STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225548	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews and record review, the facility failed to provide necessary treatment, services, or interventions to promote healing and prevent new ulcers from developing for two Residents (#111 and #32) out of 30 total sampled residents. Specifically:1a.) For Resident #111, the facility failed to prevent a new coccyx wound from developing and worsening by not ensuring the Resident's air mattress was inflated, notifying the physician of a new wound to obtain treatment orders and implementing a wound treatment without a physician's order.1b.) For Resident #111, the facility failed to prevent an existing heel wound from worsening by not assessing and monitoring the wound, not implementing physician orders for wound treatment and not following through with a referral to the wound Nurse practitioner timely.2a.) For Resident #32, the facility failed to implement the correct wound treatment according to the physician order when a packing strip (sterile gauze strip used to fill deep wounds) was observed in the wound instead of the physician ordered hydrofera blue (an antibacterial foam wound dressing). 2b.) For Resident #32, the facility failed to implement the topical medication flagyl (an antibiotic medication) according to the physician order when it was unavailable for over a week without notifying the provider or pharmacy. Findings include:Review of the facility policy titled, Pressure Injury Policy, dated July 2024, indicated the following: Purpose: To provide guidance on the provision of treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new pressure injuries from developing. The licensed nurse will assess each resident's risk for skin breakdown by completing a Norton Plus Pressure Ulcer Scale form on admission, readmission and monthly. If the assessment identifies the resident is at risk for skin breakdown, the nurse will implement a care plan to include preventative measures. The licensed nurse will conduct a weekly assessment of pressure injuries by completing the Skin Care Treatment Sheet. Care guidelines: Conduct and document assessment of the pressure injury site. Conduct pain assessment. Notify the physician of the pressure injury, of the absence or presence of pain, and of adverse changes (i.e. new onset/increase of signs/symptoms of infection, new onset/increase pain level, increase in stage and or size). The facility utilizes pressure redistribution mattresses for all residents. Apply heal suspension (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	devices, and/or wheelchair pressure registration cushion if appropriate. Develop a plan of care addressing the alteration in the skin integrity. If no improvement is noted after 14 days, notify the physician to request a change of treatment. The licensed nurse is to obtain an order from the attending physician to have a wound physician consult if the wound physician program is in place. Case Management: Weekly, residents with pressure injuries will be reviewed by the case management team. The team will discuss the residents' stop conditions and plan of care including etiology of the pressure injury, current treatment, effectiveness of treatment, need to revise treatment, nutritional needs, and other factors associated with wound failing. Review of the facility policy titled, Preventative Sin Care Protocol, dated January 2021, indicated the following: Purpose: To identify adults at risk and to define early intervention for prevention of pressure injury. Scope – the Director of Nursing is responsible for design, orientation, continuing training, and implementation of the Preventative Skin Protocol. The preventative protocol assumes all patients/residents have the potential for skin breakdown. Weekly, residents with alterations in skin integrity will be reviewed by the case management team and plan of care including current treatment, effectiveness of treatment, need to revise treatment, nutritional needs and other aspects of care potentially affecting wound healing. During daily care, the Certified Nursing Assistant will observe for changes in characteristics of skin. Skin changes will be communicated to nurses. All residents are to be assessed once a week by the Licensed Nurse during skin rounds. The results of this hands-on physical skin check are to be recorded on the resident's record. All noted stage 1 - stage 4 areas are to be recorded on the skin care treatment sheet per the pressure injury policy. 1. Resident #111 was admitted to the facility in March 2023, with diagnoses of dementia and chronic kidney disease. Review of Resident #111's most recent Minimum Data Set (MDS) assessment, dated 10/10/25, indicated the Resident had a score of 0 out of a possible 15 on the Brief Interview for Mental Status exam, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #111 is dependent on staff for all functional daily tasks including bed mobility. a.) On 12/9/25 at 7:48 A.M., 9:37 A.M., 12:38 P.M. and 4:26 P.M., Resident #111 was observed lying in bed on top of an air mattress that was not powered on. The Resident's air mattress was completely deflated, and the metal grates of the bed could be felt by the surveyor's hand. At the time of these observations, Resident #111 was unable to participate in an interview. On 12/10/25 at 7:00 A.M., and 10:50 A.M., Resident #111 was observed lying in bed on top of an air mattress that was not powered on. The Resident's air mattress was completely deflated, and the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	metal grates of the bed could be felt by the surveyor's hand. At 10:54 A.M., Nurse #1 and the surveyor observed the air mattress together and Nurse #1 said the mattress was not inflated and did not know why. Nurse #1 said a deflated air mattress could cause deterioration of skin. On 12/10/25 at 10:43 A.M., Nurse #1 and the surveyor observed Resident #111's coccyx area. The coccyx had a large, round grapefruit sized area with eschar (a dark, leathery, dry layer of dead tissue that forms over deep wounds) with an undated dressing that was only approximately one fourth the size of the area and was saturated with bloody drainage. During an interview at the time of observation, Nurse #1 said she was unaware Resident #111 had a pressure injury to his/her coccyx and that a treatment needed to be completed for this area. Review of Resident #111's nursing notes indicated the following: A wound nurse note dated 12/3/25 that indicated Notified by staff patient found with excoriated, red and inflamed area to buttock. Area gently cleansed, then patted dry. Barrier cream applied to affected area to protect skin from further moisture and skin breakdown.Will continue to monitor skin integrity. A wound nurse note dated 12/4/25 that indicated, Patient appears to be declining, with reports of increased pain and worsening excoriation in the coccyx area. A wound nurse note dated 12/8/25 that indicated, Patient appears to be declining, with reports of increased pain and worsening excoriation in the coccyx area. The patient presents with a stage 2 pressure injury to coccyx. The wound is being managed with wound cleanser and sacrum dressing. Pressure offloading is maintained, patient on air mattress, and frequent repositioning. Area is monitored closely for signs of infection. Wound care follow up with wound NP (Nurse Practitioner) assessment and treatment adjustments. Review of Resident #111's medical record failed to indicate that the physician was notified of the Resident's new coccyx wound. The medical record also failed to indicate that the order completed by the wound nurse on 12/8/25 was ordered by the physician. Further review of the nursing notes failed to indicate any monitoring of the new area by the nursing staff until a note dated 12/12/25, which indicated late entry. Wound on resident's mid buttocks width 11 cm (centimeter) at its longest, length is at 7 cm at its longest. The wound is shaped like a butterfly. Review of Resident #111's care plans failed to indicate a care plan was developed for the new coccyx pressure injury. The Resident's care plans did have skin breakdown care plan for existing wounds to his/her bilateral heels dated 11/21/25, with the following interventions: Provide pressure relieving device(s) air mattress. Provide treatment per physician orders. Monitor for improvement or decline in wound condition to identify need to change treatment in accordance to facility protocols Review of the Norton Pressure Ulcer scale, dated 11/20/25, indicated the Resident had a score of 8 and was very high risk for pressure ulcer development. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/12/25 at 8:11 A.M., Resident #111 was able to participate in an interview and said he/she had pain in his/her coccyx area. During an interview on 12/10/25 at 10:49 A.M., Unit Manager #2 said the facility has a wound nurse that works Monday through Friday and completes all skin treatments for all residents in the facility. Unit Manager #2 said the facility also has a wound Nurse Practitioner that rounds weekly, on Tuesdays. Unit Manager #2 said both the wound nurse and Nurse Practitioner were on vacation this week. Unit Manager #2 said the wound nurse noted a new skin impairment on Resident #111's coccyx prior to her leaving for vacation but was unaware if the physician had been notified or if a treatment had been initiated for this new area. Unit Manager #2 said that when the wound nurse is away, the floor nurses are responsible for all wound care. Unit Manager #2 was unable to say why the floor nurses did not monitor and assess this new wound daily or communicate with the medical provider the status of the wound or orders needed for treatment of the wound. Unit Manager #2 said Resident #111 had an order for an air mattress and this mattress should be checked for inflation frequently because the risk of further skin breakdown is high if the mattress is not used correctly. During an interview on 12/11/2025 at 1:17 P.M., Certified Nursing Assistant (CNA) #1 said she has been the primary CNA for Resident #111 since his/her admission to the facility. CNA #1 said that she had not noticed the Resident's are mattress was not inflated and she and all the other staff have the responsibility of making sure the mattress is appropriately inflated. CNA #1 said that approximately a week ago the Resident's bottom has started to deteriorate and she had informed the nursing staff. CNA #1 said she saw the wound while providing care at the start of the week and the skin was open. CNA #1 said that since the wound opened, Resident #111 has complained of pain in his/her bottom and that the nurses have been putting a treatment on the area. During an interview on 12/10/25 at 2:42 P.M., the Director of Nursing (DON) said the facility has a wound nurse that works full time at the facility and a wound Nurse Practitioner that works weekly on Tuesdays. The DON said both the wound nurse and Nurse Practitioner were on vacation this week and it was the responsibility of the floor nurses to cover all wound treatments and skin assessments. The DON said that she expects the wound nurse to communicate any new wound findings to the nurses on the floor, herself and the medical provider. The DON said she was notified by the wound nurse that Resident #111's coccyx was excoriated, however, said she was unaware that prior to her going on vacation, the wound nurse had assessed Resident #111 to have a new stage 2 coccyx pressure injury and had initiated a treatment. The DON said she needed to know this information to ensure daily monitoring of the wound occurred and that the physician was notified for appropriate wound treatment. The DON said she was also unaware that the wound nurse self-initiated a treatment order without consulting the physician and a nurse cannot complete a medical order without the order from the physician. The DON said that she herself had not seen the wound but discussed the wound with Nurse #1 and said the wound had definitely worsened since the wound nurse documented on 12/8/25 and the wound had grown well beyond the treatment area the wound nurse had treated on 12/8/25. The DON said Resident #111 has fragile skin and has care plan interventions in place to prevent skin breakdown and new pressure injuries. The DON said one of these interventions is an air mattress and the nursing staff should be checking the mattress to ensure it is functioning properly at all times. The DON said a deflated air