: Review of the facility policy titled Storage of Medications, dated April 2007, indicated The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 1. On 3/4/25 at 3:29 P.M., the surveyor observed a treatment cart on Station One unlocked in the hallway. No staff were present at the treatment cart. On 3/4/25 from 8:00 A.M. to 8:40 A.M., the surveyor observed the medication room on Station Two unlocked, the surveyor was able to access medications. No staff were present in the medication room. On 3/4/25 from 11:55 A.M. to 12:12 P.M., the surveyor observed the medication room on Station Two unlocked, the surveyor was able to access medications. No staff were present in the medication room. On 3/5/25 at 7:01 A.M., the surveyor observed the medication room on Station Two unlocked, the surveyor was able to access medications. No staff were present in the medication room. During an interview on 3/5/25 at 7:02 A.M., Nurse #1 said the medication room is unlocked and shouldn't be. Nurse #2 said the facility keeps changing the code on the door so she left it unlocked. (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 3/6/25 at 8:56 A.M., the Director of Nursing said medication carts, medication rooms and treatment carts should always be locked unless at nurse is at a cart or in the med room. 49880 2. Review of facility policy titled Storage of Medications, reviewed 10/21/24, indicated the following: -The facility shall store all drugs and biologicals in a safe, secure and orderly manner. -The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -The facility shall not use discontinued, outdated or deteriorated drugs or biologicals. -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. -Medications requiring refrigeration must be stored in a refrigerator locked in the drug room at the nurses' station or other secured location. -Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys. On 3/4/25 at 6:45 A.M., on the Station One Unit, upon entering the facility the surveyor observed two unlocked medication carts and one unlocked treatment cart on the unit. On 3/4/25 from 2:39 P.M. through 2:46 P.M., the surveyor observed the Station One low side medication cart unlocked unattended, during the continuous observation the surveyor observed one housekeeper, multiple CNAs, the Food Service Director, and the oxygen delivery man walk near the unlocked and unattended medication cart. On 3/4/25 at 3:29 P.M., 3:41 P.M., 3:47 P.M., 4:10 P.M., and 4:36 P.M., the surveyor observed the Station One treatment cart unlocked and unattended. The surveyor opened the treatment cart drawers and observed prescription ointments and creams. On 3/5/25 at 7:37 A.M. during an observation of the Station One medication room, Nurse #4 opened the medication room for the surveyor, let the surveyor in and walked away, leaving the surveyor unsupervised in the medication room. During an interview on 3/4/25 at 2:46 P.M., Nurse #3 said that the medication cart should have been locked when unattended but was 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 3/6/25 at 8:31 A.M., Unit Manager #1 said that he would expect that nurses lock the medication and treatment carts when they walk away, and it is not left unlocked and unattended. During an interview on 3/6/25 at 8:39 A.M., the Director of Nurses said that medication and treatment carts should be locked when unattended. The Director of Nurses said only authorized personnel should have access to the medication room, and the nurse should not have left the surveyor unattended in the medication room. 3. During an observation on 3/5/25 at 7:03 A.M., of the high-end medication cart on the Station One unit the following observations were made: -One unopened vial of Procrit in the medication cart in a bag that indicated to keep refrigerated. -One opened and expired vial of Insulin Aspart, dated as opened 1/24/25 and expired on 2/22/25, in the medication cart and available for administration. -One Arnuity Ellipta inhaler, dated as opened 12/22/24 and expired on 2/2/25, in the medication cart and available for administration. During an interview on 3/5/25 at 7:10 A.M., Nurse #4 said that when medications expire, they should be removed from the medication cart and if it says to refrigerate the medication it should be in the fridge until administration. During an observation on 3/5/25 at 7:13 A.M., of the low-end medication cart on the Station One Unit the following observations were made: -One open vial of Lantus Insulin, dated as opened 1/27/25 and expired on 2/24/25, in the medication cart available for administration. -One vial of Insulin lispro, dated as opened 1/27/25 and expired on 2/24/25, in the medication cart and available for administration. -One vial of Lantus Insulin, opened and undated in the medication cart and available for administration. -One Trelegy Elipta inhaler, opened and undated in the medication cart and available for administration. The inhaler reads to discard after 6 weeks. During an interview on 3/5/25 at 7:18 A.M., Nurse #4 said that nurses should be checking expiration dates before administering medications and medications that are expired should be discarded. She also said that inhalers should be labeled with an open date. During an interview on 3/6/25 at 8:31 A.M., Unit Manager #1 said that expired medications should be removed from the medication carts. He also said that any medication with a shortened expiration date should be labeled when opened to include the open and expiration date. (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 3/6/25 at 8:39 A.M., The Director of Nurses said that it is her expectation that medications with shortened expiration dates are labeled with an open and expiration date and that when they are expired, they should be removed from the medication cart.