STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225536	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43935 Based on record review and staff interview, the facility failed to ensure that the resident representative had information in advance to exercise their rights for two Residents (#77 and #5), out of a total sample of 18 residents. Specifically, the facility failed to ensure that for: 1. Resident #77, the legal guardian was provided information upon admission to sign or verbally consent to treatment at the facility and sign or consent verbally for a wound consultant; and 2. Resident #5, the Health Care Proxy (HCP: health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions) was provided information upon admission to sign or verbally consent to treatment at the facility including for the use of bilateral side rails. Findings include: 1. Resident #77 was admitted to the facility in January 2025 and had diagnoses including: Unspecified intracranial injury, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, and abnormal posture. Review of the Minimum Data Set (MDS) assessment, dated 1/14/25, indicated Resident #77 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review of the medical record indicated Resident #77 had a court ordered temporary guardian in place at the time of admission and since November 2024, naming Family Member #2 his/her legal guardian. During an interview on 4/1/25 at 12:27 P.M., Resident #77 and Family Member #1 said Family Member #2 helps the Resident make treatment decisions. During an interview on 4/1/25 at 4:53 P.M., Family Member #2 said at the time of Resident #77's admission to the facility he was the legal guardian and remained the legal guardian until 2/11/25. He said he felt the facility did not communicate well with him during this time and consents, including a consent to treat and a wound consultant consent, were not provided to him or discussed with him for him to provide informed consent for the Resident's treatment. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #77 failed to indicate a Consent to admission and treat or a wound consultant consent was obtained and those documents were blank in the record. During an interview on 4/2/25 at 12:26 P.M., Nurse #7 reviewed the medical record and said it did not appear that any consents had been signed for the Resident at the time of admission. He said upon admission if the residents are not their own person the staff will try to contact the healthcare proxy or guardians to let them know there are consents that require signature. The consents remain in the record unsigned until that person comes in to sign them, and staff documents that they are pending signature. Review of the admission note for Resident #77 indicated signed/verbal consents: tbd (to be determined). During an interview on 4/2/25 at 1:02 P.M., the Social Worker said the consents upon admission were not signed or sent to the legal guardian to the best of her knowledge, but she is not responsible for getting those signed. The Social Worker said they remain unsigned at this time. During an interview on 4/2/25 at 2:16 P.M., the Unit Manager said she could not find any evidence that the consent to treat by a wound consultant was provided to the Resident's legal guardian or that the facility had those signed consents in the paper or electronic records. During an interview on 4/2/25 at 2:49 P.M., Consulting Staff #3 said there is no policy to obtain consents to treat or wound consultant consents, but the expectation is that upon admission they would be completed by the nurse on duty. She said even if the legally responsible party were out of state the staff could fax the consents to them or temporarily obtain verbal consent until the form could be provided for a signature. She said the staff should be following the standard of practice and regulation for obtaining informed consent for any treatment. During an interview on 4/3/25 at 10:09 A.M., the Director of Nurses (DON) said the expectation would be that the legal guardian had provided informed consent for both admission consent to treat and wound consultants and there was no evidence in the medical record that had occurred. 34145 2. Resident #5 was admitted to the facility in June 2024 with diagnoses including adult failure to thrive and rheumatoid arthritis. Review of the MDS assessment, dated 2/27/25, indicated Resident #5 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15, and had an activated HCP. On 3/31/25 at 9:06 A.M., 4/1/25 at 7:01 A.M. and 4/2/25 at 9:39 A.M., the surveyor observed Resident #5 lying in bed sleeping; bilateral side rails were raised and in use. Review of the medical record indicated a physician's order, dated 7/17/24, for 1/2 lower side rails for movement and mobility. Review of July 2024 through April 2025 Medication/Treatment Administration Records (MAR/TAR) indicated 1/2 lower side rails were in place as ordered by the physician. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record indicated a side rail consent form, signed by Resident #5's HCP on 3/29/25. The form indicated that consent must be obtained prior to placing the side rails on the bed. The consent form included lines for the Resident's name, date of discussion with staff, date last reviewed by the facility that were blank. During an interview on 4/1/25 at 2:28 P.M., the DON said that nursing staff were supposed to provide information to residents and their representatives about the risks and benefits of side rails use and complete the consent form. During an interview on 4/1/25 at 3:20 P.M., Resident #5's HCP said that he was called by the facility a few weeks ago and told that he needed to sign admission paperwork because it was not done when the Resident was originally admitted in July 2024. He said he came into the facility on [DATE] and signed a stack of paperwork that was given to him and was not sure what they were. He said there was no nurse available to go over the paperwork with him, so he just signed it all. He said no one reviewed the risks and benefits for the use of side rails with him. During an interview on 4/2/25 at 10:05 A.M., the Social Worker said during a random medical record audit, she found that no admission consents were signed when Resident #5 was admitted in July 2024. She said she called the Resident's HCP and asked him to come in and sign admission paperwork. During an interview on 4/2/25 at 12:20 P.M., Unit Manager #1 said that Resident#5's HCP should have been provided admission paperwork including information about the risks and benefits of side rail use and signed the consent form before the siderails were put into place but was not.

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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. 43935 Based on document review and interview, the facility failed to ensure the legally responsible representatives were notified of changes in a resident's condition for two Residents (#77 and #44), out of a total sample of 18 residents. Specifically, the facility failed to: 1. Inform the legal guardian of Resident #77 of the development of a facility acquired deep tissue injury (DTI- a pressure-related injury to subcutaneous tissues under intact skin often appearing as a deep bruise) to the right heel on 2/2/25 or of the physician evaluation of the area on 2/4/25; and 2. Notify the Health Care Proxy (HCP) of Resident #44 of a significant weight loss. Findings include: Review of the facility's policy titled Notification of Changes, dated as reviewed/revised 10/2024, indicated but was not limited to the following: The purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. DEFINITION: Clinical complications: examples - development of pressure injury Need to alter treatment significantly: commence a new form of treatment to deal with a problem COMPLIANCE GUIDELINES: The facility must inform the resident, consult with the resident's physician and/or notify the family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: - a significant change in the resident's condition, such as deterioration in health, mental or psychosocial status; this may include clinical complications - circumstances that require a need to alter treatment; this may include: new treatment Additional considerations: - Resident incapable of making decisions: the representative would make any decisions that have to be made (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #77 was admitted to the facility in January 2025 and had diagnoses including: unspecified intracranial injury, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, and abnormal posture. Review of the Minimum Data Set (MDS) assessment, dated 1/14/25, indicated Resident #77 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review of the medical record indicated Resident #77 had a court ordered temporary guardian in place at the time of admission until 2/11/25, naming Family Member #2 his/her legal guardian. Review of the medical record indicated Resident #77 had developed a DTI on his/her right heel, first identified on 2/2/25 and evaluated by the wound physician on 2/26/25 at which time new orders were received. The record failed to indicate the Resident's legal guardian at the time, Family Member #2, was notified of the development of the pressure ulcer or any treatments necessary. During an interview on 4/1/25 at 12:27 P.M., Resident #77 and Family Member #1 said Family Member #2 was the legal guardian at the time the wound on the right heel developed and is the person that assists with treatment decisions for the Resident. During an interview on 4/1/25 at 1:27 P.M., Nurse #7 said when there is any change in condition, including the development of a wound, the Nurse would notify the physician or Nurse Practitioner (NP), the resident, and their HCP or legal guardian. He said he does not know if Family Member #2, who was the legal guardian for Resident #77 was notified at the time the right heel wound was identified. During an interview on 4/1/25 at 4:53 P.M., Family Member #2 said he was the legal guardian for Resident #77 from November 2024 until 2/11/25. He said he was not notified about the Resident developing a DTI pressure wound on their heel and was unaware any treatments or wound physicians were involved in the Resident's care. He said the facility did not communicate well with him, even when he was the legal court ordered guardian. During an interview on 4/2/25 at 10:21 A.M., the Unit Manager reviewed the medical record for Resident #77 and said she could not find any documentation or evidence that Family Member #2, who was the legal guardian at the time the right heel wound developed, was notified that the wound had developed or that the Resident was evaluated by a wound specialist and new treatment orders were received. She said since the guardianship was still valid and active at the time of the wound developing Family Member #2 should have been notified and it appears they were not. During an interview on 4/3/25 at 10:09 A.M., the Director of Nurses (DON) reviewed the medical record of Resident #77 and said there was no documentation to indicate Family Member #2, who was the legal guardian at the time, had been notified that the Resident had developed a wound on his/her right heel and he should have been in accordance with the policy and standard. 48695 2. Resident #44 was admitted to the facility in October 2022 with diagnoses including dysphagia (difficulty swallowing). (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 MDS assessment, dated 1/17/25, indicated Resident #44 had a severe cognitive deficit as evidenced by a BIMS score of 4 out of 15. Further review of Resident #44's MDS indicated he/she had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and his/her HCP was activated. Review of Resident #44's weight change note, dated 1/8/25, indicated but was not limited to: - On 1/6/25 Resident #44 weighed 108.8 pounds. On 10/2/24, Resident #44 weighed 124 pounds which is a weight loss of 15 pounds in the past 3 months, 12.2% considered significant. - NP/MD aware of weight trends. Further review of Resident #44's medical record failed to indicate his/her HCP was notified of his/her significant weight loss. During a telephonic interview on 4/2/25 at 10:29 A.M., Resident #44's HCP said they were not aware of Resident #44's weight loss. During an interview on 4/2/25 at 12:14 P.M., Nurse #5 said if a resident had a change in condition the facility must notify the Physician or NP and their Responsible Party/HCP if activated and document it in a nurse's note. Nurse #5 and surveyor reviewed Resident #44's medical record. Nurse #5 said she could not find any evidence of Resident #44's HCP being notified of their weight loss. During an interview on 4/2/25 at 2:19 P.M., the Unit Manager (UM) said if a resident had a change of condition their HCP or Guardian must be notified of the change and the notification must be documented in the resident's medical record. The UM and the surveyor reviewed Resident #44's medical record. The UM said Resident #44 had a significant weight loss in January 2025 and she could not find any documentation of his/her HCP being notified of the weight loss. The UM said Resident #44's HCP should have been notified of their weight loss but was not. During an interview on 4/2/25 at 4:02 P.M., the Director of Nursing (DON) and the surveyor reviewed Resident #44 medical record. The DON said he did not see any evidence of Resident #44's HCP being notified of their weight loss. The DON said Resident #44's HCP should have been notified of their weight loss but 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately completed to reflect the status for two Residents (#41 and #44), from a sample of 18 residents, and for one Resident (#86) of two closed records reviewed. Specifically, the facility failed to ensure: 1. For Resident #41, the MDS accurately reflected his/her psychiatric diagnosis; 2. For Resident #44, the MDS accurately reflected his/her psychiatric diagnosis; and 3. For Resident #86, the MDS accurately reflected the Resident's discharge status. Findings include: 1. Resident #41 was admitted to the facility in October 2022 with diagnoses including schizoaffective disorder bipolar type (schizoaffective disorder is a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder). Review of Resident #41's MDS assessment, dated 1/10/25, Section I indicated he/she had a diagnosis of schizophrenia (a chronic and severe mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions, often leading to hallucinations, delusions, and disorganized thinking). During an interview on 4/2/25 at 3:20 P.M., the MDS Coordinator reviewed Resident #41's MDS, dated [DATE], and his/her diagnoses and said Resident #41 did not have a diagnosis of schizophrenia. MDS Coordinator #1 said she did not accurately code the MDS; the MDS did not accurately represent Resident #41 and his/her diagnoses. During an interview on 4/2/25 at 4:02 P.M., the Director of Nursing (DON) said his expectation was for all MDS assessments to accurately represent each resident's medical conditions. 