mattress would put Resident #111 at risk for pressure ulcer development. During an interview on 12/15/25 at 10:37 A.M., the Wound Nurse said she was never notified of Resident #111's excoriated skin on his/her coccyx but just happened to be in the room while the staff were providing care to the Resident and she observed it herself. The Wound Nurse said barrier cream was initiated as a treatment that day, and she began to monitor the Resident's coccyx area. The (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound Nurse said that on 12/8/25, the coccyx area was opened, was assessed as a new stage 2 pressure injury, and she notified the Wound Nurse Practitioner by text message that she would have to assess the wound, however, never heard back from the wound Nurse Practitioner. The Wound Nurse said she was unaware the wound Nurse Practitioner was away on vacation that week. The Wound Nurse said that she never notified the physician of the new pressure injury and she self-initiated a treatment. The Wound Nurse said she should not have started a treatment without an order. The Wound Nurse said Resident #111 is on an air mattress because he/she has fragile skin and if the air mattress is not working properly/inflates, the Resident is at risk for skin deterioration and new pressure ulcer development. The Wound Nurse said she feels like a lot of resident skin issues fall through the cracks at the facility. During an interview on 12/12/25 at 10:20 A.M., Nurse Practitioner #1 said she was unaware Resident #111 had developed a new pressure injury to his/her coccyx. Nurse Practitioner #1 said no treatments should be initiated by the nursing staff, as either she or the physician is responsible for writing orders. Nurse Practitioner #1 said the risk of lying on an air mattress without it being inflated is skin deterioration. During an interview on 12/12/25 at 1:01 P.M., Physician #1, who is also the facility Medical Director, said he relies on the nursing staff and wound care nurses to provide the needed care and to notify him is a resident's status changes so he can put appropriate orders and interventions into place. Physician #1 said nursing should not initiate any medical treatments without him being involved as he oversees the medical care. Physician #1 said he was unaware Resident #111 developed a new pressure injury to the coccyx and he did not order the treatment that was provided by the wound nurse on 12/8/25. Physician #1 said that without knowing about the wound or what treatment was started it was unclear if this was an appropriate treatment. Physician #1 said Resident #111 has fragile skin and has an order for an air mattress and there would be a risk of skin deterioration if the mattress was not being used properly. During a telephone interview on 12/17/25 at 1:42 P.M., the Wound Nurse Practitioner said the wound nurse had informed her that Resident #111 had a new area on his/her coccyx, however, since she had not worked in the building since the wound opened, she had not yet assessed the new wound or recommended a treatment for it. The Wound Nurse Practitioner said nursing should never initiate a treatment without the recommendation from her or another medical provider. The Wound Nurse Practitioner said Resident #111 is on an air mattress to protect skin integrity and that if an air mattress is not working properly the risk for skin impairment increases. 1b.) Review of Resident #111's medical record indicated the Resident had a stage 3 wound to his/her left heel. On 12/10/2025 at 10:55 A.M., the surveyor observed the wound dressing changes for Resident #111's left heel wound with Nurse #1. The Resident's left heel had a dressing dated 12/8/25, two days prior. At the time of this observation, Nurse #1 said she is unsure of what the treatment orders are for the left heel. Nurse #1 said she also worked yesterday, and did not complete the ordered wound treatments. Nurse #1 said the facility has a wound nurse and she was told the wound nurse completes all wound treatments. Nurse #1 was unaware the wound nurse did not complete the wound treatment on 12/9/25. Review of Resident #111's July 2025 physician orders indicated an order, initiated on 7/6/25, for the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Apply skin prep twice a day to left outer foot area twice a day at 10am and 6pm, apply booties to both feet. Review of the July 2025 Treatment Administration Record (TAR) indicated the following nursing notes: 7/8/25: Skin prep applied to outer left foot area, area dark in color no drainage noted. Booties applied to bilat (bilateral) feet a/o (as ordered). 7/9/25 left outer foot area hard surface, skin prep applied, booties a/o. 7/16/25: left outer foot area dry, scabbed, skin prep applied, surrounding tissue clear, no redness. 7/17/25: left foot outer area area (sic), no drainage, no opening, hard and darked, skin prep applied a/o. 7/24/25: Left outer foot area appearance is peeling and hard, color after shower appeared yellowish, surrounding tissue is pink. Skin prep and booties applied. 7/30/25: Left outer foot yellow eschar (a dark, leathery, dry layer of dead tissue that forms over deep wounds). 7/31/25: Skin prep 2 left outer foot a/o. Area is worsening, center yellow area is painful to touch. Review of the July 2025 skin checks dated 7/3/25, 7/13/25, 7/21/25, 7/24/25, and 7/31/25 all failed to indicate any skin impairments noted on the TAR. There were also no nursing notes for the entire month of July 2025 with no assessment or measurement of the left foot wound. Review of Resident #111's medical record failed to indicate the physician was notified of the change in skin condition so a treatment modification could be made if indicated. Review of Resident #111's August 2025 physician orders indicated the following: Apply skin prep twice a day to left outer foot area twice a day at 10am and 6om, apply booties to both feet, discontinued on 8/5/25. Weekly skin check document and nurses note and UDA (User Defined Assessment) on day shift. Document in UDA and nurses note, initiated on 8/4/25 and discontinued on 8/14/25. Twice a day at 10 AM and 6:00 PM cleanse area to outer left foot area twice a day 7-3 and 3-11 with vashe (a brand of sterile, saline-based wound cleanser containing hypochlorous acid), pat dry, apply skin prep, then mupirocin (a prescription-only topical antibiotic used to treat bacterial skin infections), cover with border gauze. Apply booties to both feet, discontinued on 8/31/25. Weekly skin check document and nurses note and UDA on day shift. Document in UDA and nurses note, initiated on 8/14/25. Outer left foot wound 2x/day on days and evenings cleanse with vashe, pat dry, apply mupirocin and cover with border gauze. Change BID (twice a day) and PRN (as needed) for soilage/accidental (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	removal. Apply booties to both feet, initiated 8/31/25. Review of the August 2025 TAR indicated the following nurses' notes: 8/3/25: Left outer foot area open, protective dressing applied, booties on as ordered, will be seeing the wound MD, heels offloaded. 8/7/25: Area 2 left outer foot open with slough (a soft, yellowish/whitish, stringy, or patchy dead tissue acting as a barrier to healing by trapping bacteria and preventing healthy tissue growth present) no drainage noted, outer edges soft and white in color. On 8/11/25, 8/13/25, 8/16/25, and 8/30/25, the above wound order was marked as missed on the day shift and the antibiotic ointment of mupirocin was not applied to the Resident's heel for a total of 4 times. Review of the August nursing notes failed to indicate nursing implemented the physician order to document weekly on the Resident's wound. Review of the August weekly skin checks dated 8/7/25, 8/18/25 and 8/25/25, failed to indicate the nursing staff was measuring the wound to monitor for improvement or worsening of the wound. Review of Resident #111's medical record failed to indicate the Resident was referred to the wound physician as requested by nursing on 8/3/25. Review of Resident #111's September physician orders indicated the following: Weekly skin check document and nurses note and UDA on day shift. Document in UDA and nurses note, initiated on 8/14/25. Outer left foot wound 2x/day on days and evenings cleanse with vashe, pat dry, apply mupirocin and cover with border gauze. Change BID (twice a day) and PRN (as needed) for soilage/accidental removal. Apply booties to both feet, initiated 8/31/25. Review of the September 2025 TAR indicated the following: On 9/24/25, 9/25/25, 9/28/25 and 9/30/25, the above treatment to cleanse with vashe, apply mupirocin and cover with border gauze two times a day was not completed during the morning shift. There were no nursing notes to indicate why the treatments were missed. Review of the September nursing notes failed to indicate nursing implemented the physician order to document weekly on the Resident's wound. Review of the September weekly skin checks dated 9/1/25, 9/8/25, 9/15/25, 9/22/25, and 9/29/25, failed to indicate the nursing staff was measuring the wound to monitor for improvement or worsening of the wound. Review of Resident #111's October 2025 physician orders indicated the following: Weekly skin check document and nurses note and UDA on day shift. Document in UDA and nurses (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	note, initiated on 8/14/25. Outer left foot wound 2x/day on days and evenings cleanse with vashe, pat dry, apply mupirocin and cover with border gauze. Change BID (twice a day) and PRN (as needed) for soilage/accidental removal. Apply booties to both feet, initiated 8/31/25. Outer left foot wound every day on day shift cleanse with vashe, apply calcium alginate to wound bed cover with bordered foam. Change BID and PRN for soilage accidental removal. Applied booties to both feet, initiated 10/29/25. Review of the October 2025 TAR indicated the following: On 10/4/25, 10/7/25, 10/11/25, 10/12/25, 10/19/25, 10/23/25, 10/26/25, and 10/28/25 the above treatment to cleanse with vashe, apply mupirocin and cover with border gauze two times a day was not completed. There were no nursing notes to indicate why the treatments were missed. Review of the October nursing notes failed to indicate nursing implemented the physician order to document weekly on the Resident's wound. Review of the October weekly skin checks dated 10/6/25, 10/13/25, 10/20/25, and 10/27/25, failed to indicate the nursing staff was measuring the wound to monitor for improvement or worsening of the wound. Review of the nursing note dated 10/27/25 indicated Open area to the back of the outer left foot. Wound appears with deep red granulation tissue present, surrounded by hard white skin. No signs of infection or odor observed at this time period we'll have area evaluated by wound NP during wound rounds tomorrow for further evaluation and treatment plan. Review of the nursing note dated 10/28/25 indicated Stage 3 open area to the back of the left outer foot. Wound appears with deep red granulation tissue present, surrounded by macerated hard white skin. Wound NP assessed wound today and new order to cleanse area, apply calcium alginate to wound bed and wrap with caused daily/PRN. Review of the wound Nurse Practitioner's note dated 10/28/25, indicated the Wound Nurse Practitioner had started following Resident #111 on this date, over 2 months after the 8/3/25 note from nursing to refer the Resident to the wound doctor. The note indicated Patient was seen for pressure injury. On exam, the left heel has full thickness wound with granulation tissue present, consistent with stage 3 pressure injury. Review of Resident #111's November 2025 physician orders indicated the following: Weekly skin check document and nurses note and UDA on day shift. Document in UDA and nurses note, initiated on 8/14/25. Outer left foot wound every day on day shift cleanse with vashe, apply calcium alginate to wound bed cover with bordered foam. Change BID and PRN for soilage accidental removal. Applied booties to both feet, initiated 10/29/25 and discontinued 11/12/25. L (left) heel stage 3 wound, every day on day shift, cleanse area on L heel wit vashe, apply iodsorb (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(wound treatment), apply ABD pad (sterile dressing) and wrap with gauze daily, PRN for soiling, saturation and accidental removal, initiated on 11/12/25. R (right) heel every day on day shift cleanse right heel with normal saline, pat dry, apply skin prep to deep tissue injury, initiated 