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 45343 Based on observation, interview, and record review, the facility failed to provide a diet of personal preferences to one Resident (#3) out of a total sample of 26 residents. Specifically, the facility failed to provide a banana for all three meals per his/her meal ticket. Findings Include: Resident #3 admitted to the facility in April 2022 with diagnoses that included Type 2 Diabetes Mellitus, dysphagia, and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/9/25, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #3 requires dependent assistance for self-care activities. During an observation on 3/4/25 at 8:08 A.M., Resident #3 was observed eating breakfast in the dining room. The breakfast included pureed meat and eggs, honey thickened coffee and cranberry juice. Further review of Resident #3's meal ticket indicated the following Assist Instructions: High protein. Banana with all meals. Resident #3 did not receive a banana for breakfast. During an observation on 3/5/25 at 8:05 A.M. and 8:25 A.M., Resident #3 was observed eating breakfast in the dining room. The breakfast included pureed meat and waffles, honey thickened coffee and cranberry juice. Resident #3 did not receive a banana for breakfast. During an observation on 3/5/25 at 5:06 P.M., Resident #3 was observed eating dinner in the dining room. The dinner included pureed meat, potatoes and vegetables, honey thickened coffee and cranberry juice. Resident #3 did not receive a banana for dinner. Review of Resident #3's physician's orders indicated the following: -House regular diet consistency-puree texture, liquids-honey thick consistency, no dairy, initiated 5/10/24. -Banatrol plus packet (Banana flakes), give one packet by mouth with meals for diarrhea, initiated 12/27/24. Review of Resident #3's nutrition care plan, last revised 1/15/25 indicated the following: - Chronic loose stools have lessened somewhat and is the reason why no dairy is an order and Banatrol is used daily. [sic] During an interview on 3/6/25 at 8:45 A.M., Unit Manager #2 said Resident #3 has chronic diarrhea and we give him/her Banatrol flakes with a banana with his/her meals. Unit Manager #2 said he was not aware the Resident was not receiving a banana with all of his/her meals, but she would look into the matter. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 9:03 A.M., the Director of Nursing (DON) said resident food preferences and allergies are documented on the meals slips. The DON said she expects meal ticket preferences to be followed.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 45343 Based on documentation review and staff interview, the Facility staff failed to comprehensively assess the facility resources needed to provide sufficient support and care for the resident population as outlined in the Facility Assessment. Findings include: Review of the Facility Assessment, dated 1/9/25, indicated the following: - Religious, ethnic, or cultural factors that affect the delivery of care and services, such as: Facility Answer: -Food and Nutrition requirements: many modified diets for dysphagia, puree or moist ground with thickened liquids. -Activities: no significant factors identified. -Language translation requirements: One resident speaks Creole understands simple English and this resident has expressive aphasia in both English and primary language. The Facility did not fully assess, describe, or identify all ethnic or cultural groups specific to their population. -Equipment and Supplies (medical and non-medical): Facility Answer: sufficient resources. The facility did not identify medical and non-medical equipment and supplies needed to provide sufficient support and care to the facility resident population. - Detailed review of resources available to meet the needs of the resident population: Facility Answer: A breakdown of the training, licensure, education, skill level and measures of competency for all personnel; all are updated at present time-education and in-servicing needs are identified with new admissions, readmissions, declines in function and capability of residents needing more care and potentially specified needs met now vs prior, short term vs long term debility changes that warrant staff intervention-notification to Staff Ed include Admissions, Medical Director, Director of Clinical Services, Physicians, DON (Director of Nursing), MDS (Minimum Data Set) Nurse, Administration and Managers, Rehab, Administrator, etc. The Facility did not identify a comprehensive description of education and competencies needed to provide sufficient care to the facility resident population. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Nursing: Facility Answer: Nursing continues with staff vacancies, mainly with staff put on medical leave. Have been able to staff facility, however staff have been performing overtime. This is increasing payroll. The Facility did not assess or provide an individualized or comprehensive description on how the Facility plans to recruit, maintain or collaborate with medical practitioners. The Facility did not complete an adequate, specific, comprehensive and individualized Facility Assessment to reflect how the Facility ensures that resident specific needs are met based on its population and staffing. During an interview with the Administrator on 3/6/25 at 11:53 A.M., the above observations were discussed. The Administrator said we have just followed what we have been using provided to us by the insurance company and was not aware education and other information was required. The Administrator then said we as an independent facility made up a Facility Assessment template of what DPH (Department of Public Health) might want.