2. Resident #44 was admitted to the facility in October 2022 with diagnoses including schizoaffective disorder bipolar type. Review of Resident #44's MDS assessment, dated 1/17/25, Section I indicated he/she had a diagnosis of schizophrenia. During an interview on 4/2/25 at 3:20 P.M., the MDS Coordinator reviewed Resident #44's MDS, dated [DATE], and his/her diagnoses and said Resident #44 did not have a diagnosis of schizophrenia. MDS Coordinator #1 said she did not accurately code the MDS; the MDS did not accurately represent Resident #44 and his/her diagnoses. During an interview on 4/2/25 at 4:02 P.M., the DON said his expectation was for all MDS assessments to accurately represent each resident's medical conditions. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	34145 3. Resident #86 was admitted to the facility in January 2025 and had diagnoses including multiple injuries and fractures following a motor vehicle accident, muscle wasting, and atrophy. Review of a Social Services Note, dated 1/13/25, indicated Resident #86 would be discharged to home with visiting nurse services when he/she becomes weight bearing. Review of a Nursing Progress Notes, dated 1/17/25, indicated Resident #86 was discharged home with services. Review of the MDS assessment, dated 1/17/25, Section A: Indicated Resident #86 was discharged to a short-term general hospital. During an interview on 4/2/25 at 3:13 P.M., the MDS Coordinator reviewed Resident #86's medical record and discharge MDS assessment. She said she made an error and should have coded the Resident's discharge as a discharge to home and not to the hospital.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 43935 Based on document review and interview, the facility failed for one Resident (#77), out of a total sample of 18 residents, to involve the Resident's legal guardian in the baseline care plan process and offer or provide them with a copy of the baseline care plan summary. Findings include: Review of the facility's policy titled Baseline Care Plans, dated as reviewed/revised: 9/2024, indicated but was not limited to the following: - a baseline care plan will be developed within 48 hours of a resident's admission - a written summary of the baseline care plan shall be provided to the resident and representative in a language they can understand; the summary shall include the initial goals of care, summary of the resident's medications and dietary instructions, any services or treatments to be administered by the facility and personnel acting on behalf of the facility - the person providing the written summary of the baseline care plan shall obtain a signature from the resident/representative to verify the summary was provided and make a copy for the medical record - if the summary was provided by telephone, the nurse shall indicate the discussion, sign the summary document, and make a copy of the written summary before mailing the summary to the resident representative Resident #77 was admitted to the facility in January 2025 and had diagnoses including: Unspecified intracranial injury, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, and abnormal posture. Review of the Minimum Data Set assessment, dated 1/14/25, indicated Resident #77 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15 Further review of the medical record indicated Resident #77 had a court ordered temporary guardian in place at the time of admission until 2/11/25, naming Family Member #2 his/her legal guardian. During an interview on 4/1/25 at 12:27 P.M., Resident #77 and Family Member #1 said they do not recall having any meetings regarding a care plan or what services the facility planned on offering the Resident, nor have they been offered or received any documents that summarize the care and plan for the Resident's stay. They said Family Member #2 was the legal guardian at that time and is the person that assists with treatment decisions for the Resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #77 failed to indicate a baseline care plan meeting was provided or summary was created within the first 72 hours of the Resident's stay at the facility. Further review indicated the facility did have an initial care plan meeting on 1/30/25, but the legal guardian was not in attendance, nor was the Resident, and a copy of the care plans was not documented as being offered (this question was left blank). During an interview on 4/1/25 at 4:53 P.M., Family Member #2 said he was the Resident's legal guardian from November 2024 until 2/11/25. He said the facility did not communicate well with him. He said he was not involved in any care plan meeting, or offered to be, nor was he offered a copy or summary of the baseline care plan summary. He said this involvement and these documents would certainly have been beneficial for him to have better insight into the care and services the facility was providing to Resident #77 since he lives out of state. Review of the progress notes for Resident #77 failed to indicate a discussion was had with Family Member #2 (the legal guardian at the time of admission) regarding the Resident's initial goals of care, summary of the resident's medications and dietary instructions, any services or treatments to be administered by the facility and personnel acting on behalf of the facility or a baseline care plan was mailed to or offered to Family Member #2. During an interview on 4/2/25 at 10:07 A.M., the Unit Manager reviewed the Resident's medical record and said she could not find any evidence or documentation that Resident #77's legal guardian was involved or offered a care plan summary or a copy of the baseline care plans as he should have been. She said the process for baseline care plans does not appear to have been followed. During an interview on 4/2/25 at 1:42 P.M., the Social Worker said she had a brief talk with Family Member #2 at the time of admission when she was doing her evaluation of the Resident. She said to the best of her knowledge Family Member #2 was not offered or mailed a copy of the baseline care plans and was not involved in the initial care plan meeting.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34145 Based on observation, interview and record review the facility failed to develop, implement and individualize comprehensive care plans for four Residents (#10, #29, #12, and #73), out of a total sample of 18 residents. Specifically, the facility failed to ensure: 1. For Resident #10, a comprehensive care plan was developed to address the use of Quetiapine Fumarate (Seroquel-antipsychotic medication) that identified Resident specific targeted behaviors, non-pharmacological interventions, and measurable goals of treatment; 2. For Resident #29, a comprehensive care plan was developed to address the use of Risperdal (antipsychotic medication) that identified Resident specific targeted behaviors, non-pharmacological interventions, and measurable goals of treatment; 3. For Resident #12, to develop and implement a care plan to address the Resident's smoking status as well as his/her smoking preferences; and 4. For Resident #73, to ensure a comprehensive care plan was developed and implemented to address the Resident's use of a continuous positive airway pressure (CPAP-helps treat sleep apnea) machine. Findings include: Review of the facility's policy titled Comprehensive Care Plans, last revised 9/2024, indicated but was not limited to: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. -The comprehensive care plan will describe, at a minimum, the following: -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. -Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. -The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. -The objectives will be utilized to monitor the resident's progress. -Alterative interventions will be documented, as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #10 was admitted to the facility in September 2023 and had diagnoses including bipolar disorder. Review of the Minimum Data Set (MDS) assessment, dated 3/6/25, indicated Resident #10 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15, and received antipsychotic medication on a daily basis. Review of the medical record indicated a physician's order for Quetiapine Fumarate 25 milligrams (mg) at bedtime for bipolar disorder (2/1/24). Review of January 2025 through April 2025 Medication Administration Records (MAR) indicated Quetiapine was administered as ordered by the physician. Review of comprehensive care plans included but was not limited to: - Focus: Resident uses antipsychotic medications related to Bipolar (initiated: 9/28/23). - Interventions: Administer medication per physician's orders. Observe for side effects and effectiveness each shift, report any negative signs/symptoms (s/sx) to physician (initiated 9/28/23). -Goal: Will be free from discomfort or adverse reactions related to antipsychotic medication through the review date (initiated 9/28/23; target date: 3/17/25). The care plan developed for the use of Quetiapine failed to identify Resident specific targeted signs/symptoms of bipolar disorder, non-pharmacological interventions and measurable goals of treatment to meet the Resident's needs. During an interview on 4/2/25 at 12:20 P.M., Unit Manager #1 said nursing staff are responsible for care plan development for psychotropic medications. She said Resident #10's care plans should include identification of all psychotropic medications administered with resident specific behaviors, signs/symptoms for their use as well as resident specific, non-pharmacological interventions and measurable goals but do not. 2. Resident #29 was admitted to the facility in October 2022 and had diagnoses including disorders of psychological development, anxiety disorder, and dementia, unspecified severity with anxiety. Review of the MDS assessment, dated 2/13/25, indicated Resident #29 had severe cognitive impairment as evidenced by a BIMS score of 6 out of 15, and received psychotropic medication on a daily basis. Review of the medical record indicated a physician's orders for: -Depakote (antiseizure medication used to treat mood) 125 mg, give two tablets two times a day for mood (2/11/25). -Risperdal 0.5 mg one time a day for impulsivity, intrusiveness, self-injurious behaviors (SIB) (3/20/25) -Risperdal 0.5 mg one time a day for disinhibition and behavior management (3/20/25) (continued on next page)

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Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sertraline HCl (antidepressant) 100 mg in the morning related to anxiety disorder (12/26/24) -Sertraline HCl 25 mg in the morning related to anxiety disorder (2/14/25) -Trazodone HCl (antidepressant) 50 mg at bedtime for insomnia (2/14/25) Review of December 2024 through April 2025 MARs indicated the psychotropic medications were administered as ordered by the physician. Review of comprehensive care plans included but was not limited to: -Focus: Resident uses antidepressant medication (Trazodone) related to insomnia, depression (10/8/22) -Interventions: Administer antidepressant medications as ordered by the physician. Monitor/document side effects and effectiveness every shift (10/8/22); Follow-up with psych/physician as needed (12/7/23) -Goal: Resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (10/8/22) The care plan for the use of Trazodone failed to include non-pharmacological interventions and measurable goals of treatment. Further review of comprehensive care plans failed to indicate care plans had been developed for the use of Depakote, Sertraline and Risperdal that identified Resident specific targeted behaviors, Resident-specific interventions, including non-pharmacological approaches, and measurable goals of treatment to meet the Resident's needs. During an interview on 4/2/25 at 12:20 P.M., Unit Manager #1 said nursing staff are responsible for care plan development for psychotropic medications. She said Resident #29's care plans should include identification of all psychotropic medications administered with resident specific behaviors, signs/symptoms for their use as well as resident specific, non-pharmacological interventions and measurable goals but do not. 48362 3. Review of the facility's policy titled Smoking Policy -Residents, dated as revised 3/2024, indicated but was not limited to: - This facility shall establish and maintain safe resident smoking practices. - Smoking is permitted in designated resident smoking areas located outside of the facility. - Smoking is not allowed inside the facility under any circumstances. - The resident will be evaluated upon admission and/or when a resident chooses to smoke, to determine the resident's ability to smoke safely. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) as determined by staff. - Any smoking-related concerns will be noted in the resident care plan. Resident #12 was admitted to the facility in January 2024 with diagnoses including chronic obstructive pulmonary disease (COPD), hypertension, and peripheral vascular disease. Review of Resident #12's MDS assessment, dated 3/7/25, indicated he/she had moderate cognitive impairment as evidenced by a BIMS score of 9 out of 15. Furthermore, the MDS assessment indicated Resident #12 required assistance from staff for activities of daily living. Review of the list of smokers provided by the facility upon entrance indicated Resident #12 was a smoker residing in the facility. During an interview on 3/31/25 at 9:00 A.M., Resident #12 said he/she is a smoker and goes out several times a day during the facility's allotted smoking hours with the supervision of staff to smoke. Review of Resident #12's Smoking Evaluation, dated 12/9/24, indicated but was not limited to the following: - Protective Smoking Equipment: Not Applicable (NA). - Resident is an independent smoker. - Resident is independent with lighting cigarette. Review of Resident #12's Smoking Evaluation, dated 2/6/25, indicated but was not limited to the following: - Protective Smoking Equipment: not indicated. - Resident is safe to smoke with supervision without protective smoking equipment. - Resident is safe to light own cigarette with staff supervision. Review of Resident #12's comprehensive care plans failed to indicate a smoking care plan was developed or implemented. During an interview on 4/2/25 at 8:17 A.M., Nurse #1 said Resident #12 does go out during the allotted smoking times when he/she desires. Nurse #1 said Resident #12's smoking equipment, including cigarettes and lighters, are kept at the receptionist's desk in a locked box. During an interview on 4/2/25 at 8:50 A.M., Receptionist #1 said Resident #12 does participate in smoking during the scheduled timeframes. Receptionist #1 said all smoking equipment is kept in a locked box at the reception desk and he generally takes the residents who smoke out during the allotted times. Receptionist #1 said Resident #12 does require a protective apron during smoking times but is otherwise just supervised when he/she is smoking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/25 at 11:15 A.M., Social Worker (SW) #1 said Resident #12 did not smoke when he/she was initially admitted to the facility but expressed interest in December. SW #1 said an initial assessment for Resident #12 smoking status was completed at that time. SW #1 said she was not sure how often nursing repeated the assessments but believed they would be completed with any change in condition. SW #1 said there was a period of time recently when Resident #12 did not go out to smoke at all but recently started to go out again throughout the day when he/she desired. SW #1 said she would expect there to be a care plan related to Resident #12 smoking status. During an interview on 4/2/25 at 11:36 A.M., the Director of Nursing (DON) said the expectation was for any resident in the facility who smoked to have a care plan related to their smoking status. The DON said the care plan should reflect any changes in the resident's smoking status. 42742 4. Resident #73 was admitted to the facility in December 2024 with diagnoses including sleep apnea (sleep disorder in which breathing repeatedly stops and starts). Review of current Physician's Orders indicated the following: -CPAP @10 cm (centimeters of water pressure) H2O inspiration; 5 cm H2O expiration, on at HS (before sleep at bedtime), off in AM, at bedtime for sleep apnea, 12/26/24 During an observation with interview on 4/1/25 at 10:40 A.M., the surveyor observed a CPAP machine stored on top of the Resident's side table. Resident #73 said he/she used the machine for sleep apnea. Review of the medical record failed to indicate that an interdisciplinary comprehensive care plan was developed with measurable objectives and timeframes to address the Resident's use of the CPAP machine related to his/her diagnosis of sleep apnea. During an interview on 4/2/25 at 9:56 A.M., the surveyor reviewed the medical record with the Unit Manager who said there was no care plan for the Resident's use of the CPAP machine. During an interview on 4/2/25 at 3:13 P.M., the surveyor reviewed the medical record with the DON and Regional Nurse #1 who said the Resident used the CPAP machine for sleep apnea every night. Regional Nurse #1 said the Resident should have been care planned for the use of the CPAP equipment but wasn't. The DON said the focus, measurable goals and interventions would have been listed in the care plan for it. Regional Nurse #1 said she would expect it to have been completed but it wasn't.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34145 Based on record review and interviews, the facility failed to review and revise the care plan for one Resident (#10), out of a total sample of 18 residents. Specifically, the facility failed to ensure the care plan for pressure ulcers was updated to reflect the resolution of two pressure ulcers (a localized area of skin damage that develops when prolonged pressure is applied to the body). Findings include: Review of the facility's policy, Comprehensive Care Plans, last revised 9/2024, indicated but was not limited to: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. -The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Resident #5 was admitted to the facility in June 2024 with diagnoses including adult failure to thrive, rheumatoid arthritis, and a stage 2 (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure ulcer to his/her coccyx and a stage 2 pressure ulcer to his/her right lateral dorsal foot. Review of the Minimum Data Set (MDS) assessment, dated 6/24/24, indicated Resident #5 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15, was at risk for developing pressure ulcers and had two unhealed stage 2 pressure ulcers. Review of the MDS assessment, dated 2/27/25, indicated Resident #5 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15, was at risk for developing pressure ulcers and had no unhealed pressure ulcers. Review of comprehensive care plans indicated a pressure ulcer care plan as follows: -Focus: Pressure Ulcer: Resident has a stage 2 to his/her coccyx and a stage 2 to his/her right lateral dorsal foot (6/18/24) -Interventions: Consult and treatment by Certified Wound Medical Doctor (MD) or Certified Wound Nurse as needed (prn); Follow facility protocol and regime for treating breaks in skin integrity/pressure ulcers; Monitor for changes and update provider; special mattress as ordered; Treatment as ordered; Turn and reposition as needed; use two person transfer and use turn sheet to avoid friction/shearing of resident skin as needed. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	-Goal: Resident's wounds will not get any larger in size/stage of pressure ulcer through the review date; Resident will not have signs of infection through the review date (target date 3/23/25) Review of Physician's Orders indicated but was not limited to the following: -Treatment to right lateral dorsal foot: normal saline wash, pat dry, apply Hydrafera blue foam to fit the wound bed followed by dry gauze, then secure with gauze bordered dressing (Initiated: 6/19/24; Discontinued: 10/24/24) -Cleanse coccyx area with normal saline. Pat dry. Apply skin prep to surrounding skin. Small count (sic) Silvadene to wound bed. Cover with foam dressing. Change daily and as needed (prn) (Initiated: 6/19/24; Discontinued: 10/27/24) Review of a Pressure Ulcer Evaluation document, dated 10/7/24, indicated the stage 2 pressure ulcer to his/her coccyx healed on 10/7/24. A Pressure Ulcer Evaluation document, dated 8/15/24, indicated the wound to his/her right lateral dorsal foot was a stage 3 (deep wound that may impact muscle, tendons, ligaments, and bone) and measured 2 centimeters (cm) x 1.5 cm x 0.3 cm with scant exudate (fluid that seeps out). No further Pressure Ulcer Evaluation Documents were found in the medical record to indicate the pressure ulcer to the Resident's right lateral dorsal foot had healed. Review of interdisciplinary care plan meeting documentation indicated care plan meetings were held on 1/2/25 and 3/20/25 without a revision to the care plan to reflect the Resident's stage 2 pressure ulcers to his/her coccyx and right lateral dorsal foot had resolved and no longer required treatment. During an interview on 4/2/25 at 12:20 P.M., Unit Manager #1 reviewed Resident #5's medical record with the surveyor. She said the Resident's coccyx wound healed on 10/7/24, and the physician's order for coccyx wound care was discontinued on 10/27/24. She said the last skin assessment for the right dorsal foot was dated 8/15/24, and indicated it was a stage 3 and measured 2 cm x 1.5 cm x 0.3 cm. She said there were no other skin assessments of that wound to indicate when the wound healed, although the treatment order for the right lateral dorsal foot was discontinued on 10/24/24. Unit Manager #1 said there should have been documentation in a skin assessment that the foot wound was healed and the care plan for the pressure ulcers should have been updated during the next care plan meeting following the resolution of the wounds and was not.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observations, interviews, and records reviewed, for four Residents (#41, #63, #5 and #10) of 18 sampled residents, the facility failed to ensure care was provided to residents in accordance with professional standards of practice. Specifically, the facility failed: 1. For Resident #41, a. to ensure feeding tube formula was administered per physician's orders, and b. to ensure a dietary consult was obtained as ordered by the Physician; 2. For Resident #63, to ensure a physician's order was obtained prior to sending him/her to the hospital; 3. For Resident #5, to ensure the air mattress was set according to physician's orders and accurately documented in the medical record; and 4. For Resident #10, a. to ensure medication was administered as ordered; b. to ensure the air mattress was set according to physician's orders and accurately documented in the medical record. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Review of the facility's policy titled Care and Treatment of Feeding Tubes, last revised September 2024, indicated but was not limited to: - It is the policy of the facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush. Resident #41 was admitted to the facility in October 2022 with diagnoses including cerebral infarction and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 1/10/25, indicated Resident #11 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. Further review of Resident #41's MDS indicated he/she had a feeding tube and received 51% or more of their total calories from the feeding tube. Review of Resident #41's Physician's Orders indicated but was not limited to: - Enteral feed Jevity 1.5 Calorie, administer 54 milliliters (ml)/hour (hr) for a total of 20 hours with 150 ml of free water flushes every 4 hours for total of 1080 ml of formula daily, dated 11/8/2024 a. On 3/31/25 at 8:54 A.M., the surveyor observed Resident #41 in bed with Jevity 1.5 Calorie running. On 4/1/25 at 7:10 A.M., the surveyor observed Resident #41 in bed with Jevity 1.5 Calorie running. On 4/1/25 at 8:26 A.M., the surveyor observed Resident #41 in bed with Jevity 1.5 Calorie off and not running. On 4/1/25 at 10:21 A.M., the surveyor observed Nurse #8 administer medications to Resident #41 and start Jevity 1.5 Calorie. During an interview on 4/1/25 at 10:21 A.M., Nurse #8 said she was starting Resident #41's tube feed because it was supposed to start at 10:00 A.M. Nurse #8 said the tube feed was supposed to be off for four hours and was due to be restarted at 10:00 A.M. During an interview on 4/2/25 at 6:57 A.M., Nurse #6 said she had worked the 11:00 P.M. to 7:00 A.M. shift from 3/30/25 to 3/31/25. Nurse #6 said Resident #41's tube feed was supposed to be turned off at 6:00 A.M. and remain off until 10:00 A.M. Nurse #6 said Resident #41's tube feed was supposed to run for only 20 hours a day. Nurse #6 said she must have forgotten to turn off Resident #41's tube feed on 3/31/25 at 6 A.M. , but she should have shut it off per physician's orders. During an interview on 4/2/25 at 8:31 A.M., Nurse #5 said Resident #41 received Jevity 1.5 Calorie via gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication) for 20 hours a day. Nurse #5 said the tube feed is turned off at 6:00 A.M. every morning and is turned back on at 10:00 A.M. Nurse #5 said she thought the tube feed was turned off at 6:00 A.M. on 3/31/25 but she could not be sure because it is the responsibility of the 11:00 P.M. to 7:00 A.M. shift nurse to turn it off. Nurse #41 said she did not recall if she had started Resident #41's tube feed at 10:00 A.M. on 3/31/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/25 at 2:19 P.M., the Unit Manager (UM) said Resident #41 had an order for Jevity 1.5 Calorie for 20 hours a day, start at 10:00 A.M. and turn off at 6:00 A.M. The UM said all nurses must follow physician's orders and turn the Jevity 1.5 Calorie off at 6:00 A.M. and restart it at 10:00 A.M. as ordered. During an interview on 4/2/25 at 4:02 P.M., the Director of Nursing (DON) said his expectation was for all staff to follow physician's orders for feeding tubes. b. Review of Resident #41's Physician's Orders indicated but was not limited to: - Dietitian Consult related to weight gain, dated 3/11/25 Review of Resident #41's weights indicated but was not limited to: 3/31/25 212.0 pounds 3/17/25 211.0 pounds 3/10/25 211.0 pounds 3/10/25 211.0 pounds 3/3/25 210.5 pounds 2/5/25 202.0 pounds Further review of Resident #41's medical record failed to indicate a Dietitian Consult had been obtained on 3/11/25 or after. During an interview on 4/2/25 at 12:14 P.M., Nurse #5 reviewed Resident #41's medical record and said a Dietitian consult was ordered for Resident #41 due to his/her weight gain. Nurse #5 said if a consultation was conducted by the Dietitian, it would have been documented in a note. Nurse #5 said she did not see a note from the Dietitian. During an interview on 4/2/25 at 2:19 P.M., the UM said Dietitian consultations were documented either in a note or in a dietary assessment. The UM reviewed Resident #41's medical record and said she did not see a Dietitian note or dietary assessment in Resident #41's chart on 3/11/25 or after that. During a telephonic interview on 4/3/25 at 2:11 P.M., the Regional Registered Dietitian said the facility had a Registered Dietitian and she would conduct the dietary consults. The Regional Registered Dietician reviewed Resident #41's medical record and said she could not see that a Dietitian Consultation was conducted as ordered by the physician. During an interview on 4/2/25 at 4:02 P.M., the DON said his expectation was for all staff to follow physician's orders for a Dietary Consult and the dietary consult to be completed within a week. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A call was placed to the facility's Registered Dietitian on 4/2/25 at 11:47 A.M. and on 4/3/25 at 7:48 A.M. with no call back. 2. Review of the facility's policy titled Transfer and Discharge (including AMA), last revised September 2024, indicated but was not limited to: - Emergency Transfer/Discharge- initiated by the facility for medical reasons to an acute care setting such as a hospital, for immediate safety and welfare of a resident. - Obtain physician's orders for emergency transfer or discharge. Resident #63 was admitted to the facility in February 2023 with diagnoses including dementia and chronic kidney disease. Review of the MDS assessment, dated 1/31/25, indicated Resident #63 had a severe cognitive deficit as evidenced by a BIMS score of 6 out of 15. Review of Resident #63's medical record indicated he/she was transferred to the hospital on 10/23/24 and 12/10/24 for a change in condition. Further review of the medical record failed to indicate an order was obtained prior to transferring Resident #63 to the hospital on 10/23/24 and 12/10/24. During an interview on 4/2/25 at 12:14 P.M., Nurse #5 said prior to transferring a resident to the hospital they must obtain an order from the physician or physician's extender. Nurse #5 said the order must then be transcribed in the resident's medical record. During an interview on 4/2/25 at 2:19 P.M., the UM said prior to transferring a resident to the hospital they must obtain an order from the physician or physician's extender. The UM said the order must then be transcribed in the resident's medical record. The UM reviewed Resident #63's medical record and said she did not see an order to the transfer Resident #63 to the hospital on 10/23/24 and 12/10/24 but he/she should have had an order. During an interview on 4/2/25 at 4:02 P.M., the DON reviewed Resident #63's medical record and said he did not see an order to transfer Resident #63 to the hospital on 10/23/24 and 12/10/24 but he/she should have had an order. The DON said all residents must have an order to be transferred to the hospital. 34145 3. Resident #5 was admitted to the facility in June 2024 with diagnoses including adult failure to thrive, rheumatoid arthritis, and a stage 2 (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure ulcer to his/her coccyx and a stage 2 pressure ulcer to his/her right lateral dorsal foot. Review of the MDS assessment, dated 2/27/25, indicated Resident #5 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15, was at risk for developing pressure ulcers and had a pressure reducing device in bed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician's Orders indicated but was not limited to: -Air mattress set at 100, check function and setting every shift for skin integrity (3/26/25) On 3/31/25 at 9:06 A.M., 11:37 A.M., 12:18 P.M. and 2:45 P.M., the surveyor observed Resident #5 sitting upright in bed. An air mattress was in place and set between 320 pounds (lbs.) and 400 lbs. On 4/1/25 at 7:01 A.M., the surveyor observed Resident #5 lying in bed sleeping. An air mattress was in place and set between 320 lbs. and 400 lbs. Review of the April 2025 Medication Administration Record/Treatment Administration Record (MAR/TAR) indicated nursing staff signed off that the air mattress was in place and set to 100 lbs. on all shifts on 3/31/25 during the time of the surveyor's observations of it set between 320 lbs. and 400 lbs. During an interview on 4/1/25 at 2:28 P.M., the DON said that although sometimes air mattress settings can be changed by mistake, such as if the dial is moved when staff change bed linens, nursing staff are to check the setting every shift to ensure it is set according to physician's orders. He said Resident #5's air mattress should be set to 100 lbs. according to physician's orders. 4. Resident #10 was admitted to the facility in September 2023 and had diagnoses including protein calorie malnutrition and weakness. Review of the MDS assessment, dated 3/6/25, indicated Resident #10 had severe cognitive impairment as evidenced by a BIMS score of 7 out of 15, was at risk for developing pressure ulcers, had a pressure reducing device in bed and received anticoagulant medication on a daily basis. Review of Physician's Orders indicated but was not limited to: -Eliquis (anticoagulant-blood thinner) 2.5 mg twice a day (7/9/24) -Pressure redistribution mattress, setting 180, check function and setting every shift (3/26/25) a. On 3/31/25 at 9:00 A.M., the surveyor observed Resident #10 lying in bed awake. A clear plastic medication cup with a round yellow pill inside was on the overbed table next to the Resident's bed. The Resident said he/she does not take medications independently and did not know what the pill was. Review of the medical record failed to indicate Resident #10 was assessed to self-administer any medications. On 3/31/25 at 9:39 A.M., the surveyor observed Resident #10 sitting upright in bed awake. Nurse #3 was at the Resident's bedside adjusting his/her oxygen tubing. A clear plastic medication cup with a round yellow pill inside was on the overbed table next to the Resident's bed. Nurse #3 then left the Resident's bedside and began to walk toward the door. The surveyor called the Nurse back to the Resident's bedside and showed him the pill in the medication cup. He said the pill was levothyroxine (thyroid hormone) and should have been administered at 6:00 A.M. The nurse said the night nurses sometimes leave medications for residents to take on their own when they shouldn't. (continued on next page)

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Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the medical record indicated Resident #10 did not have a physician's order for levothyroxine. During a subsequent interview on 3/31/25 at 2:22 P.M., Nurse #3 said the medication left at Resident #10's bedside this morning was Eliquis 2.5 mg and not levothyroxine as he indicated to the surveyor previously. He said the Resident is not prescribed levothyroxine, but receives Eliquis at 9:00 A.M. and 9:00 P.M. He said he worked a double shift on 3/30/25 (7:00 A.M. to 3:00 P.M. and 3:00 P.M. to 11:00 P.M.) and was the only nurse to administer the Eliquis. He could not explain how the medication was left at the bedside. The nurse said after the surveyor brought the pill at the bedside to his attention, he discarded it. Nurse #3 said he did not inform the Resident's physician or nursing supervisor that a dose of Eliquis was found at the bedside and not administered. Review of the April 2025 Medication Administration Record indicated Nurse #3 signed off that Resident #10 was administered Eliquis 2.5 mg on 3/30/25 at 9:00 A.M. and 9:00 P.M. and 3/31/25 at 9:00 A.M. b. On 3/31/25 at 9:00 A.M. and 9:39 A.M., the surveyor observed Resident #10 sitting upright in bed. An air mattress was in place and set at 150 lbs. On 4/1/25 at 8:31 A.M., 1:59 P.M. and 2:20 P.M., the surveyor observed Resident #10 lying in bed asleep. An air mattress was in place and set at 150 lbs. Review of March and April 2025 MAR/TARs indicated nursing staff signed off that the air mattress was in place and set to 180 lbs. on 3/31/25 and 4/1/25 during the time of the surveyor's observations of it set at 150 lbs. During an interview on 4/1/25 at 2:28 P.M., the Director of Nursing (DON) said that although sometimes air mattress settings can be changed by mistake, such as if the dial is moved when staff change bed linens, nursing staff are to check the settings every shift to ensure it is set according to physician's orders. He said Resident #10's air mattress should be set to 180 lbs. according to physician's orders. The DON said that he was not notified that Resident #10's dose of Eliquis was left at the bedside and not administered. He said the physician should have been notified of the missed dose of Eliquis so he could determine if any blood work or monitoring is necessary.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43935 Based on observation, interview, and document review, the facility failed for one Resident (#77), out of a sample of 18 residents, to ensure the Resident received consistent care and treatment to prevent the further deterioration of a deep tissue injury (DTI- a pressure-related injury to subcutaneous tissues under intact skin often appearing as a deep bruise) to the right heel that went from dime sized and intact on 3/29/25 to quarter sized and open with drainage on 4/3/25. Findings include: Review of the facility's policy titled Pressure Injury Prevention and Management, dated as reviewed 10/2024, indicated but was not limited to the following: - the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable and to provide treatment and services to heal the pressure ulcer/injury DEFINITIONS: Pressure Ulcer/Injury: refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical device Avoidable: means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and other risk factors, define and implement interventions that are consistent with resident needs, resident goals and professional standards of practice; monitor and evaluate the impact of the interventions as appropriate. POLICY EXPLANATION AND COMPLIANCE GUIDELINES: - the facility will establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate - Licensed nurses will conduct a pressure injury risk assessment, the assessment will be used in conjunction with other risk factors not captured by the risk assessment tool. Examples of risk factors include: impaired/decreased mobility and functional ability; co-morbid conditions; drugs that may affect healing; impaired blood flow; refusal of care of treatments; cognitive impairment; exposure of skin to incontinence (loss of control of bowels or bladder); under nutrition, malnutrition, or hydration deficits; the presence of previously healed pressure injuries - Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Assessments of pressure injuries will be performed by a Licensed nurse, and documented; the staging of pressure injuries will be clearly documented to ensure correct coding on the Minimum Data Set (MDS) INTERVENTIONS FOR PREVENTION AND TO PROMOTE HEALING: - after completing a thorough assessment, the interdisciplinary team (IDT) shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions - interventions will be based on specific factors and identified risks including: nutritional factors, wound staging, assessment, impaired mobility, moisture management, and wound characteristics - evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present, which could include but are not limited to: redistribution of pressure (such as repositioning, pressure relieving mattress, protecting or offloading heels, etc.) - the goals and preferences of the resident and/or authorized representative will be included in the plan of care - interventions will be documented in the care plan and communicated to all relevant staff; compliance with interventions will be documented in the weekly summary charting MONITORING: - the unit manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risk, progression towards healing, and compliance at least weekly and document a summary of findings in the medical record - the attending physician will be notified of the presence of a new pressure injury upon identification; the progress towards healing, or lack of healing and any complications as needed - a focused incident review will be performed on each pressure injury that develops in the facility and reported in the monthly facility Quality Assurance (QA) committee meeting MODIFICATIONS OF INTERVENTIONS: - any changes to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner - interventions on a resident's care plan will be modified as needed Resident #77 was admitted to the facility in January 2025 and had diagnoses including: Unspecified intracranial injury, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, and abnormal posture. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 1/14/25, for Resident #77 indicated but was not limited to the following: - Section C: Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the Resident was cognitively intact - Section GG: Exhibited functional limitation in range of motion with impairment on the bilateral (both sides) lower extremities and was dependent with care for toileting, bathing, lower body dressing, putting on and taking off footwear, rolling from left to right on the bed, moving from sitting to lying, lying to sitting, sitting to standing, and transferring from bed to chair - Section M: At risk of developing a pressure ulcer/injury, does not have one or more unhealed pressure ulcers/injuries Review of the Norton Scale for predicting risk of pressure ulcers for Resident #77 indicated a score of high risk (less than 10 in accordance with the assessment key) on 1/16/25, 1/23/25, and 1/30/25. Review of the medical record indicated Resident #77 had developed a DTI to his/her right heel that was first observed by staff on 2/2/25 and was first evaluated by the wound physician on 2/4/25. The wound physician last evaluated the Resident's wound on 2/11/25 and documented the area as Pressure, unstageable, and intact skin with purple/maroon discoloration measuring: 1.5 centimeters (cm) long by (x) 1.5cm wide. The plan was for pressure off-loading booties and follow up with wound physician in 2 weeks or sooner if needed. On 2/26/25 the wound physician group had not seen the Resident but signed off from the case related to the termination of the facility contract. The Resident had not had their right heel wound evaluated by a wound consultant, a Physician, Nurse practitioner or any Licensed nurse in the facility for wound measurements and progress towards healing of the wound since the last visit on 2/11/25. During an interview on 4/1/25 at 10:53 A.M., Resident #77 said he/she had a wound on their right foot. The Resident said he/she used to have booties but does not know what happened to them. During an interview with observation on 4/1/25 at 12:21 P.M., Family Member #1 said he visits Resident #77 daily and the Resident is dependent on the staff for all care and positioning. He said the Resident still had the wound on his/her right heel and there are booties that are usually up on the shelf in the room and not on the Resident. Family Member #1 and the Resident showed the surveyor the area on the Resident's right heel which was dark red to maroon in color and intact without any signs of drainage. Review of the current orders for Resident #77, as of 4/1/25, indicated but were not limited to the following: - Booties/heel protectors on at all times as tolerated, every shift (2/4/25) - Wound Care: Unstageable DTI of right heel. Cleanse with NS or wound cleanser, apply skin prep to wound surface, leave open to air (LOTA). Place heel in bootie every day shift (2/4/25) - Wound MD consult as indicated (1/8/25) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/1/25 at 12:53 P.M., Resident #77 and Family Member #1 said the nurse had just been in the room to do the treatment to the Resident's right heel. The surveyor observed the offloading booties were not in place. The Resident said he/she does not refuse the use of the booties and doesn't know where they are. Family Member #1 said the booties have been up on the shelf in the Resident's room for quite some time and they were not aware of why the booties were no longer used on the Resident even though the Resident still had the area to their right heel. During an interview on 4/1/25 at 1:27 P.M., Nurse #7 observed the Resident in his/her room with the surveyor and Family Member #1. He said he provided the wound treatment of cleansing and skin prep to the Resident's right heel area approximately 45 minutes prior. He said the Resident is supposed to wear booties to offload his/her heels and the Certified Nursing Assistants (CNA) are supposed to put them on the Resident. He doesn't know why they do not put them on the Resident. He said the heels should be offloaded to prevent further issues with pressure but they are not. He said he did not attempt to place the offloading booties on the Resident at the time of the treatment being provided and was not observed to offer or attempt to place the booties on the Resident prior to leaving the room. Throughout the survey the surveyor made the following observations of Resident #77: - 4/1/25: In bed, on his/her back, without offloading boots in place or any type of offloading provided to keep the Resident's heel off the bed at 10:05 A.M., 10:53 A.M., 12:21 P.M., 12:53 P.M., and 4:23 P.M. - 4/2/25: bed, on his/her back, without offloading boots in place or any type of offloading provided to keep the Resident's heel off the bed at 6:52 A.M., 7:41 A.M., 7:54 A.M., 8:42 A.M., 10:11 A.M. During an interview on 4/1/25 at 4:26 P.M., CNA #1 said she knows the Resident but was unaware that the Resident had an area on his/her right heel and required booties to be worn to offload their heels. During an interview on 4/1/25 at 4:28 P.M., CNA #2 said she knows the Resident well and the Resident is dependent on care including repositioning in the bed and she was not aware that the Resident was supposed to wear offloading booties at all times and if the CNAs do not know, this is likely the reason the Resident is not wearing them. During an interview on 4/2/25 at 7:54 A.M., CNA #3 said she knows the Resident well and used to take care of him/her all the time. She said the Resident is dependent on staff for all care and had an area on his/her right heel and was supposed to be wearing booties at all times. She said she does not know why the Resident is no longer wearing the booties. Review of the current care plans for Resident #77 failed to indicate a care plan was developed for the right heel DTI. Review of the Nursing progress notes for Resident #77 indicated on 3/29/25 that the wound remained on the right heel and was intact, red and dime sized. Further review of the nursing progress notes failed to consistently reflect information on the known right heel wound that was being treated throughout the months of February and March 2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Physician and NP progress notes for Resident #77 indicated but were not limited to the following: - 2/6/25: Resident seen by a wound specialist on 2/4/25, an unstageable DTI on the right heel; wound orders put in place, unable to visualize wound. High risk for skin breakdown and poor wound healing. Assessment: L 89.616 (diagnosis code for Pressure-induced deep tissue damage of right heel); followed by facility wound specialist, wound care orders are in place. At risk for poor wound healing and further skin breakdown due to limited mobility. - 2/11/25: Unable to visualize the right heel wound. High risk for skin breakdown and poor wound healing. Followed by facility wound specialist. - 2/20/25: Skin normal color and turgor, unable to visualize the right heel wound; high risk for skin breakdown and poor wound healing. - 2/25/25: DTI of the right heel continues to have intact skin with purple discoloration. High risk for skin breakdown and poor wound healing, continue skin prep. During an interview with observation on 4/2/25 at 10:11 A.M., the surveyor and Unit Manager (UM) #1 observed the Resident in bed, lying on his/her back with their feet resting on the bed, not offloaded with their ordered booties. UM #1 said the Resident would be at risk for pressure to his/her heels, especially with the head of their bed elevated, and the heels should be offloaded but were not. Nurse #7 entered the room and confirmed the Resident had a DTI on his/her right heel and was supposed to have their heels offloaded with the ordered booties, which were available in the room, but not placed on the Resident. During an interview on 4/2/25 at 10:12 A.M., UM #1 said she was not aware that the Resident still had a wound on their right heel and had thought the wound had resolved and therefore the Resident was not seen during wound rounds the day prior. She reviewed the record and said the order was still in place for skin prep and offloading booties to the Resident at all times for the right heel DTI and the Resident should have had the offloading booties on and did not. She said even though the nurses are signing off the TAR indicating the booties are in place to the Resident, based on her observation and the surveyor's observations this was not occurring as it should be and the TAR was inaccurate; the nurses are just signing off the orders. She said the record indicated the Resident was first observed to have an area to his/her right heel on 2/2/25 and was seen by the consultant wound physician for initial evaluation on 2/4/25. She said when the wound to the right heel was identified, a resident centered care plan should have been developed and implemented to help heal and prevent any further deterioration of the area but at this time there still was no care plan in place for the care or treatment of the Resident's right heel DTI. She said she could not find any evidence that a Licensed nurse completed a pressure wound evaluation or that a physician or NP had evaluated the Resident's wound since the consultant wound physicians had stopped coming to the facility in February. She said the Resident may have been missed in error and that is why his/her wound was unknown to the wound team and not managed and monitored as it should have been. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/3/25 at 10:14 A.M., the Director of Nurses (DON) said there was not a care plan developed or implemented for the care and treatment of Resident #77's right heel pressure area and there should have been. He reviewed the CNA care Kardex and said the Kardex does not reflect the need for offloading booties to be on the Resident at all times and that is likely why some of the CNAs were unaware of the need for the booties. During an interview on 4/3/25 at 10:26 A.M., the DON said the Resident appeared to have developed a deep tissue pressure injury to his/her right heel that was first identified on 2/2/25 and was evaluated by the consultant wound physician on 2/5/25. He said there was no documentation in the record that he could find that the right heel wound had resolved, or that the Resident had been evaluated by the Licensed nurses using the pressure ulcer evaluation tool or any physician or NP after the consultant wound physician stopped coming to the facility. He was made aware of the surveyor's observations of the Resident not having their offloading booties in place, even after the surveyor spoke to staff about the missing booties, and said the order was active and signed off on the TAR and the staff should have ensured the MD orders were followed and the offloading booties were in place as ordered. During an interview on 4/3/25 at 12:29 P.M., Regional Nurse #1 provided the surveyor with an assessment of the Resident's right heel wound, dated 4/3/25, that indicated the wound was approximately quarter sized (larger than 1.5 cm x 1.5 cm), open and had an area of drainage with the physician being contacted for new orders. She said she is aware that these changes to the wound indicate further deterioration of the area had occurred since the last observation of the area by the staff on 3/29/25 and the surveyor on 4/1/25. During an interview on 4/3/25 at 3:38 P.M., NP #1 said she cares for Resident #77 regularly and knows him/her well. She said back in February she was notified that the Resident had developed a DTI to the right heel and the Resident was being seen by the consultant wound care physician for the management of their pressure injury to the right heel. She said once the wound developed the orders for offloading for this Resident should be followed consistently to prevent any further deterioration of the area and failing to use the offloading booties as ordered would be a contributing factor to the pressure area further deteriorating. She said she spoke with the facility today and was made aware that the pressure area on the right heel had deteriorated and was now open with drainage and larger in size. She said she was not aware that the Resident still had the wound to his/her right heel and assumed it had resolved since there was no indication in the record that the Resident was still being seen by a wound physician for management or any documentation that spoke to the evaluation or progress of the wound and that is why she had not seen and evaluated the wound herself. She said she believed that the Resident's case was missed when the wound consultant left the facility at the end of February and the new wound care physician team began and that was likely why the Resident did not receive consistent evaluation, care and management of the area since 2/11/25.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and record review, the facility failed to ensure appropriate alternatives were attempted prior to installing a side or bed rail and risks and benefits of bed rails were reviewed with the resident and/or resident's representative and informed consent obtained prior to installation of bed rails for two Residents (#79 and #5), out of a total sample of 18 residents. Findings include: Review of the facility's policy titled Proper Use of Bed Rails, revised October 2024, indicated but was not limited to the following: -It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Resident Assessment: -As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs: a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms b. Size and weight c. Sleep habits d. Medication(s) e. Acute medical or surgical interventions f. Underlying medical conditions g. Existence of delirium h. Ability to toilet self safely i. Cognition j. Communication k. Mobility (in and out of bed) (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	l. Risk of falling -The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. Informed Consent: -Informed consent from the resident or representative must be obtained after appropriate alternatives have been attempted prior to the installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. -The information that the facility should provide to the resident, or resident representative includes, but is not limited to: a. What assessed medical needs would be addressed by the use of bed rails; b. The resident's benefits from the use of bed rails and the likelihood of these benefits; c. The resident's risks from the use of bed rails and how these risks will be mitigated; and d. Alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate. -Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail. 1. Resident #79 was admitted to the facility in March 2025 and had diagnoses including anoxic brain damage, unspecified convulsions, abnormalities of gait and mobility, lack of coordination, restlessness and agitation, and extrapyramidal and movement disorder. Resident #79 had a temporary guardian in place upon admission. Court documents indicated an extension of the appointment of the temporary guardian on 3/26/25, expiring on 4/30/25. Review of the Minimum Data Set (MDS) assessment, dated 3/10/25, indicated a Brief Interview for Mental Status (BIMS) score of 99 indicating the interview was unable to be completed to assess Resident #79's cognitive function. On 3/31/25 at 8:53 A.M., 4/1/25 at 12:53 P.M., and 4/2/25 at 7:00 A.M., the surveyor observed Resident #79 lying in bed with bilateral upper side rails in the upright position and in use. Review of the medical record failed to indicate appropriate alternatives that had been attempted and failed. The Resident's Side Rail Consent Form was prefilled with the Resident's name and date of birth but the sections for when the consent was reviewed by the facility, signature of the Resident or Resident's Representative and date, and witness signature and date lines were blank. The form indicated consent must be obtained prior to placing the side rails on the bed. (continued on next page)