11/13/25. Review of the wound Nurse Practitioner note dated 11/11/25, indicated the wound Nurse Practitioner recommended obtaining an x-ray of the left heel to evaluate for possible underlying bony involvement or osteomyelitis. Review of the nursing note dated 11/13/25 indicated Resident started on Doxy (Doxycycline - an oral antibiotic) twice daily indefinitely until the results of the MRI are in. Review of Resident #111's medical record indicated that the x-ray obtained on 11/12/25 with the conclusion Findings suspicious for calcaneal osteomyelitis, recommend MRI. The Resident was sent for an MRI on 11/28/25 and the MRI was terminated early secondary to the Resident's inability to handle the test. Review of the physician note dated 11/25/25 indicated (Resident #111) will require initiation of IV (intravenous) antibiotic management. During an interview on 12/15/25 at 10:37 A.M., the Wound Nurse said she became involved in Resident #111's care when his/her heel wound became a stage 3. The Wound Nurse said she believed the wound had been worsening for some time, and the treatment of mupirocin had probably been used for too long of a period, making it ineffective. The Wound Nurse said that communication regarding skin impairments and wound status is poor in the building and she was hired specifically to fix this problem. The Wound Nurse said she was unaware of the nursing note to refer the Resident to the wound physician and said if she had, she would have done that much sooner than 10/28/25. During interviews on 12/10/25 at 2:42 P.M., and 12/11/25 at 9:02 A.M., the Director of Nursing (DON) DON said all residents should have skin checks completed weekly and all skin impairments should be documented on the skin check. The DON said nurses should also be documenting the status of wounds in the daily or weekly nursing notes. The DON said that the skin documentation should include shape, condition and measurements of the wound for the nursing staff and physician to be able to determine if the wound is improving, worsening or if a change of treatment plan is needed. The DON said the facility also has a full-time wound nurse and a consulting wound nurse practitioner once a week on Tuesdays. The DON said both of these staff members were not available this week and on vacation and in their absence, the nurses on the floor should take over all wound treatments and care. The surveyor reviewed the missing wound treatments from the days of survey as well as the previous months and the DON said there is never a reason to miss a treatment as that could result in a worsening wound. During a follow-up interview on 12/16/25 at 10:05 A.M., the DON discussed the origin of Resident #111's left heel wound and its progression. The DON said she was unaware of the wound being present in July and worsening in July, as she only can see orders for treatment beyond skin prep in August. The DON said the July skin checks were inaccurate as the wound was not documented and she would have expected the nurses to document and be specific in their documentation. The DON said that if a scab or slough was present, both wound indicate the worsening of a wound and the need for a change in treatment. The DON said she was also unaware of the note from nursing to refer the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident to the wound doctor on 8/3/25 and it was a significant delay in treatment to not have the Resident seen until October 28, 2025. The DON said that if the wound Nurse Practitioner had started treating Resident #111 earlier, the wound could have possibly not progressed to this point. During a third follow-up interview on 12/17/25 at 10:37 A.M., the DON said any resident with a wound is discussed in the at-risk meeting to ensure an interdisciplinary approach and that the treatments in place are effective The DON provided the surveyor with all at-risk meeting notes taken on Resident #111. Review of the notes indicated the at-risk interdisciplinary team did not start following the Resident for his/her left heel wound until 10/29/25, when it had become a stage 3 wound. When asked why the team did not follow the Resident until this date, the DON said it was probably because that was when she was first made aware of Resident #111's heel wound. During an interview on 12/16/2025 at 12:10 P.M. Nurse Practitioner #1 said she was not aware of the 8/3/25 nursing note to refer Resident #111 to the wound physician. Nurse Practitioner #1 said not being seen until 10/28/25 was a delay in care and that could possibly cause worsening of the wound. During an interview on 12/17/25 at 1:22 P.M., the Physician, who is also the Medical Director of the facility, said that if he was aware of the worsening wound on Resident #111's left heel he would have documented that in his notes. When the surveyor said she could not see anything in his July notes regarding the wound, the Physician said that he must not have been made aware of the worsening wound until later, possibly August. The Physician said he was not aware of the note from nursing to refer the Resident to the wound physician at the beginning of August. During a telephone interview on 12/17/25 at 1:42 P.M., the Wound Nurse Practitioner said she began working in the facility in March 2025 and is notified of any resident's new skin impairment or worsening of wound and becomes involved in their treatment. The Wound Nurse Practitioner said she does not have access to the facility's electronic health record and said this would be helpful so she could be fully informed of a resident's status. The Wound Nurse Practitioner said she was never notified of the nursing note for a wound consultation written on 8/3/25 and only began working with Resident #111 at the end of October. The Wound Nurse Practitioner said she can't comment on the worsening of Resident #111's heel and can only say that at the end of October when she first assessed the right heel she had concerns of possible infection due to the longevity of the wound, the look of the wound and the Resident's pain level when wound care was provided. 2.) Resident #32 was admitted to the facility in September 2018 with diagnoses including dementia and malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/26/25, indicated Resident #32 had severe cognitive impairment as e

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to keep two Residents (#12 and #82) free from accidents out of a total sample of 30 residents. Specifically, the facility failed to:1) Ensure Resident #12 was supervised during waking hours resulting in a fall with major injury.2) Ensure a fall intervention for alarm when in bed was implemented for Resident #82 after he/she had recently sustained a fall. Findings include:Review of the facility policy titled, Quality Assurance & Performance Improvement Falls Policy and Procedure, dated as revised 9/2025, indicated the following: The interdisciplinary team shall review potential contributing/causative factors associated with the fall and implement individualized interventions accordingly. 1. Resident #12 was admitted to the facility in January 2024 with diagnoses including dementia. Review of Resident #12's most recent Minimum Data Set (MDS) assessment, dated 11/21/25, indicated the Resident scored a 4 out of a possible 15 on the Brief Interview for Mental Status exam which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #12 was dependent on staff for all mobility tasks. On 12/9/25 at 7:59 A.M., Resident #12 was observed lying in bed. His/her bed was in the lowest position and there was a mattress on either side of the bed. The Resident was unable to participate in an interview about his/her fall history. Review of an incident report dated 10/16/25, indicated the following: Alarm sounded, resident (a different resident of the facility) witnessed (Resident #12) falling onto the floor. The incident report included two staff interviews that indicated neither were in the dining room at the time of the fall to witness the fall occurring. Review of the nursing progress notes failed to indicate a note was written on 10/16/25 with details regarding Resident #12's fall. A nursing note dated 10/18/25 indicated, pt (patient) x-ray showed an acute appearing left sub capital femoral (thigh bone) fracture, NP (nurse practitioner) on call recommended pt be sent to the ER (emergency room), (he/she) was sent out at 0615am, family notified. Review of the acute hospital Discharge summary dated [DATE], indicated Resident #12 was admitted to the hospital status post fall and was diagnosed with a left femoral neck fracture. Review of Resident #12's fall prevention care plan indicated the following intervention that was current at the time of the Resident's fall on 10/16/25: Bring to nurse's station while awake s/p (status post) fall on 1/15/24. Review of Resident #12's medical record failed to indicate a falls assessment was completed or the falls care plan was reviewed and updated after the Resident's fall on 10/16/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/10/25 at 1:33 P.M., the Director of Nursing (DON) said she was not working at the time of the fall as she was out on leave. The Director of Nursing said although the intervention to be supervised at the nurse's station may have been old, it was still an active fall intervention, and she expects all interventions to be followed as written. The DON said she also would have expected a falls assessment to be completed as well as a review of the Resident's care plans and a new intervention added if appropriate. The DON said the medical record indicates these two things did not happen after Resident #12's fall on 10/16/25. During an interview on 12/15/25 at 9:02 A.M., Certified Nursing Assistant (CNA) #1 said all staff should be aware of the residents' care plan interventions by either going on the computer and reviewing or the staff reporting the interventions verbally. CNA #1 said she is very familiar with Resident #12 and often provides care to him/her. CNA #1 said Resident #12 would often attempt to stand on his/her own and become agitated, requiring supervision from staff to ensure safety. CNA #1 said Resident #12 often sits in his/her wheelchair in the dining room when out of bed and should always have supervision while in the dining room. CNA #1 said she was unaware the Resident had a care plan intervention to be by the nurse's station when awake. During a follow-up interview on 12/15/25 at 1:17 P.M., the DON said all nursing staff should be aware of each resident's care plan interventions and if not, look them up in the medical record. The surveyor reviewed the schedule for October 16, 2025 and interviewed all staff who was working on that unit at the time of Resident #12's fall. During an interview on 12/15/25 at 9:15 A.M., Unit Manager #2 said she is Resident #12's primary nurse and she was working the day the Resident fell. Unit Manager #2 said she was unaware the Resident had a care plan intervention to be at the nurse's station while awake and said the nurses would typically be passing out medication in different rooms so that would not be an effective intervention anyways. Unit manager #2 said she was not in the dining room when Resident #12 fell and is unaware if any staff were supervising the Resident. During an interview on 12/15/25 at 1:04 P.M., Nurse #17 said she was working the day Resident #12 fell and she was not in the dining room supervising the Resident and did not witness the fall. Nurse #17 was unaware of the care plan intervention to have Resident #12 supervised at the nursing station while awake and could not remember if any staff were supervising the Resident at the time of the fall. Nurse #17 said Resident #12 does become agitated and attempt to stand on his/her own and it would be important for him/her to have supervision. Nurse #17 said there is always supposed to be a staff member in the dining room to provide supervision as needed. Nurse #17 said she was the nurse who completed the fall incident report and did not have any staff who witnessed the fall to get witness statements from. During an interview on 12/16/2025 11:43 A.M., CNA #15 said she worked the day Resident #12 fell and was not in the dining room to witness the fall. CNA #15 said she is unaware if any staff were in the room providing supervision. During an interview on 12/16/2025 3:01 P.M., CNA #18 said he worked the day Resident #12 fell and was not in the dining room to witness the fall. CNA #15 said he is unaware if any staff were in the room providing supervision. During an interview on 12/17/2025 7:02 A.M., CNA #5 said she worked the day Resident #12 fell and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was not in the dining room to witness the fall. CNA #5 said she is unaware if any staff were in the room providing supervision. During an interview on 12/17/2025 7:18 A.M., CNA #3 said she worked the day Resident #12 fell and was not in the dining room to witness the fall. CNA #3 said she is unaware if any staff were in the room providing supervision. During an interview on 12/16/25 at 11:43 A.M., CNA #15 said she worked the day Resident #12 fell and was not in the dining room to witness the fall. CNA #15 said she is unaware if any staff were in the room providing supervision. During an interview on 12/17/25 at 9:28 A.M., the 2 East Activity Director said the activity staff are typically on the floor until 5:00 P.M. The Activity Director said she does not remember Resident #12 falling, however if any activity staff were in the room and witnessed a fall, they would have written a witness statement. The Activity Director said since no activity staff wrote a witness statement, no staff were in the room providing supervision and witnessed the Resident falling. 