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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** 43846 Based on observation, record review, and interview, the facility failed to maintain accurate medical records for two Residents (#24 and #50) out of a total sample of 26 residents. Specifically, 1. For Resident #24, the facility failed to document a bruise below his/her left eye that was first observed on 2/16/25 by nursing staff. 2. For Resident #50, the nursing staff documented in the Treatment Administration Record (TAR) that a nebulizer tubing was replaced when it was not. Findings Include: Review of the facility policy titled Charting and Documentation, dated 7/17, indicated the following: Policy Statement - All services provided to the residents, progress toward the care plan goals, and any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation - Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1. Resident #24 was admitted to the facility in July 2021 with diagnoses that included Alzheimer's disease, dysphagia, anxiety and depression. Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 1/14/25, indicated he/she was assessed by nursing staff to have moderate cognitive impairments. On 3/4/25 at 7:40 A.M., the surveyor observed Resident #24 in bed with a dark purple bruise under his/her left eye that was approximately 3 inches by 1 inch. On 3/4/25 at 11:52 A.M., the surveyor observed Resident #24 in the dining room with a dark purple bruise under his/her left eye. Review of Resident #24's physician order, dated 7/26/21, indicated Skin Check weekly on the 11-7 (11:00 P. M. to 7:00 A.M.) shift on Monday day of the week - document condition of skin in assessment nursing - weekly skin check. [sic] (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's weekly skin check, dated 2/18/25, indicated Resident's skin is dry, warm and intact. No bruise was noted on the skin check. Review of Resident #24's weekly skin check, dated 2/25/25, indicated Resident's skin is dry, warm and intact. No bruise was noted on the skin check. Review of Resident #24's weekly skin check, dated 3/4/25, indicated All skin areas with no discoloration, dry and with no open areas. No skin issues. No bruise was noted on the skin check. Review of Resident #24's nursing progress notes from 1/14/25 to 3/4/25 failed to indicate the Resident had a bruise under his/her left eye. During an interview on 3/5/25 at 6:55 A.M., the surveyor and Certified Nurse Aide (CNA) #4 observed Resident in bed with a purple yellowish bruise under his/her left eye. CNA #4 said she just came back from vacation yesterday and noticed it right away. During an interview on 3/5/25 at 6:57 A.M., CNA #2 said he takes care of the Resident a lot and noticed the bruise under his/her left eye over a week ago. During an interview on 3/5/25 at 7:00 A.M., Nurse #1 said the Resident has had a bruise under his/her left eye for a long time before but did not put it on the skin check but she just did on 3/4/25. On 3/5/25 at 7:04 A.M., Nurse #1 reviewed Resident #24's medical record and was unable to find a skin check that supports it has been there or a nursing progress note. During an interview on 3/6/25 at 7:43 A.M., Unit Manager #2 said Resident #24 has had a bruise under his/her left eye since 2/16/25 and it was much bigger then. Unit Manager #2 said the bruise under his/her left eye should have been noted on every skin check since 2/16/25. 45343 2. Resident #50 was admitted to the facility in June 2021 with diagnoses including acute respiratory failure with hypoxia, shortness of breath, bacterial pneumonia, and asthma. Review of Resident #50's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she had a Brief Interview for Mental Status (BIMS) exam score of 9 out of a possible 15, indicating he/she has moderate cognitive impairments. Further review of the MDS indicated Resident #50 requires dependent assistance for daily self-care activities and is on oxygen therapy. Review of Resident #50's physician orders indicated the following: - Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (milligrams per milliliter) (Ipratropium-Albuterol), 3 ml inhale orally every 6 hours for Shortness of Breath or Trouble Breathing, initiated 2/2/24. -Nebulizer-change nebulizer administration setup every week on Wednesday 3-11 shift, every evening shift, every Wednesday, initiated 4/24/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225531	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sudbury Pines Extended Care	642 Boston Post Road Sudbury, MA 01776

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 8:05 A.M., and 4:09 P.M., 3/5/25 at 9:53 A.M., and 5:10 P.M., and 3/6/24 at 7:50 A.M., the surveyor observed Resident #50's nebulizer machine and tubing on his/her nightstand with the tubing dated 1/8/25. Review of the January and February Treatment Administration Record (TAR) indicated that the tubing was changed 1/15/25, 1/22/25, 2/5/25, 2/12/25, 2/19/25, and 2/26/25. During an interview 3/6/25 at 8:41 A.M., Unit Manager #2 said nurses should accurately document the day the nebulizer tubing was changed in the medical record. During an interview on 3/6/25 at 9:10 A.M., the Director of Nursing said any resident on oxygen, or a nebulizer should have the tubing changed weekly and she would expect it to be accurately documented in the medical record.