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	225536	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record failed to indicate a physician's order was obtained prior to the installation and use of the bed rails. During an interview on 4/1/25 at 2:56 P.M., the Unit Manager (UM) said the side rail consent form was sent to the legal guardian, but she could not locate a completed form in the Resident's medical record. She said the consent should have been completed prior to the use of the side rails and there should be an order for them but there wasn't. A call was placed to the legal guardian on 4/1/25 at 3:40 P.M. with no call back. During an interview on 4/2/25 at 2:29 P.M., the Director of Nursing (DON) and Regional Nurse #1 said on admission, an admission assessment is done to determine if a resident needs side rails. They said if a resident is not their own person, then they contact the family to educate them on the risks vs. benefits and obtain consent. They said the assessment is done to determine the need for the side rails and said if they don't consent, then the facility will not use them. The DON said completed consent should have been obtained prior to the use of Resident #79's side rails. Regional Nurse #1 said the Resident's admission assessment was completed but did not include any alternatives attempted prior to their installation and did not know where it would be documented. She said upon receiving consent, an order would have been obtained for the use of the specified bed rail and medical diagnosis and functional reason for use but wasn't. 34145 2. Resident #5 was admitted to the facility in June 2024 with diagnoses including adult failure to thrive and rheumatoid arthritis. Review of the MDS assessment, dated 2/27/25, indicated Resident #5 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15, and had an activated HCP. On 3/31/25 at 9:06 A.M., 4/1/25 at 7:01 A.M. and 4/2/25 at 9:39 A.M., the surveyor observed Resident #5 lying in bed resting with bilateral side rails up and in use. Review of the medical record indicated a physician's order, dated 7/17/24, for 1/2 lower side rails for movement and mobility. Review of July 2024 through April 2025 Medication/Treatment Administration Records (MAR/TAR) indicated 1/2 lower side rails were in place as ordered by the physician. Further review of the medical record indicated a side rail consent form, signed by Resident #5's HCP on 3/29/25 (255 days after the side rails were initiated). The form indicated that consent must be obtained prior to placing the side rails on the bed. The consent form included lines for the Resident's name, date of discussion with staff, date last reviewed by the facility that were blank. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/25 at 3:20 P.M., Resident #5's HCP said that he was called by the facility a few weeks ago and told that he needed to sign admission paperwork because it was not done when the Resident was originally admitted in July 2024. He said he came into the facility on [DATE] and signed a stack of paperwork that was given to him and was not sure what they were. He said there was no nurse available to go over the paperwork with him, so he just signed it all. He said no one reviewed the risks and benefits for the use of side rails with him. During an interview on 4/2/25 at 12:20 P.M., Unit Manager #1 said that Resident #5's HCP should have been provided with information about the risks and benefits of side rail use and provided informed consent before the side rails were put into place and was not.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43935 Based on document review and interview, the facility failed to ensure monthly medication regimen reviews (MRR) were communicated to the physician and addressed in a timely manner for two Residents (#60 and #10), out of a total sample of 18 residents. Specifically, the facility failed to: 1. Ensure a recommendation from June 2024 left by the consultant pharmacist for Resident #60 to potentially reduce their medication load of Famotidine (a medication that decreases the amount of acid the stomach produces) from twice a day to once a day; and 2. For Resident #10, to ensure the August, September and October 2024 consultant pharmacist recommendations were acted upon timely to clarify the need for two as needed orders for Duoneb (inhalation solution to help open the airways in the lungs). Findings include: Review of the facility's policy titled Medication Regimen Review, undated, indicated but was not limited to the following: - the drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist and includes a review of the medical record - the MRR is an evaluation with the goal to promote positive outcomes and minimize adverse consequences and potential risks associated with medications - the pharmacist will document, either manually or electronically, that each MRR was completed and document either no irregularity or the nature of any identified irregularities - written communications from the pharmacist will be a permanent part of the medical record - staff shall act upon all recommendations according to procedures for addressing MRR irregularities 1. Resident #60 was admitted to the facility in February 2024 with diagnoses including: adult failure to thrive, abscess of the pharynx, and dysphagia (inability to swallow well). Review of the medical record indicated a full MRR was completed by the consultant pharmacist in June 2024 and to see report for irregularities and/or recommendations. The record failed to indicate what those irregularities were or that they were addressed by a physician. Review of the MRR from June 2024 was a recommendation left to the prescriber and indicated the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident has received Famotidine 20 milligrams (mg) twice daily since admission for gastroesophageal reflux disease (GERD). Would it be appropriate to consider reducing Famotidine dose to 20mg every night (QHS) as maintenance therapy? The physician response section was not completed by the physician, instead the Director of Nurses (DON) contacted the attending and completed the bottom of the form indicating disagree, but failed to indicate a rationale for the disagreement, and dated the recommendation as addressed on 4/1/25, 8 months after the recommendation was placed. During an interview on 4/2/25 at 12:25 P.M., the Director of Nursing (DON) said once the facility located the MRR recommendation yesterday, he contacted the Nurse Practitioner (NP) about Resident #60's recommendation from June 2024. He said he asked the NP if they ever had awareness of this recommendation in the past and they told him they couldn't recall it. He said he informed them of the recommendation and the NP at this time decided to decline the change and maintain the current orders of Famotidine 20mg twice daily until the Resident could be re-evaluated. He said he did not have a rationale for the declined recommendation and just signed it as completed on 4/1/25. He said the process for MRR being addressed is that they are completed by the NP or physician timely, which he considers to be within one month of the original recommendation being placed and that when a recommendation is declined a rationale is documented in the medical record. He said this process does not appear to have been in place or effective since Resident #60's June MRR recommendation was not addressed for eight months after it was placed. 34145 2. Resident #10 was admitted to the facility in September 2023 and had diagnoses including chronic obstructive pulmonary disease (COPD-lung disease causing restricted airflow and breathing problems). Review of the medical record indicated Pharmacy Consultant Notes, dated 8/14/24, 9/9/24 and 10/8/24 which indicated that recommendations were made and to see the Consultant Pharmacist report for the recommendations. Further review of the entire medical record failed to indicate consultant pharmacy recommendations dated 8/14/24, 9/9/24, and 10/8/24. During an interview on 4/2/25 at 10:35 A.M., the DON said the previous owners of the facility had all of the pharmacy recommendations in their computer system. He said after the survey team requested to review pharmacy recommendations yesterday, they had to call the previous owners and requested the past year of pharmacy recommendations. He said the 8/14/24, 9/9/24 and 10/8/24 pharmacy recommendations were addressed by Resident #10's Nurse Practitioner yesterday, 4/1/25 (more than 230 days since the first recommendation).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34145 Based on observation, record review, and interview, the facility failed to ensure all drugs and biologicals were stored in a safe and secure manner as required for two Residents (#10 and #17) out of a total sample of 18 residents. Specifically, the facility failed to ensure: 1. For Resident #10, medication was not left unattended in the Resident's room; and 2. For Resident #17, ensure a medicated cream was not left unattended in his/her room. Findings include: Review of the facility's policy titled Medication Storage, last reviewed 9/2024, indicated but was not limited to: -Policy Explanation and Compliance Guidelines: - All drugs and biologics will be stored in locked compartments. -During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 1. Resident #10 was admitted to the facility in September 2023 and had diagnoses including a history of stroke. Review of the Minimum Data Set (MDS) assessment, dated 3/6/25, indicated Resident #10 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15, and was administered anticoagulant (blood thinner) medication. On 3/31/25 at 9:00 A.M., the surveyor observed Resident #10 lying in bed awake. An overbed table was parallel to the bed with a clear medication cup lying on its side with one round dark yellow pill in it. Resident #10 said he/she did not know what the yellow pill was. Review of Resident #10's medical record failed to indicate Resident #10 was assessed to self-administer medications. On 3/31/25 at 9:39 A.M., the surveyor observed Nurse #3 adjust Resident #10's oxygen tubing while standing next to the overbed table with the clear plastic medication cup that contained the dark yellow pill. When the nurse finished adjusting the tubing, he left the Resident's bedside and walked to the door to exit the room. The surveyor asked the nurse to come back to the Resident's bedside and showed him the medication cup with the yellow pill in it. Nurse #3 said the pill was levothyroxine (thyroid hormone) and the third shift nurse must have left the Resident alone with it. He said the medication should not have been left on the table in the medication cup and the nurse should have stayed with the Resident to ensure he/she took it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician's orders failed to indicate Resident #10 was prescribed levothyroxine. During a subsequent interview on 3/31/25 at 2:22 P.M., Nurse #3 said he researched the pill left at Resident #10's bedside this morning and determined that it was Eliquis 2.5 milligrams (mg) and not levothyroxine as he told the surveyor that morning. He said the Resident is prescribed Eliquis 2.5 mg twice a day at 9:00 A.M. and 9:00 P.M. Nurse #3 said he discarded the pill. The nurse said he worked a double shift for the two days prior but could not explain why the pill was left at the Resident's bedside unattended and why the MAR indicated the medication was administered as ordered. During an interview with the Director of Nursing (DON) on 4/1/25 at 2:28 P.M., the surveyor reviewed the observation and interviews with Nurse #3 regarding the yellow pill in the medication cup left at Resident #10's bedside unattended. The DON said Resident #10's medication should not have been left at the bedside and the nurse should have stayed with the Resident to ensure it is taken and not leave the medication unattended in his/her room. 48695 2. Resident #17 was admitted to the facility in November 2015 with diagnoses of muscle weakness and abnormal posture. Review of the MDS assessment, dated 2/20/25, indicated Resident #17 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Review of Resident #17's current Physician's Orders indicated but was not limited to: - Silver Sulfadiazine Cream (antimicrobial) 1% Apply to buttocks/coccyx topically every shift for skin breakdown, dated 3/14/25 On the following days and times, the surveyor observed Silver Sulfadiazine Cream on Resident #17's nightstand: - 3/31/25 at 8:41 A.M., - 3/31/25 at 2:25 P.M., - 3/31/25 at 4:39 P.M., - 4/1/25 at 7:08 A.M., - 4/1/25 at 8:28 A.M., - 4/1/25 at 10:34 A.M., and - 4/1/25 at 4:39 P.M. During an interview on 3/31/25 at 8:41 A.M., Resident #17 said the nurses would put the Silver Sulfadiazine Cream on to his/her buttocks. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/31/25 at 8:46 A.M., Nurse #5 said Resident #17 should not have their Silver Sulfadiazine Cream on their nightstand. Nurse #5 said medicated creams should be locked up in the treatment cart and not left out unattended. During an interview on 4/1/25 at 4:39 P.M., Nurse #4 said Resident #17 should not have their Silver Sulfadiazine Cream on their nightstand and it should be locked up in the treatment cart. Nurse #4 said all medication and treatments should never be left out and unattended. During an interview on 4/2/25 at 2:55 P.M., the Unit Manager (UM) said all medication and treatments should never be left out and unattended. The UM said Resident #17 should not have Silver Sulfadiazine Cream on their nightstand. During an interview on 4/2/25 at 4:02 P.M., the DON said all medication and treatments should never be left out and unattended and not left in residents' rooms.