2.) Resident #82 was admitted to the facility in October 2024 with diagnoses including Parkinson's disease and orthostatic hypotension (a drop in blood pressure which causes dizziness upon standing). Review of the most recent Minimum Data Set (MDS) assessment, dated 9/26/25, indicated Resident #82 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 12 out of 15. This MDS also indicated Resident #82 required supervision or touching assistance to walk 150 feet. Review of Resident #82's nursing progress notes indicated: -12/1/25: Resident frequently had to be reminded to use walker at all times. -12/2/25: Resident had an unwitnessed fall. Review of Resident #82's plan of care related to falls, revised 12/2/25, indicated a new intervention for the following: -Tab alarm when in bed, initiated 12/2/25. On 12/9/25 at 8:56 A.M., the surveyor observed Resident #82 walking out of the bathroom wearing sneakers which were only halfway on. The backs of the sneakers were folded over and crooked, leaving the Resident's heels not inside the sneaker. Resident #82 was walking in an unsteady, shuffled gait using his/her walker incorrectly by pushing the side of the walker. Resident #82 said he/she did not need any help with going to the bathroom. Resident #82 continued to walk back to his/her bed with shoes on incorrectly in an unsteady gait and got into bed. The surveyor observed no alarm on his/her bed and heard no alarms during this observation. On 12/9/25 at 2:03 P.M., the surveyor observed Resident #82 get out of bed and put on his/her jacket. No alarm sounded when Resident #82 self-transferred out of bed and the surveyor observed no alarms on his/her bed. On 12/10/25 at 6:56 A.M., the surveyor observed Resident #82 in bed without any alarms on his/her (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bed. On 12/10/25 at 8:32 A.M., the surveyor observed Resident #82 in bed without any alarms on his/her bed. Resident #82 said he/she had fallen recently. Resident #82 said he/she doesn't have any alarms on the bed. The Resident's roommate said Resident #82 often gets out of bed in the middle of the night and is afraid he/she's going to fall again. The Resident's roommate said Resident #82 used to have alarms but hasn't heard them in a while. During an interview on 12/11/25 at 6:54 A.M., Certified Nurse Assistant (CNA) #12 and CNA #13 said they work the night shift and care for Resident #82. CNA #12 and CNA #13 said Resident #82 does not have any alarms on his/her bed. CNA #13 said Resident #82 fell within the last month. CNA #12 and CNA #13 said they do not have access to the care plan or any type of form that would provide resident care instructions, but gets that type of information, such as if alarms are required, through nurse report. CNA #12 and CNA #13 said they were unaware Resident #82 required alarms when in bed. During a follow-up observation on 12/11/25 at 7:03 A.M., the surveyor observed Resident #82 in bed without any alarms on his/her bed. During an interview on 12/11/25 at 7:04 A.M, CNA #14 said Resident #82 is compliant with care and doesn't think he/she would refuse alarms. CNA #14 said Resident #82 does not have any alarms on his/her bed because he/she is constantly walking. During an interview on 12/11/25 at 7:08 A.M., Nurse #10 said CNAs do not have access to the care plan or any type of form that would provide resident care instructions, but the nurses are expected to communicate fall interventions, such as alarms, to them. Nurse #10 said care plan interventions should be implemented, but they often only check the care plan once a week because it's very busy. Nurse #10 said he was unaware Resident #82 had an intervention for a tab alarm when in bed. During an interview on 12/11/25 at 2:07 P.M., the Director of Nursing (DON) said Resident #82 should have been on alarms when in bed, because it was an intervention on his care plan, but was not.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility 1) failed to provide a dignified existence for one Resident (#89) out of a total sample of 30 residents and 2a.) failed to provide a dignified dining experience for one Resident (#38) out of a total sample of 30 residents and 2b.) on two of three units. Specifically:1. For Resident #89 the facility failed to ensure privacy during incontinent care.2a. For Resident #38 the staff removed his/her utensils and guided him/her to eat syrup covered pancakes with his/her hands.2b. In the unit dining rooms residents waited for long periods to be served after their table mates were served, staff stood while feeding and staff referred to residents as feeders, rather than by their name. Findings include: Review of the facility policy titled, Resident [NAME] of Rights, dated as revised 6/2017, indicated the following: -The resident is treated with consideration, respect and full recognition of his dignity and individuality, including privacy and treatment and care of his personal needs. 1. Resident #89 was admitted to the facility in February 2024 with diagnoses including stroke. Review of Resident #89's most recent Minimum Data Set (MDS) assessment, dated 9/19/25, indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status exam which indicates he/she had severe cognitive impairment. The MDS also indicated Resident #89 was dependent on staff for all self-care and mobility tasks. On 12/9/25 at 12:19 P.M., Resident #89 was taken to the bathroom for incontinence care. The Resident was sitting on a commode in the bathroom with both doors to the bathroom and bedroom open. As Resident #89 was sitting on the commode without pants on, the Resident's roommate was taken into the bedroom to use the bathroom and was placed in front of the open bathroom door and Resident #89 was visible to the roommate. The Certified Nursing Assistant (CNA) continued to provide incontinence care to Resident #89 while he/she was visible to his/her roommate. During an interview on 12/15/25 at 9:02 A.M., CNA #1 said all residents should be given privacy when care was being provided and Resident #89's roommate should not have been able to visualize the Resident during care. CNA #1 said the door should have been closed. During an interview on 12/15/25 at 10:03 A.M., the Director of Nursing said the staff should always respect each resident's privacy in order to maintain their dignity. The Director of Nursing said Resident #89's roommate should have been kept out of the room while waiting for the bathroom. 2a. Resident #38 was admitted to the facility in February 2022 and has diagnoses that include dementia and unspecified protein-calorie malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/21/25, indicated that Resident #38 was unable to participate in the Brief Interview for Mental Status exam and was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #38 had no behavior of rejecting care. On 12/09/25 at 8:30 A.M., Resident #38 was observed seated at a table in the unit day room watching (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his/her table mate eat breakfast for 12 minutes. The surveyor continued to make the following observations: At 8:30 A.M., a staff person delivered breakfast of pancakes and syrup to Resident #38. Between 8:40 A.M., and 8:43 A.M., Resident #38 was sucking on an empty milk container. There were no staff present providing redirection or assist. At 8:55 A.M., Resident #38 picked up a fork and made his/her first attempt to self-feed since being served 37 minutes earlier. Certified Nursing Assistant (CNA) #5 observed Resident #38 struggling to use the fork and walked over to him/her, removed the fork from Resident #38's hand, placed Resident #38's hand directly in the pancakes with syrup and said it is here, eat this. Resident #38 then used his/her hand to place pancakes in his/her mouth, CNA #5 replied good and then walked away to feed another resident. As soon as the CNA walked away Resident #38 took his/her hands out of the syrup covered pancakes and stopped eating. On 12/10/25 at 8:56 A.M., during breakfast a CNA offered Resident #38 a glass of water however Resident #38's hand was shaking, and he/she was struggling to manage the glass. The CNA pushed Resident #38's tray of food further away from him/her and walked away. The surveyor continued to make the following observations: At 9:06 A.M., Resident #38 had finished drinking the water and was sucking on the empty glass. At 9:08 A.M., a CNA seated at the table observed this, went and retrieved a cup of milk for Resident #38 to drink. When the CNA returned to the table, he took a fork that was in Resident #38's pancakes and used it to stir the milk before handing it to Resident #38. At 9:12 A.M., a CNA gave Resident #38 a glass of juice. At 9:19 A.M., another CNA took the juice away from the Resident, saying he/she couldn't have the juice because he/she would spill it. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing said that if Resident #38 was attempting to eat with a fork staff should not have placed his/her hands in pancakes or encouraged Resident #38 to eat with his/her hands. During an interview on 12/15/25 at 8:48 A.M., CNA #1 said that Resident #38 was able to feed him/herself but needed ongoing cueing through the meals. CNA #1 said that Resident #38 does best with finger foods and should not be encouraged to eat pancakes with syrup on them because he/she does not like the sticky feeling of syrup on his/her hands. 2b. Staff failed to provide a dignified dining experience on two of three resident units. During an observation of breakfast on the Dementia Special Care Unit (DSCU) on 12/9/25 the following was observed: A nurse was overheard asking which residents were feeders. A Certified Nursing Assistant (CNA) was observed standing while assisting a resident with her breakfast while she was lying in bed. The bed was not raised to eye level. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Three residents were seated at Table 1: At 8:18 A.M., the first resident was served breakfast. At 8:29 A.M., the third resident was served breakfast, 11 minutes after his/her table mate was served breakfast. Two residents were seated at Table 2: At 8:21 A.M., the first resident was served breakfast. At 8:32 A.M., the second resident at the table was served breakfast, 11 min after his/her table mate was served breakfast. During an observation of breakfast on the Dementia Special Care Unit (DSCU) on 12/10/25 the following was observed: Two residents were seated at Table 1: At 8:09 A.M., the first resident was served breakfast. At 8:25 A.M., the second resident at the table was served breakfast, 16 min after his/her table mate was served breakfast. Five residents were seated at Table 2: At 8:10 A.M., the first resident was served breakfast while the four other residents waited. At 8:51 A.M., the last resident at the table was served, 41 minutes after the first resident at the table was served breakfast. Four residents were seated at Table 3: At 8:15 AM the first resident was served breakfast while the four other residents at the table waited. At 8:36 A.M., the final resident at the table was served, 21 minutes after the first resident at the table was served breakfast. During an observation of Lunch on the DSCU on 12/10/25 the following was observed: Three residents were seated at Table 1: At 12:17 P.M., the first resident was served lunch. At 12:33 P.M., 16 minutes later the second resident was served lunch. A 12:35 P.M., the daughter of the third resident seated at the table stated to the tablemates my father/mother is last again. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:37 P.M., the daughter got up and retrieved her father's/mother's tray for him/her, 20 minutes after the first resident at the table was served. Five residents were seated at Table 2: At 12:16 P.M., the first resident was served lunch while the four other residents waited. At 12:41 A.M., the last resident at the table was served, 25 minutes after the first resident at the table was served lunch. Five residents were seated at Table #3: At 12:22 P.M., the first resident was served lunch while the four other residents waited. At 12:34 P.M., the last resident at the table was served, 12 minutes after the first resident at the table was served lunch. During an observation of breakfast on the DSCU on 12/11/25 the following was observed: Five residents seated at Table 2: At 8:14 A.M., the first resident at the table was served breakfast while the other four residents waited. At 8:42 A.M., the last resident at the table was served, 28 minutes after the first resident at the table was served breakfast. Three residents were seated at Table 3. At 8:14 A.M., the first resident at the table was served breakfast while the other two residents waited. At 8:28 A.M., a CNA placed a covered tray at the table for the 3rd resident at the table and walked away. At 8:32 A.M., the CNA returned to the table to feed the 3rd resident, 18 minutes after the first resident at the table was served. On 12/11/25 at 8:06 A.M., on the Two [NAME] unit a nurse yelled from one end of a resident hall to staff at the other end is that for her or is she a feeder . is there any feeders. The nurse then turned to the surveyor and said, the last are feeders. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing said that her expectation that everyone at the table should be served at the same time and not wait for long periods of time watching the other residents at their table eat. The Director of Nursing said residents should not be referred to by labels such as feeders.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observations, interviews and record review, the facility failed to notify the physician of a significant change in the resident's skin condition and/or obtain wound treatment orders for four Residents (#111, #89, #32 and #3) out of a total sample of 30 residents. Specifically:1.) For Resident #111, the facility failed to notify both the physician and the Resident's healthcare proxy of the development of a new: a) stage 2 coccyx wound. b) stage 3 heel wound.2.) For Resident #89, the facility failed to notify the physician of a significant weight loss. 3.) For Resident #32, the facility failed to ensure nursing notified the physician that a topical medication (flagyl) was not being administered due to unavailability and instead discontinued the order without any physician order to do so.4.) For Resident #3, the facility failed to ensure nursing notified the physician of the development of a new pressure wound. Findings include:Review of the facility policy titled, Resident Change in Condition Policy, revised February 2024, indicated the following: Prior to contacting the physician, the nurse will conduct clinical assessment and collect pertinent information to report to the physician, for example, history of present illness and recent and previous test results for comparison. The resident's physician, legal representative and/or responsible party is to be notified. Nursing administration is to be notified of all resident changes in condition. A change in condition will be documented in the nurses' notes, shift report book, and other areas of the medical record as required. 1. Resident #111 was admitted to the facility in March 2023, with diagnoses of dementia and chronic kidney disease. Review of Resident #111's most recent Minimum Data Set (MDS) assessment, dated 10/10/25, indicated the Resident had a score of 0 out of a possible 15 on the Brief Interview for Mental Status exam, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #111 is dependent on staff for all functional daily tasks including bed mobility. 1a.) Review of Resident #111's nursing notes indicated the following: A wound nurse note dated 12/3/25 that indicated Notified by staff patient found with excoriated, red and inflamed area to buttock. Area gently cleansed, then patted dry. Barrier cream applied to affected area to protect skin from further moisture and skin breakdown.Will continue to monitor skin integrity. A wound nurse note dated 12/4/25 that indicated, Patient appears to be declining, with reports of increased pain and worsening excoriation in the coccyx area. A wound nurse note dated 12/8/25 that indicated, Patient appears to be declining, with reports of increased pain and worsening excoriation in the coccyx area. The patient presents with a stage 2 pressure injury to coccyx. The wound is being managed with wound cleanser and sacrum dressing. Pressure offloading is maintained, patient on air mattress, and frequent repositioning. Area is monitored closely for signs of infection. Wound care follow up with wound NP (Nurse Practitioner) assessment and treatment adjustments. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #111's physician notes and orders failed to indicate the physician or wound Nurse Practitioner were notified of the new pressure injury and treatment initiated by the wound nurse on 12/8/25. On 12/10/25 at 10:43 A.M., Nurse #1 and the surveyor observed Resident #111's coccyx area. The coccyx had a large grapefruit sized area with eschar (a dark, leathery, dry layer of dead tissue that forms over deep wounds) with an undated dressing that was only approximately one fourth the size of the area and was saturated with bloody drainage. Further review of the nursing note dated 12/12/25, indicated late entry. Wound on resident's mid buttocks width 11 cm (centimeter) at its longest, length is at 7 cm at its longest. The wound is shaped like a butterfly. During an interview on 12/10/25 at 10:49 A.M., Unit Manager #2 said the facility has a wound nurse that works Monday through Friday and completes all skin treatments for all residents in the facility as well as a wound Nurse Practitioner that rounds weekly, on Tuesdays. Unit Manager #2 said the wound nurse was on vacation this week starting on 12/9/25 and the Wound Nurse Practitioner was also on vacation this week. Unit Manager #2 said the wound nurse noted a new skin impairment on Resident #111's coccyx on 12/8/25 but was unaware if the physician had been notified or if a treatment had been initiated for this new area. Unit Manager #2 was unable to say why the floor nurses did not communicate with the medical provider the status of the wound or orders needed for treatment of the wound. During an interview on 12/10/25 at 2:42 P.M., the Director of Nursing (DON) said that she expects the wound nurse to communicate any new wound findings to the nurses on the floor, herself and the medical provider. The DON said she was notified by the wound nurse that Resident #111's coccyx was excoriated, however, said she was unaware that on 12/8/25 the wound nurse had assessed Resident #111 to have a new stage 2 coccyx pressure injury and had initiated a treatment for new wound. The DON said that she herself had not seen the wound but discussed the wound with Nurse #1 and said the wound had worsened since the wound nurse documented on 12/8/25 and the wound had grown well beyond the treatment area the wound nurse had treated on 12/8/25. The DON said it is important to notify the physician immediately so the appropriate wound treatment can be started. The DON said not notifying the physician can lead to a delay in treatment that ultimately leads to a worsening wound. During an interview on 12/15/25 at 10:37 A.M., the Wound Nurse said that on 12/8/25, the coccyx area was opened, was assessed as a new stage 2 pressure injury, and she notified the Wound Nurse Practitioner by text message that she would have to assess the wound, however, never heard back from the wound Nurse Practitioner. The Wound Nurse said she was unaware the wound Nurse Practitioner was away on vacation that week. The Wound Nurse showed the text message without a response to the surveyor during this interview. The Wound Nurse said that she never notified the physician of the new pressure injury and she self-initiated a treatment without first speaking to a member of the medical team. During an interview on 12/12/25 at 10:20 A.M., Nurse Practitioner #1 said she was unaware Resident #111 had developed a new pressure injury to his/her coccyx until 12/10/25. Nurse Practitioner #1 said she or the physician should be notified immediately of the change in status of a residents, such as a new wound. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/25 at 1:01 P.M., Physician #1, who is also the facility Medical Director, said he relies on the nursing staff and wound care nurse to provide the needed care and to notify him is a resident's status changes so he can put appropriate orders and interventions into place. Physician #1 said he was unaware Resident #111 developed a new pressure injury to the coccyx until the facility informed him on 12/10/25. Physician #1 said he would want to be notified of a change in condition immediately so the appropriate treatment can be put into place and a delay in treatment did not occur. During an interview on 12/16/25 at 10:02 A.M., Resident #111's son said he only found out last night (12/16/25) that the Resident had a new wound on his/her coccyx. Resident #111's son said he is the Resident's healthcare proxy, and as the proxy feels it is important to be kept up to date with the clinical concerns of his parent. Resident #111's son said he feels the communication between he and the facility is poor. 1b.) Review of Resident #111's medical record indicated the Resident has a stage 3 wound to his/her left heel. Review of the July 2025 Treatment Administration Record (TAR) indicated the following nursing notes: 7/8/25: Skin prep applied to outer left foot area, area dark in color no drainage noted. Booties applied to bilat (bilateral) feet a/o (as ordered). 7/9/25 left outer foot area hard surface, skin prep applied, booties a/o. 7/16/25: left outer foot area dry, scabbed, skin prep applied, surrounding tissue clear, no redness. 7/17/25: left foot outer area area (sic), no drainage, no opening, hard and darked, skin prep applied a/o. 7/24/25: Left outer foot area appearance is peeling and hard, color after shower appeared yellowish, surrounding tissue is pink. Skin prep and booties applied. 7/30/25: Left outer foot yellow eschar (a dark, leathery, dry layer of dead tissue that forms over deep wounds). 7/31/25: Skin prep 2 left outer foot a/o. Area is worsening, center yellow area is painful to touch. Review of Resident #111's medical record failed to indicate the physician was notified of the change in skin condition to the Resident's left heel throughout the month of July. Review of the August 2025 TAR indicated the following nurses' notes: 8/3/25: Left outer foot area open, protective dressing applied, booties on as ordered, will be seeing the wound MD, heels offloaded. Review of the August nursing notes failed to indicate the nursing staff notified the physician of the need to be seen by the wound doctor and the Resident was not seen by the consulting wound nurse practitioner. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the wound Nurse Practitioner's note dated 10/28/25, indicated the Wound Nurse Practitioner had started following Resident #111 on this date, over 2 months after the 8/3/25 note from nursing to refer the Resident to the wound doctor. The note indicated Patient was seen for pressure injury. On exam, the left heel has full thickness wound with granulation tissue present, consistent with stage 3 pressure injury. During an interview on 12/16/25 at 10:05 A.M., the Director of Nursing (DON) discussed the origin of Resident #111's left heel wound and its progression. The DON said she expects to be notified of all resident changes in status, especially wounds. The DON said she was never notified of the left heel opening and worsening in July. The DON said she was also not notified of the note from nursing to refer the Resident to the wound doctor on 8/3/25 and it was a significant delay in treatment to not have the Resident seen until October 28, 2005. The DON said that if the wound Nurse Practitioner had started treating Resident #111 earlier, the wound could have possibly not progressed to this point. During a follow-up interview on 12/17/25 at 10:37 A.M., the DON said any resident with a wound is discussed in the at-risk meeting to ensure an interdisciplinary approach and that the treatments in place are effective The DON provided the surveyor with all at-risk meeting notes taken on Resident #111. Review of the notes indicated the at-risk interdisciplinary team did not start following the Resident for his/her left heel wound until 10/29/25, when it had become a stage 3 wound. When asked why the team did not follow the Resident until this date, the DON said it was probably because that was when she was first made aware of Resident #111's heel wound. During an interview on 12/16/2025 at 12:10 P.M. Nurse Practitioner #1 said she was not aware of the 8/3/25 nursing note to refer Resident #111 to the wound physician. Nurse Practitioner #1 said not being seen until 10/28/25 was a delay in care and that could possibly cause worsening of the wound. During an interview on 12/17/25 at 1:22 P.M., the Physician, who is also the Medical Director of the facility, said that if he was notified of the worsening wound on Resident #111's left heel he would have documented that in his notes. When the surveyor said she could not see anything in his July notes regarding the wound, the Physician said that he must not have been made aware of the worsening wound until later, possibly August. The Physician said he was not notified of the note from nursing to refer the Resident to the wound physician at the beginning of August. During a telephone interview on 12/17/25 at 1:42 P.M., the Wound Nurse Practitioner said she began working in the facility in March 2025 and is notified of any resident's new skin impairment or worsening of wound and becomes involved in their treatment. The Wound Nurse Practitioner said she does not have access to the facility's electronic health record and said this would be helpful so she could be fully informed of a resident's status. The Wound Nurse Practitioner said she was never notified of the nursing note for a wound consultation written on 8/3/25 and only began working with Resident #111 at the end of October when the wound nurse suggested she evaluate Resident #111. During an interview on 12/16/25 at 10:02 A.M., Resident #111's son said that about a month ago he noticed his parent had a decline and was constantly in bed. The Resident's son said he had also noticed the Resident had begun to wear blue booties on his/her feet and he was never told why. He said he had asked the nursing staff and they told him the Resident had poor circulation and failed to notify him that his parent had wound on his/her left heel. Resident #111's son said the staff have poor communication skills and fail to keep him notified of changes with the Resident's status. 2. Resident #89 was admitted to the facility in February 2024 with diagnoses including stroke. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #89's most recent Minimum Data Set (MDS) assessment, dated 9/19/25, indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status exam which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #89 was dependent on staff for self-feeding and toileting and section H of the MDS indicated the Resident was frequently incontinent of both bladder and urine. Review of Resident #89's weight report indicated the Resident was identified as having a significant weight loss as of 12/12/25. Review of Resident #89's nutritional care plan, last revised 1/6/25, indicated the following interventions: -Notify physician of significant weight change. Review of Resident #89's paper and electronic medical record failed to indicate the physician was notified of the Resident's significant weight loss. The Registered Dietitian wrote recommendations on 12/12/25, however on 12/17/25, the Registered Dietitian's recommendations were still flagged (raised to alert the nursing staff) in the chart and had not yet been communicated to the physician. During an interview on 12/16/25 at 7:42 A.M., the Director of Nursing (DON) said the physician needs to be notified of all significant changes in weight so an intervention should be initiated immediately. During an interview on 12/15/25 at 1:42 P.M., the Registered Dietitian (RD) said she monitors for all significant weight changes in the building and if a significant weight loss is confirmed she immediately makes recommendations for weight loss interventions. The RD said when a significant weight loss occurs, the physician needs to be notified so that he can review her recommendations, and they can be made into an order if he is in agreement. The RD said Resident #89 did have a significant weight loss identified by the RD on 12/12/25. The RD said she had made recommendations for nutritional interventions at this time, however, did not say she notified the physician. During a follow-up interview on 12/16/25 at approximately 1:00 PM., the DON said the physician was never informed by the nursing staff or RD of Resident #89's significant weight loss and because of this, the interventions recommended by the RD on 12/12/25 had not yet been implemented. During an interview on 12/16/25 at 12:10 P.M., Nurse Practitioner #1 said she was never notified of Resident #89's significant weight loss. During an interview on 12/17/25 at 1:22 P.M., Resident #89's physician said he was never notified about Resident #89's significant weight loss or the interventions recommended by the RD. The Physician said he would expect to be notified of a significant weight change immediately so that interventions can be put into place as soon as possible. 3.) Resident #32 was admitted to the facility in September 2018 with diagnoses including dementia and malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/26/25, indicated Resident #32 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. This MDS also indicated Resident #32 had an unstageable pressure ulcer. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/15/25 at 9:33 A.M., the surveyor observed the Wound Nurse complete the wound dressing change for Resident #32's coccyx pressure ulcer. After the Wound Nurse gathered dressing supplies, the surveyor observed her approach Unit Manager #2 requesting the flagyl that was indicated to be used in the active physician's order. Unit Manager #2 told the Wound Nurse the flagyl had been discontinued the day prior, but she forgot to put the new order into the electronic medical record. The surveyor then observed the Wound Nurse complete Resident #32's wound dressing change without flagyl. During a follow-up interview on 12/15/25 at 10:07 A.M., Unit Manager #2 said the Weekend Supervisor told her to discontinue the order yesterday, but she forgot to put it in the electronic medical record. Unit Manager #2 said she did not implement flagyl in Resident #32's coccyx wound the day before (12/14/25). Unit Manager #2 said she never personally notified the physician prior to changing the order but assumed the Weekend Supervisor had since a physician is required to order any treatment changes. During an interview on 12/15/25 at 10:43 A.M., the Weekend Supervisor said he asked Unit Manager #2 to follow-up regarding Resident #32's flagyl order because it was input incorrectly in the electronic record, resulting in it not being sent by the pharmacy. The Weekend Supervisor said he was told by the nurses that there was no flagyl available for Resident #32's wound treatment and that the Resident was not receiving the flagyl as ordered by the physician. The Weekend Supervisor said he never personally contacted the pharmacy or a physician to clarify the order or notify them that they flagyl was unavailable, but Unit Manager #2 was supposed to. Review of Resident #32's physician's orders indicated: Cleanse wound to coccyx with vashe, cleanse soak with vashe for 10 minutes apply hydrofera blue to the wound secure with SAD (super absorbent dressing), change daily, initiated 12/15/25. Cleanse wound to coccyx with vashe cleanse soak with vashe for 10 minutes applying crushed flagyl, hydrofera blue to the wound secure with SAD, initiated 12/2/25 and discontinued 12/15/25. Review of Resident #32's treatment administration record, dated 12/9/25 to 12/14/25, indicated the treatment to Cleanse wound to coccyx with vashe, cleanse soak with vashe for 10 minutes applying crushed flagyl, hydrofera blue to the wound secure with SAD (super absorbent dressing), Change daily and PRN was documented as implemented as ordered: 12/9/25 by Nurse #7 12/10/25 by Unit Manager #2 12/11/25 by Unit Manager #2 12/12/25 by Unit Manager #2 12/13/25 by a nurse unable to be interviewed 12/14/25 by Unit Manager #2 During an interview on 12/15/25 at 11:43 A.M., Unit Manager #2 said she implemented Resident #32's (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's physician's order, initiated 10/24/25, indicated: Cleanse area to coccyx with wound cleanser, let dry, apply barrier cream every shift for preventative of skin breakdown [sic], every shift. Review of Resident #3's assessment titled Weekly Skin Assessment, dated 12/7/25, indicated the coccyx was pink and blanchable. This assessment failed to indicate Resident #3 had any open wounds. During an interview on 12/10/25 at 11:43 A.M., Certified Nurse Assistant (CNA) #9 and CNA #10 said they have recently provided incontinence care to Resident #3 and had not observed any wounds on his/her coccyx. During an interview and observation on 12/10/25 at 11:43 A.M., Nurse #12 said she consistently cares for Resident #3 and that she was not aware of Resident #3 having any wounds. The surveyor observed Resident #3's coccyx with Nurse #12 which had a dime sized open wound. Nurse #12 said that she thought it was a pressure wound but had not seen or heard about it prior. Nurse #12 said she was unaware of the facility process of what to do when a new wound is identified because the Wound Nurse was responsible for all wound care. During an interview on 12/10/25 at 11:53 A.M., Nurse #3 said she consistently is assigned to care for Resident #3 and took care of him/her the day prior on 12/9/25. Nurse #3 said she was unaware of any current wound on Resident #3's coccyx. Nurse #3 said Resident #3 used to have a pressure wound on his/her coccyx in September that developed during a hospital stay, but that it had resolved a while back. Nurse #3 said she knew the Wound Nurse monitored the coccyx breakdown, but that it currently was intact. Review of Resident #3's plan of care related to stage two pressure ulcer on coccyx, dated 9/14/25, indicated: Stage two pressure ulcer was noted on readmission from hospital. Monitor for improvement or decline in wound condition to identify need to change treatment in accordance with facility protocols. Review of Resident #3's nursing progress note, dated 12/10/25 to 12/15/25, failed to indicate any mention of open area on his/her coccyx or notification to provider of change in skin condition. During an interview on 12/15/25 at 9:06 P.M., the Director of Nursing (DON) said she was unaware the Resident #3 had a wound on his/her coccyx. The DON said she was never notified of an open area after Nurse #12 observed that wound with the surveyor present but should have been. The DON said the Wound Nurse and the Wound Nurse Practitioner had been on vacation since 12/9/25, but that the Wound Nurse had returned today. During an interview on 12/15/25 at 9:30 A.M., the Wound Nurse said she had been on vacation since 12/9/25. The Wound Nurse said she kept a close eye on Resident #3's coccyx because it was at high risk for breaking down and often opened and closed. The Wound Nurse said she saw Resident #3 the week prior to her vacation and the skin was intact. The Wound Nurse said that Nurse #12 should have notified a physician regarding the change in Resident #3's skin since she was on vacation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 12/15/25 at 9:45 A.M., the Wound Nurse said she had concerns about communication of wounds within the facility and even when not on vacation she often wasn't notified that wounds have developed. During an interview on 12/16/25 at 11:58 A.M., the Nurse Practitioner reviewed communication between the facility and her provider group and said they were never notified of the development of a new wound for Resident #3 but should have been since the Wound Nurse Practitioner was on vacation. During a follow-up interview on 12/17/25 at 11:30 A.M., Nurse #12 said she did not notify the provider after she observed a new pressure wound on Resident #3's coccyx with the surveyor. Nurse #12 said she didn't know what the process was because she thought the Wound Nurse was responsible. Nurse #12 said she wished the facility offered more training regarding wounds because she was responsible for providing wound care on weekends.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide a homelike environment for the residents in the facility. Specifically, the facility failed to maintain bedrooms and furniture in good condition on 3 out of 3 resident units. Findings include:The following was observed on the 2 East unit on 9/16/25 at 6:30 A.M.:-The dining room wainscoting had chipping paint and scuff marks throughout the room.-In room [ROOM NUMBER], there were gouges in the wall behind both A and B beds. Opposite the bathroom door were two small homes in the upper wall next to the armoire.-In room [ROOM NUMBER], there were gouges in the wall behind the A bed with wallpaper missing from the wall. The dresser for the B bed had a broken drawer.-In room [ROOM NUMBER], there were significant gouges in the wall behind the A bed with wallpaper missing. There were significant gouges in the wall behind the B bed with wallpaper missing. Between the beds, the call light box was hanging from the wall with wires exposed.-In room [ROOM NUMBER], there were gauges behind the B bed with wallpaper missing. The side table next to the B bed had a broken cabinet door. Opposite the A bed an electrical cover for cable plug was coming apart from the wall and next to that a section of the wall was missing wallpaper exposing the underneath drywall.-In room [ROOM NUMBER], there was a hole in the wall behind the door handle when entering the room. There is a ceiling tile above the B bed with extensive staining.-In room [ROOM NUMBER], the chair rail on top of the wainscoting behind both beds was missing, exposing plaster grout and glue. In this area there was also wallpaper that had loosened from the wall and was peeling.-In room [ROOM NUMBER] the chair rail above the wainscoting behind both the A and B beds was broken in several places with holes in the wainscoting. There were significant scuff marks in the wall with paint completely removed behind the B bed and across from the a bed an electrical socket was loose from the wall.-In room [ROOM NUMBER], the wall to the left when first entering the room had drip stains and scuff marks the length of the wall.-In room [ROOM NUMBER], there was a hole in the wall between the beds where wires were exposed. Across from the B bed, there was a hole in the wall with an electrical wire extending from it.-In room [ROOM NUMBER], wallpaper was significantly ripped and peeling from the wall behind the B bed.-In room [ROOM NUMBER], there was a hole in the wall across from the television with a wire going through the wall without an electrical socket cover.-In room [ROOM NUMBER], the light in the bathroom did not turn on with multiple attempts. Plaster was exposed on the wall to the right of the toilet, and the toilet paper holder was broken and not able to hold the toilet paper.-In room [ROOM NUMBER], there was a significant large rectangular gouge on the wall with half of it being a full hole behind the A bed. There was also wallpaper peeling away from the wall.-In room [ROOM NUMBER], a section of the wallpaper was missing to the right of the bathroom door with this wall also significantly stained. Opposite the B bed, there was a hole in the wall with wires protruding and a face cloth stuffed into the hole. Next to the A bed, the baseboard was coming apart from the wall.-In room [ROOM NUMBER], two Electrical outlets opposite both beds did not have a cover and wires were protruding from the holes.-In room [ROOM NUMBER], wallpaper was peeling apart from the wall across from the B bed above the television.-In room [ROOM NUMBER], wallpaper was significantly peeling apart from the wall above the B bed.-In room [ROOM NUMBER], behind the B bed wallpaper was peeling apart from the wall.-In room [ROOM NUMBER], there were gouges in the baseboard across from both beds and behind the A bed. The light switch did not turn on the bathroom light, and the bathroom light could only be turned on from the adjoining room.-In room [ROOM NUMBER], there were gouges in the wallpaper behind both the A and B bed. When first entering the room, the wallpaper to the left of the bathroom door was peeling away from the wall. The following was observed on 2 [NAME] on 12/16/25 at 9:00 A.M.:-In room [ROOM NUMBER], there is a large area of peeling wallpaper underneath the window.-In room [ROOM NUMBER], there was peeling and chipped paint (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	around the entirety of the window pane. Behind the A bed, there was peeling wallpaper to the bottom right of the bed which appeared to be reattached to the wall with push pins. -in room [ROOM NUMBER], the wood trim was missing behind both beds with old, dried glue visible. In the bathroom, wallpaper was peeling the cover of the electrical outlet was missing a screw with the electrical socket coming off from the wall and the baseboard was peeling behind and around the toilet.-In room [ROOM NUMBER], above the B bed a large ceiling tile was warped downward, and the wood trim was missing behind the bed. Between the beds, the call light box was hanging from the wall with wires exposed. As you entered the room there were stains on the ceiling tiles above the entrance to the room. The ceiling vent had significant dust and a dark substance on the vent. Oh-In room [ROOM NUMBER], behind the door, the wallpaper was peeling vertically away from the wall. The wood trim behind the bed was missing with chipped paint, and behind the B bed a cable outlet was loosened from the wall. A second outlet next to the dresser was detached from the wall.-In room [ROOM NUMBER], the wallpaper near the baseboard on the right side of the bathroom door was peeling away from the wall. In the bathroom, the vent was coming off the wall the walls had brown stains, the wall was ripped in the middle, and the external center of the ceiling then had a dark substance. Behind the B bed, there was a gauge in the wallpaper leaving drywall exposed. There were multiple stains on the wallpaper underneath the window area with yellow discoloration.-In room [ROOM NUMBER], there were multiple areas with scuff [NAME] and chip paint on the wall behind the door expanding the entire left side of the wall. There was missing wood trim behind both beds with peeling wallpaper.-In room [ROOM NUMBER], the ceiling vent had significant visible dust. Behind the B bed there were two holes in the wall.-In room [ROOM NUMBER], the vent on the left side of the door was loose at the top. There was broken trim on the wall behind both beds and the resident in the room said the facility was supposed to fix this weeks ago. Behind the B bed, the electrical cable outlet was loose from the wall. In the bathroom, the ceiling vent was significantly dusty, and there were approximately 19 to 20 patched holes in the wall with inconsistent wallpaper color and texture and there was a large square hole in the tile where the plumbing enters the wall.-In room [ROOM NUMBER], there was a broken doorstep behind the door. There were two large stains on the ceiling. The resident in the room at this time said the ceiling tiles have to be replaced because they are often stained. Between both beds the call light box was hanging from the wall with exposed wires.-In room [ROOM NUMBER], the door stopped behind the door was broken.-In room [ROOM NUMBER], the baseboard to the right of the bathroom door was cracked and discolored. Behind the bed was significant gouges in the paint in a large area of peeling wallpaper above the bed. In the bathroom, there was a large crack on the flooring spanning the length of the wall. There were brown stains resembling rust on the wall against the right side of the toilet.-In room [ROOM NUMBER], a water stain was visible in the corner above the B bed. Between the beds, the call light boxes hanging from the wall with exposed wires. Above the A bed, the wood trim was detached from the walls with nails exposed. Above the A bed, a wire was hanging from the ceiling.-In room [ROOM NUMBER], between both beds the call light box was hanging from the wall with wires exposed. The wood trim behind both beds was broken and splintered.-In room [ROOM NUMBER], there was peeling paper behind the door, ripped wallpaper around the cable outlet, and unfinished wood trim with nails exposed behind both beds.-In room [ROOM NUMBER], there was a large area of wallpaper ripped by the A bed with a loose outlet cover by the A bed. There was a ceiling tile above the bed with a stain on it. In the bathroom, there was a large dark gray scuff mark spanning the entire wall across from the toilet, the ceiling vent was significantly dusty, and there was a broken wall outlet on the bottom of the wall.-Above the nursing station there was a cluster of stains on the ceiling.-In the dining room, the right corner of the ceiling had stains, the left side of the air conditioner was detached from the wall with a nail protruding. And the baseboards and walls had significant scuff marks.-In room [ROOM NUMBER], the air conditioner was missing the vent cover, and the bathroom had a large section of wallpaper missing behind the grab bar.-Outside of room [ROOM NUMBER] there was a stain on the ceiling tile.-In room [ROOM NUMBER], a piece of printer (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paper was taped horizontally on the left side of the air conditioner, and the air conditioner cover was falling off to the left side. There was a warped ceiling grid above the a bed. In the bathroom the vent was detached from the wall with sharp edges, the baseboard was peeling off the wall leaving a gap on the right side of the toilet. There was significant dust in the ceiling fan. The resident in this room said the vent falling off the bathroom floor is bothersome.-In room [ROOM NUMBER], the base board was warped in two areas behind the door and along the left side of the room period a large ventilation hole was above the door uncovered and a large area of dust was on the ceiling tile.-In room [ROOM NUMBER] there was a stain on the ceiling tile next to the light above the B bed. Behind the B bed was a hole in the wall with a missing electrical outlet, and the missing outlet was visible underneath the resident's bed. The wood trim was missing behind the bed, there was a yellow hardened substance on the window curtain, and in the bathroom a large ventilation hole in the ceiling was uncovered with visible dust inside.Above the bed there is a stain on the ceiling tile and the ceiling tile in the corner of the room had a tear in it.-In room [ROOM NUMBER], behind the B bed, an electrical outlet was falling out of the wall. Above this bed, there was 1/4 sized hole in the ceiling and a stain on the ceiling above the armoire in the corner of the room. The back of the bedroom door had two areas of chipped wood on the right side with one area having jagged edges. During an observation of the 1 [NAME] unit on 12/16/25 at 11:27 A.M., the following was observed: -In room [ROOM NUMBER], there was a broken chair rail (molding on the wall) off of half of the circumference of the room's walls.-In room [ROOM NUMBER], there were 2 large circular brown stains on the ceiling tile in the bathroom and 2 rectangular holes in the wall opposite the beds with cable wires coming out of them.-In room [ROOM NUMBER], there was a large circular brown stain covering two ceiling tiles in the bathroom.-In room [ROOM NUMBER], 3 ceiling tiles had several brown circular stains in the bathroom.-In room RM [ROOM NUMBER], there was a broken chair rail running 3/4 the length of the wall behind the resident's beds, and2 ceilings tile with large brown stains in the bathroom.-In room [ROOM NUMBER], there was a quarter dollar sized hole in bathroom ceiling tile.-In room [ROOM NUMBER], there was a 2 inch circumference hole in the wall and peeling wallpaper behind the door and bed. -In room [ROOM NUMBER], there were long gouges in walls throughout the room with missing paint. During an interview on 12/17/25 at 11:34 A.M., the Maintenance Assistant said staff typically tell him if something is broken or they have the ability to put a work order in a system named TELS. The Maintenance Assistant said he also does daily rounds to ensure he has eyes on every room in the facility to see if anything needs to be fixed. The Maintenance director was told of the environmental findings of the surveyors and said he was aware that they call light boxes are often hanging from the walls and this is a constant issue in the building. He also said he was aware the light in room [ROOM NUMBER]'s bathroom has not been working for over a week, and he has not yet ordered the new light fixture. The Maintenance Assistant said he was unaware of the other environmental observations of the surveyors. During an interview on 12/17/25 at 11:51 A.M., the Administrator said staff should know how to use the TELS work order system and they also let maintenance know of broken equipment or things needed to be fixed by word of mouth. The Administrator said she was aware of a couple of rooms that needed the chair rail fixed and some rooms had wallpaper that needed regluing but did not have a full list of rooms or a proposed timeline of when these fixes would be made. The Administrator said the environmental observations made by the surveyors indicated the environment was not homelike for the residents.