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F 0844 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 42742 Based on interview and review of the Health Care Facility Reporting (HCFS-State agency reporting system), the facility failed to provide written notice to the State Agency when a change in the facility's Administrator and Director of Nursing (DON) occurred. Findings include: During the entrance conference interview on 3/31/25 at 8:59 A.M., the Administrator said she was the facility's new Administrator, effective 3/10/25, and the facility had a new Director of Nursing (DON), effective 3/15/25. The Administrator said the changes were not reflected in HCFRS yet but were in process and would provide documentation of such to the surveyor. Review of the HCFRS indicated the last reported change in the facility's Administrator was 12/6/24 and the last reported change in the facility's DON was 5/23/24 but no changes were indicated that the Administrator and DON were no longer working at the facility. Further review of the HCFRS failed to indicate the State Agency was notified when the change took place for the current Administrator on 3/10/25 and DON on 3/15/25. During an interview on 3/31/25 at 3:10 P.M., the Administrator provided the surveyor with an email, dated 3/31/25, that indicated she did not have access to HCFRS yet, but the current DON did. During an interview on 3/31/25 at 4:15 P.M., the Administrator and DON said the previous company (prior to 3/1/25) said they would put the changes in HCFRS for them, but they did not. They said there were staff still working in the facility from the previous company that had access to HCFRS for reporting, but they did not report it either. They said it was their responsibility to ensure that it was done and said when there's a change in Administrator or DON it should be reported in HCFRS, but it wasn't. During an interview on 4/2/25 at 3:19 P.M., Regional Nurse #1 said the changes in Administrator and DON should have been reported in HCFRS prior to their start or immediately after.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on records reviewed and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Specifically, the facility failed to: 1. Perform surveillance activities to monitor and investigate causes of infections and the manner of spread throughout the facility; 2. Have a facility specific written water management plan to ensure a facility risk assessment was conducted to identify where Legionella (bacteria that can cause Legionnaires' disease, a serious type of pneumonia) and other opportunistic waterborne pathogens could grow and spread in the facility's water system; 3. For Resident #41, ensure Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication) equipment was maintained in a clean and sanitary manner to decrease the risk of potential contamination and infection; 4. For Resident #49, ensure respiratory equipment including oxygen and nebulizer tubing was properly stored in a clean and sanitary manner to decrease the risk of potential contamination and infection; 5. For Resident #73, ensure the proper care and storage of the Resident's continuous positive airway pressure (CPAP-helps treat sleep apnea) machine; and 6. For Resident #77, ensure nebulizer (drug delivery device used to administer medication in the form of a mist inhaled into the lungs) mask and tubing was stored in a sanitary manner. Findings include: 1. Review of the facility's policy titled Infection Surveillance, last revised September 2024, indicated but was not limited to: - A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. The purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices to reduce infections and prevent the spread of infections. - Infection surveillance refers to an ongoing systemic collection, analysis, interpretation, and dissemination of infection-related data. - The Facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The facility will communicate staff and/or prescribing practitioner's information related to infection rates and outcomes in order to revise interventions/approaches and/or re-evaluate medical interventions as indicated. - Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends. - All residents and infections will be tracked. On 3/31/25 at 3:27 P.M., the surveyor requested to see the facility's completed surveillance logs for December 2024, January 2025, and February 2025. During an interview on 3/31/25 at 4:31 P.M., Support Staff #2 said the facility did not have access to December 2024, January 2025, and February 2025 completed surveillance logs and was working on getting them. During an interview on 4/1/25 at 12:53 P.M., Support Staff #2 said the facility was not able to provide any surveillance logs prior to March 1, 2025, to the survey team. During an interview on 4/2/25 at 1:08 P.M., the Director of Nursing (DON) and Support Staff #2 said there were no surveillance logs that the facility could provide to the survey team. 2. Review of Centers for Medicare & Medicaid Services (CMS) Memorandum titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease, revised July 2018, indicated but was not limited to the following: - In manmade water systems, Legionella can grow and spread to susceptible hosts, such as persons who are at least [AGE] years old, smokers, and those with underlying medical conditions such as chronic lung disease or immunosuppression. Legionella can grow in parts of building water systems that are continually wet, and certain devices can spread contaminated water droplets via aerosolization. Review of the facility's policy titled Legionella Water Management Program, dated November 2017, indicated but was not limited to: -Policy: Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. -Guideline: - As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. - The water management team will consist of at least the following personnel: - Infection Preventionist - Administrator (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Medical Director - Director of maintenance - Other members as assigned by the Administrator -The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionella Disease. -The water management program used by our facility is based on applicable federal and state regulations. The water management program may include the following elements: - A description and diagram of the water system in the facility is available upon request; - The Identification of area in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria; Review of the facility's Water Management Plan, dated 11/5/24, indicated but was not limited to: - Medical Director signature -Blank - Water enters the basement on the property - Hot water is distributed to plumbing fixtures in the basement - Areas where Legionella could grow and spread: - Fountains - Hydrotherapy During an interview on 4/1/25 at 4:44 P.M., the Director of Maintenance (DOM) said the Medical Director had never been part of the Water Management team. The DOM said the facility was built on a slab and did not have a basement. The DOM said the facility did not have any hydrotherapy and the only fountains in the facility were water fountains which were capped off and shut off over five years ago. The DOM said the water management plan was not specific to the facility and did not accurately represent the facility. During an interview on 4/2/25 at 1:08 P.M., the DON and Support Staff #2 said the Facility's water plan was not specific to the facility but should have been. 3. Review of the facility's policy titled Care and Treatment of Feeding Tubes, last revised September 2024, indicated but was not limited to: - Direction for staff on how to provide the following care will be provided: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Rehab and Healthcare	160 Main Street Walpole, MA 02081

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Use of infection control precautions and related techniques to minimize the risk of contamination. Review of the facility's policy titled Flushing a Feeding Tube, last revised October 2024, indicated but was not limited to: - Change the 60 ml catheter tip syringe used every 24 hours or as needed. - Store in a bag or container. Resident #41 was admitted to the facility in October 2022 with diagnoses including cerebral infarction and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 1/10/25, indicated Resident #11 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. Further review of Resident #41's MDS indicated he/she had a feeding tube and received 51% or more of their total calories from the feeding tube. Review of Resident #41's current Physician's Orders indicated but was not limited to: - Enteral feed Jevity 1.5 Calorie, administer 54 milliliters (ml)/hour (hr) for a total of 20 hours with 150 ml of free water flushes every 4 hours for total of 1080 ml of formula daily, dated 11/8/2024 a. On the following dates and times, the surveyor observed dried splatters of a thick, tacky, tan colored substance on Resident #41's tube feeding pump, pole, the floor underneath the pump, the bedrail of his/her bed, and on their privacy curtain: - 3/31/25 at 8:58 A.M., - 3/31/25 at 10:18 A.M., - 3/31/25 at 12:06 P.M., - 3/31/25 at 2:30 P.M., - 3/31/25 at 4:43 P.M., - 4/1/25 at 7:10 A.M., - 4/1/25 at 10:01 A.M., - 4/1/25 at 10:21 A.M., - 4/1/25 at 11:57 A.M., and - 4/2/25 at 8:31 A.M. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/2/25 at 8:31 A.M., Nurse #5 and the surveyor observed the dried splatters of the thick, tacky, tan colored substance on Resident #41's tube feeding pump, pole, floor underneath the pump, the bedrail of his/her bed, and on their privacy curtain. Nurse #5 said it was the nurse's responsibility to wipe up any tube feeding formula they had spilled or dripped. Nurse #5 said housekeeping was responsible for cleaning the floor and cleaning the privacy curtain. During an interview on 4/2/25 at 8:38 A.M., Unit Manager (UM) #1 said the expectation was for all feeding tube equipment and the surrounding area to be kept in a clean and sanitary manner to promote healthy infection control practices. UM #1 said that whoever spilled the formula should have wiped down the spilled formula and notified housekeeping to clean and replace the privacy curtain. During an interview on 4/2/25 at 4:02 P.M., the DON said that the expectation was for all feeding tube equipment and the surrounding area to be kept in a clean and sanitary manner to promote healthy infection control practices. b. On 3/31/25, the surveyor observed Resident #41's piston syringe lying uncovered dated 3/29/25 on his/her dresser: - 8:58 A.M., - 10:18 A.M., - 12:06 P.M., - 2:30 P.M., - 4:43 P.M. On 4/1/25 at 8:26 A.M. and 10:01 A.M., the surveyor observed Resident #41's piston syringe lying uncovered, dated 3/29/25, on a towel his/her overbed table. On 4/1/25 at 10:21 A.M., the surveyor observed Nurse #8 administering Resident #41's medications using the piston syringe, dated 3/29/25. Nurse #8 said she used the syringe from Resident #41's overbed table because she could not find a new syringe and she needed to hang his/her tube feeding. Nurse #8 said she should not have used the piston syringe from Resident #41's overbed table because it was not stored in a clean manner and was outdated. Nurse #8 said piston syringes should be replaced daily and stored in a bag. On 4/1/25 at 3:23 P.M., Regional Nurse #1 said piston syringes should be changed daily and stored in a sealed bag. Regional Nurse #1 said piston syringes should not be stored out of a sealed bag when not in use. 48362 4. Review of the facility's policy titled Oxygen Administration, dated last revised 9/2024, indicated but was not limited to the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered plans, and the resident's goals and preferences. - Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include a.) Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated; d.) If applicable, change nebulizer tubing and delivery devices weekly and as needed if it becomes soiled or contaminated; e.) Keep delivery devices covered in plastic bag when not in use. - Cleaning and care of equipment shall be in accordance with facility policies for such equipment. Review of the facility's policy titled Nebulizer Therapy, dated last revised 9/2024, indicated but was not limited to the following: - It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. - Care of Equipment: 1.) Clean after each use; 2.) Wash hands before handling equipment; 3.) Disassemble parts after every treatment; 4.) Rinse the nebulizer cup and mouthpiece with sterile or distilled water; 5.) Shake off excess water; 6.) Air dry on an absorbent towel; 7.) Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag; 8.) Change the nebulizer tubing every seventy-two hours or per facility policy; 9.) Periodically disinfect unit per manufacturer's recommendations. Resident #49 was admitted to the facility in January 2024 with diagnoses including pulmonary fibrosis and emphysema. Review of Resident #49's MDS assessment, dated 12/26/24, indicated he/she was cognitively intact as evidenced by a BIMS of 15 out of 15. Furthermore, the MDS assessment indicated he/she required assistance from staff for activities of daily living. Review of Resident #49's Physician's Orders indicated but was not limited to the following: - 3/27/25: May apply O2 (oxygen) at 1-3 L (liters) via NC (nasal cannula) to maintain saturation 94% of above; if saturation is 94 or above on O2, turn O2 down/off every shift - 3/26/25: Oxygen 1L per minute via NC and titrate to keep saturation above 93%. - 3/26/25: Duoneb Solution 0.5-2.5 3MG (milligrams)/3mL (milliliters); 3mL inhale orally via nebulizer every 8 hours as needed for SOB (shortness of breath). Review of Resident #49's March and April Medication Administration Records (MAR) indicated he/she received the Duoneb Solution treatment on 3/26/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation with interview on 3/31/25 at 2:46 P.M., the surveyor observed Resident #49 resting in bed; an oxygen concentrator was on and set to 2L of oxygen. Nasal cannula tubing was attached to the concentrator. The nasal cannula tubing was observed to be on the ground on the left side of the bed and the tubing was not dated. A nebulizer mask and tubing were noted to be resting on the nightstand next to Resident #49's bed. The nebulizer mask and tubing were exposed to the environment, was not dated, and was not covered with a plastic bag. Resident #49 said he/she was recently diagnosed with pneumonia and was requiring nebulizer treatments and oxygen. Resident #49 said none of the oxygen equipment, including nasal cannula tubing and nebulizer mask/tubing, had been changed since he/she started using the equipment. On 4/1/25 at 10:55 A.M., the surveyor observed Resident #49 resting in bed with nasal cannula tubing donned (on). The oxygen concentrator was set to 2L. The nasal cannula tubing was not dated. A nebulizer mask and tubing were noted to be resting on the nightstand next to Resident #49's bed. The nebulizer mask and tubing was exposed to the environment, was not dated, and was not covered with a plastic bag. On 4/1/25 at 4:11 P.M., the surveyor observed Resident #49 asleep in bed without nasal cannula tubing donned. The oxygen concentrator was set to 2L. The nasal cannula tubing was not dated and was found resting across Resident #49's lap exposed to the environment. A nebulizer mask and tubing were noted to be resting on the nightstand next to Resident #49's bed. The nebulizer mask and tubing were exposed to the environment, was not dated, and was not covered with a plastic bag. On 4/2/25 at 7:49 A.M., the surveyor observed Resident #49 resting in bed without nasal cannula tubing donned. The oxygen concentrator was set to 2L. The nasal cannula tubing was not dated and was found resting across Resident #49's lap exposed to the environment. A nebulizer mask and tubing were noted to be resting on the nightstand next to Resident #49's bed. The nebulizer mask and tubing were exposed to the environment, was not dated, and was not covered with a plastic bag. Review of Resident #49's medical record failed to indicate any documentation indicating that the oxygen tubing and/or nebulizer mask/tubing was changed. During an interview on 4/2/25 at 8:16 A.M., Nurse #1 said oxygen equipment is changed weekly at the facility or if it is soiled. Nurse #1 said when nebulizer or oxygen equipment is not in use it should be stored in a bag. Nurse #1 said tubing should be dated to indicate the last time it was changed. During an interview on 4/2/25 at 11:07 A.M., the Assistant Director of Nursing (ADON) said all oxygen equipment, including nebulizer equipment, should be stored in a bag when it is not in use. The ADON said oxygen and nebulizer tubing should be dated to indicate when it was last changed. The ADON and the surveyor reviewed the observations made during the survey process. The ADON said all items needed to be changed as they were potentially contaminated. The ADON said the items should have been stored properly when not in use. During an interview on 4/2/25 at 11:32 A.M., the DON said all oxygen equipment should be stored in a bag when not in use and should not be left on the ground or on a nightstand exposed to the environment. The DON said tubing should be dated to indicate to the staff how recently it was changed. The DON said Resident #49's oxygen and nebulizer equipment was not stored appropriately. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	43935 5. Resident #77 was admitted to the facility in January 2025 and had diagnoses including: Unspecified intracranial injury, abnormalities of gait and mobility, muscle wasting and atrophy, unsteadiness on feet, and abnormal posture. Review of the MDS assessment, dated 1/14/25, indicated Resident #77 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of the current Physician's Orders for Resident #77 indicated but were not limited to the following: - Albuterol sulfate inhalation nebulizer solution (2.5 milligrams / 3 milliliters) 0.083% inhale one application orally via nebulizer every 12 hours, as needed (PRN) for shortness of breath (SOB) (1/8/25) Throughout the survey the surveyor made the following observations: 4/1/25: nebulizer mask and tubing on the bedside table touching other items on the table, exposed to environmental debris and germs in the environment, not stored in a plastic bag at 10:05 A.M., 10:52 A.M., 12:21 P.M. and 1:23 P.M. During an interview on 4/1/25 at 12:21 P.M., Family Member #2 and the Resident said they were unsure of the last time the Resident had received a nebulizer treatment. Family Member #2 said the nebulizer mask and tubing had been left on top of the bedside table and stored there consistently. During an interview on 4/1/25 at 1:23 P.M., Nurse #7 observed the nebulizer tubing and mask with the surveyor. He said the nebulizer tubing and mask were not supposed to be stored that way and the equipment was dirty and would need to be replaced. He said the Resident is on nebulizer treatments PRN and he had not provided a treatment to the Resident recently. During an interview on 4/2/25 at 10:09 A.M., the Unit Manager said nebulizer tubing and mask or mouthpiece equipment is to be cleaned after each use and then stored in a plastic bag to protect it from germs. She said it does not appear that the process was followed in this instance and the Resident's nebulizer mask and tubing should have been stored in a sanitary manner. During an interview on 4/3/25 at 10:14 A.M., the DON said the process for storing nebulizer tubing and mask or mouthpiece is to clean it after each treatment and store it in a bag once it is dried for infection control reasons. He said that process was not followed for Resident #77 based on the surveyor's observations. 42742 6. Review of Lippincott Nursing Procedures. Eighth edition. [Philadelphia: Wolters Kluwer, (2019)] indicted but was not limited to the following: Continuous Positive Airway Pressure (CPAP) Use (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administering CPAP: -When the treatment is over-in the morning or on discontinuation of the order-turn off the pressure generator and remove the headgear and appliance from the patient. -Clean and disinfect the equipment and store it properly. Resident #73 was admitted to the facility in December 2024 with diagnoses including sleep apnea (sleep disorder in which breathing repeatedly stops and starts). During an observation with interview on 4/1/25 at 10:40 A.M. and 2:06 P.M., the surveyor observed Resident #73 sitting up in bed. A CPAP machine was stored on top of the Resident's side table. The face mask and tubing were observed attached to the machine and resting on top of the side table potentially exposed to environmental contaminants. The face mask and tubing were not stored in a protective bag when not in use by the Resident. Resident #73 said he/she used the machine for sleep apnea. Review of current Physician's Orders indicated the following: -CPAP @10 cm (centimeters of water pressure) H2O inspiration; 5 cmH2O expiration, on at HS (before sleep at bedtime), off in AM, at bedtime for sleep apnea, 12/26/24 During an observation with interview on 4/1/25 at 2:49 P.M., the surveyor and Unit Manager (UM) entered the Resident's room and observed a CPAP machine stored on top of the Resident's side table. The face mask and tubing were observed attached to the machine and resting on top of the side table potentially exposed to environmental contaminants. The face mask and tubing were not stored in a plastic bag when not in use by the Resident. The UM said the mask and tubing should have been stored in a protective bag when not in use secondary to the potential for infection control concerns related to the danger of exposure to contaminants. On 4/2/25 at 6:58 A.M., the surveyor observed Resident #73 sitting up in bed. A CPAP machine was stored on top of the Resident's overbed tray table. The face mask and tubing were observed attached to the machine and resting on top of the tray table potentially exposed to environmental contaminants. The face mask and tubing were not stored in a protective bag when not in use by the Resident. During an interview on 4/2/25 at 3:13 P.M., the DON and Regional Nurse #1 said the Resident uses a CPAP machine for sleep apnea every night. They said the mask and tubing should be stored in a bag when not in use to avoid potential contamination.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 48695 Based on record review and interview, the facility failed to establish and maintain an infection prevention and control program that included an antibiotic stewardship program with antibiotic use protocols and a system to monitor antibiotic use. Findings include: Review of the facility's Antibiotic Stewardship Program policy, undated, indicated but was not limited to the following: - It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. On 3/31/25 at 3:27 P.M., the surveyor requested to see the facility's antibiotic use for December 2024, January 2025, and February 2025. During an interview on 3/31/25 at 4:31 P.M., Support Staff #2 said the facility did not have access to December 2024, January 2025, and February 2025 antibiotic use records. Support Staff #2 said the facility was working on getting the completed antibiotic use records for the facility. During an interview on 4/1/25 at 8:20 A.M., Support Staff #2 said the facility was still working on obtaining the facility's antibiotic use for December 2024, January 2025, and February 2025. During an interview on 4/1/25 at 11:03 A.M., Support Staff #2 said there was someone on their way to the facility with some files which may contain the completed records for antibiotic use. During an interview on 4/2/25 at 1:08 P.M., the Director of Nursing and Support Staff #2 said they were not able to provide any documentation of the facility's antibiotic use prior to March 1, 2025, to the survey team.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on interview and record review, the facility failed to provide the pneumococcal immunizations as requested/consented for three Residents (#10, #14, and #17), out of a total sample of five residents. Findings include: Review of the facility's policy titled Pneumococcal Vaccine, last revised January 2025, indicated but was not limited to: - It is our policy to offer our residents and staff immunization against pneumococcal disease in accordance with current Centers for Disease Control and Prevention (CDC) guidelines and recommendations. - Every resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. - Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization. - The resident/representative retains the right to refuse the immunization. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record. - The type of pneumococcal vaccine (PCV15, PCV20, PCV21 or PPSV23) offered will depend upon the recipients age, having certain risk conditions, and previously received pneumococcal vaccines, in accordance with current CDC guidelines and recommendations. Review of the Centers for Disease Control and Prevention (CDC) guidance titled Recommended Adult Immunization Schedule for Ages [AGE] years or Older, United States, 2025, indicated but was not limited to the following: Pneumococcal Vaccination Age [AGE] years or older who have: -Previously received both PCV13 and PPSV23, but no PPSV23 was received at age [AGE] years or older: 1 dose of PCV20 or 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine dose. A. Resident #10 was admitted to the facility in September 2023 and is currently [AGE] years old. - Review of the immunization history for Resident #10 failed to indicate he/she had received the pneumococcal vaccine. Review of Resident #10's medical record indicated but was not limited to: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Immunization Consent, signed 9/22/23, consent to recommended administration of pneumococcal vaccination. During an interview on 4/2/25 at 2:58 P.M., Support Staff #1 said she had checked the MIIS (The Massachusetts Immunization Information System (MIIS) is a web-based immunization registry. All providers who administer immunizations in Massachusetts are mandated to report immunization data to the MIIS) and it failed to indicate Resident #10 had received a pneumococcal vaccine, but he/she should have. B. Resident #14 was admitted to the facility in October 2022 and is currently [AGE] years old. - Review of the immunization history for Resident #14 indicated but was not limited to: - PCV 13 pneumococcal vaccination, administered 11/25/19 Review of Resident #14's medical record indicated but was not limited to: - Immunization Consent, signed 10/20/23, consent to recommended administration of pneumococcal vaccination. During an interview on 4/2/25 at 1:08 P.M., Support Staff #1 said Resident #14 was overdue for the PCV20 pneumococcal vaccine and should have received it. C. Resident #17 was admitted to the facility in November 2015 and is currently [AGE] years old. Review of the immunization history for Resident #17 indicated but was not limited to: - Pneumococcal Unspecified Formation, administered 9/28/20 Review of Resident #17's medical record indicated but was not limited to: - Immunization Consent, signed 10/20/23, consent to recommended administration of pneumococcal vaccination. During an interview on 4/2/25 at 1:08 P.M., Support Staff #1 said she reviewed Resident #17's MIIS information and it indicated he/she received the PCV pneumococcal vaccination on 9/1/21. Support Staff #2 said Resident #17 was overdue for the PCV20 pneumococcal vaccine and should have received it.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on record review and interview, the facility failed to provide education and/or offer the COVID-19 vaccination as required or appropriate per the Centers for Disease Control and Prevention (CDC) recommendations for two Residents (#10 and #17), out of a total sample size of five residents reviewed for immunizations. Findings include: Review of the facility's policy titled COVID-19 Vaccine, last revised October 2024, indicated but was not limited to: - It is the policy of the facility to have an immunization program against COVID-19 disease in accordance with national standards of practice. - COVID-19 vaccination will be offered to residents when supplies are available, as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refused to receive the vaccine. Review of CDC guidance titled Use of COVID-19 Vaccines in the U.S., revised October 2024, indicated but was not limited to the following: - People ages 5-[AGE] years should receive 1 dose of an age appropriate 2024-2025 COVID-19 vaccine. Ages 12-[AGE] years (Previous COVID-19 vaccination before 2024-2025 vaccine): - Receive 1 dose of 2024-2025 vaccine - People ages [AGE] years and older, vaccinated under the routine schedule, are recommended to receive 2 doses of an 2024-2025 COVID-19 vaccine (i.e., Moderna, Novavax, or Pfizer-BioNTech) separated by 6 months (minimum interval 2 months) regardless of vaccination history, with one exception: Unvaccinated people who initiate vaccination with 2024-2025 Novavax COVID-19 Vaccine are recommended to receive 2 doses of Novavax followed by a third dose of any COVID-19 vaccine 6 months (minimum interval 2 months) later. Review of the Resident Council Minutes, dated 1/15/25, indicated but was not limited to: - Residents would like to know when the Covid booster will be available? A. Resident #10 was admitted to the facility in September 2023. - Review of the immunization history for Resident #10 failed to indicate he/she had received the COVID-19 vaccine. (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's medical record indicated but was not limited to: - Immunization Consent, signed 9/22/23, consent to administration of COVID-19 Vaccine/Booster. During an interview on 4/2/25 at 2:58 P.M., Support Staff #2 said she had checked the MIIS (Massachusetts Immunization Information System (MIIS) is a web-based immunization registry. All providers who administer immunizations in Massachusetts are mandated to report immunization data to the MIIS) and the Resident's chart and both failed to indicate Resident #10 had received a COVID-19 vaccine, but he/she should have. B. Resident #17 was admitted to the facility in November 2015. Review of the Minimum Data Set assessment, dated 2/20/25, indicated Resident #17 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. During an interview on 3/31/25 at 8:41 A.M., Resident #17 said he/she had not received their COVID-19 vaccine for the 2024/2025 season. Resident #17 said he/she had asked for the vaccine numerous times and was told it was on order. Review of the immunization history for Resident #17 indicated but was not limited to: - COVID-19, administered 11/10/23 Review of Resident #17's medical record indicated but was not limited to: - Immunization Consent, signed 10/20/23, consent to administration of COVID-19 Vaccine/Booster. During an interview on 4/2/25 at 1:08 P.M., Support Staff #2 said Resident #17 had a consent to receive the COVID-19 booster but had not received it as he/she should have.