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F 0657 Level of Harm - Minimal harm or potential for actual 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. Based on record reviews and interviews, the facility failed to complete quarterly care plan review meetings with an interdisciplinary team and a resident representative for one Resident (#111) out of a total sample of 30 residents. Findings include:Review of the facility policy titled, Care Plan Policy, dated May 2025, indicated the following:Our facilities care planning interdisciplinary team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.The resident, the resident's representative or court appointed resident representative or surrogate are encouraged to participate in the development of his or her person-centered plan of care. Including: a. The resident's right to know his or her total health status, including but not limited to his or her medical conditions c. The right to participate in the planning process, and the right to request meetings, d. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care, e. The right to be informed, in advance, of changes to the plan of care.The facility shall inform the resident of the right to participate in his/her treatment and shall support the resident in this right.The care planning interdisciplinary team is responsible for the review and updating of care plans, d. At least quarterly.The resident has the right to refuse to participate in the development of his or her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. Resident #111 was admitted to the facility in March 2023, with diagnoses of dementia and chronic kidney disease. Review of Resident #111's most recent Minimum Data Set (MDS) assessment, dated 10/10/25, indicated the Resident had a score of 0 out of a possible 15 on the Brief Interview for Mental Status exam, which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #111 was dependent on staff for all functional daily tasks. During an interview on 12/16/25 at 10:02 A.M., Resident #111's son said he was his parent's health care proxy. The Resident's son said the facility had not kept him informed of Resident #111's medical status, recent decline in status and wound status. Resident #111's son said the facility called him last week to say his parent had to go to the hospital because of an infection in a wound and he said he was not even aware the Resident had a wound, was on antibiotics or was this medically ill. Resident #111's son said he had not been invited to any formal meetings at the facility and the staff have very poor communication with him. Resident #111's son said he would attend a care plan meeting if invited. Review of Resident #111's medical chart indicated the following care plan meeting notes for the past year:Dated 11/13/24. The note failed to indicate the Resident or the Resident's son were invited to the meeting. An invitation to a care plan meeting to take place on 2/12/25, however the medical record and social worker were unable to provide documentation that the meeting occurred. Dated 5/7/25: the note failed to indicate the Resident or Resident's son was invited, just that they were not in attendance. The facility was unable to provide a copy of the invitation that was mailed to the son inviting him to the meeting. Dated 7/24/25: the note failed to indicate if the family attended the meeting or declined to come to the meeting. The note indicated the only staff member present was the social worker and the care plan was not reviewed by the interdisciplinary team. Dated 10/17/25: the note failed to indicate if the family attended the meeting or declined to come to the meeting. The note indicated the only staff member present was the social worker and the care plan was not reviewed by the interdisciplinary team. The facility provided the surveyor with a copy of the invitation to the meeting that was mailed to the son. The invitation listed the date of the meeting on 10/23/25 and failed to indicate the son was informed on the meeting on 10/17/25. The medical record failed to indicate anyone from the facility met with Resident #111's son (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 10/23/25. During an interview on 12/16/25 at 1:05 P.M., Social Worker #1 said care plan meetings occur every quarter, following the MDS assessment schedule. Social Worker #1 said all residents and their representatives were invited to the meetings and if they do not attend, she documents the refusal to attend. Social Worker #1 said Resident #111's son was invited but never came to the meetings and she was unable to say why there was no documentation of him declining the invitation. Social Worker #1 said the entire interdisciplinary team should be attending the care plan meetings to ensure all levels of care are reviewed and that it was not a true care plan meeting if she was the only person in attendance. During an interview on 12/16/25 at 2:13 P.M., the Director of Nursing said all care plan meetings occur quarterly following the MDS assessment schedule and the entire interdisciplinary team should attend and give input at the meetings. The Director of Nursing said the care plan meetings for Resident #111 did not occur if only the social worker was present. The Director of Nursing said that Resident #111 had several medical issues during the last three months, including wounds, and his/her care would require an interdisciplinary approach.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide assistance with Activities of Daily Living (ADL) care for six Residents (#14, #38, #77, #78, #89 and #93) out of a total sample of 30 residents. Specifically, the facility failed to provide incontinence care for extended periods of time for all six residents. Findings include: Review of the facility policy titled, Bowel and Bladder Program, revised June 2025, indicated the following: -Purpose: to prevent skin breakdown through routine incontinent care and to enhance dignity and self-esteem. -If there is no discernible pattern, the resident will be checked for incontinence and provided with incontinent care at least every two hours and PRN (as needed). 1.Resident #14 was admitted to the facility and has diagnoses that include Multiple Sclerosis, severe vascular dementia and hypertensive heart with chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/3/25, indicated that on the Brief Interview for Mental Status exam Resident #14 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #14 was frequently incontinent of bowel and bladder. Review if Resident #14's active physician orders include: -Lasix 40 mg (Milligrams) by mouth daily. (Lasix is a diuretic with side effects including increased urination). Review of Resident #14's current care plans included the following care plans: An at risk for skin break down care plan due to urinary incontinence and cognitive deficits. An MS (multiple sclerosis) care plan. Interventions include: Toileting-Resident #14 is incontinent of bowel and bladder at times and needs assist to dependent of one with toileting and incontinent care due to unable to maintain proper personal hygiene. A risk for infection care plan due to getting frequent UTIs. Interventions include: provide incontinence care as needed. An Activities of Daily Living care plan that indicates Resident #14 is incontinent of bowel and bladder and needs assist to dependent with incontinence care. Review of Resident #14's Kardex (resident specific care instructions) indicated: -Resident #14 is incontinent of bowel and bladder. Review of Resident #14's most recent [NAME] +Pressure Ulcer Care, dated 11/30/25, indicated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #14 scored an 11 (high risk of developing pressure ulcers). Review of Resident #14's Annual Bladder (incontinent) Functioning Assessment, dated 4/18/25, indicated the Resident was incontinent at all times. Review of Resident #14's Annual Bowel (incontinent) Functioning Assessment, dated 4/18/25, indicated the Resident was incontinent at all times. During an observation on 12/9/25 at 7:45 A.M., Resident #14 was observed seated in the unit day room. The surveyor continued to make the following observations: -By 12:45 P.M., Resident #14 had not yet been offered toileting since the initial observation 5 hours earlier. On 12/11/25 at 7:41 A.M., Resident #14 was wheeled into the unit day room and seated at his/her table. The surveyor continued to make the following observations: -At 11:26 A.M., Resident #14 was offered toileting for the first time since arriving to the day room three hours and 45 minutes earlier. The staff took Resident #14 to his/her room, accompanied by a surveyor, and the smell of feces filled the room as soon as care was started. The two staff stood Resident #14 by the toilet and removed his/her incontinence pad that was soiled with both feces and urine. The feces looked dried and had been there for some time. During an interview on 12/11/25 at 12:54 P.M., Certified Nursing Assistant (CNA) #8 said that she had provided incontinence care that day to Resident #14 at 7:00 A.M., and 11:30 A.M., CNA #8 said that she changed Resident #14 at 11:30 A.M., because she noticed he/she had a bowel movement. CNA #8 could not say how often she should check or change incontinent residents. CNA #8 could not say what a Kardex or care plan was. During an interview on 12/11/25 at 1:08 P.M., Nurse Unit Manager #2 said residents should be checked for incontinence and changed every three hours and as needed. Nurse Unit Manager #2 said not providing incontinence care timely put the resident at risk for skin breakdown. During an interview on 12/11/25 at 1:17 P.M., Certified Nursing Assistant (CNA) #1 said that every resident should get incontinent care in the morning with morning care, after breakfast around 10-10:30 A.M., and then again after lunch. CNA #1 said that the CNAs know the level of care for each resident by looking at the Kardex and that the continence status of each resident was listed on their Kardex. CNA #1 said that each morning she gave the CNAs a verbal report of the resident care needs. CNA #1 said that it was very important to change a resident who was wet or soiled immediately to avoid skin break down and other complications and that Resident #14 should have been changed after breakfast each day but that the challenge was the CNAs need more support and that they consistently need five CNAs which they often don't get. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing said it was her expectation that staff provided incontinence care at least every two hours and as needed. The Director of Nursing said not providing timely care can put a resident at risk for skin breakdown. 2. Resident #38 was admitted to the facility in February 2022 and has diagnoses that include dementia and unspecified protein-calorie malnutrition. (continued on next page)

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	225548	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 11/21/25, indicated that Resident #38 was unable to participate in the Brief Interview for Mental Status exam and was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #38 was frequently incontinent of bowel and bladder. Review of Resident #38's Kardex (resident specific care instructions) indicated: -Resident #38 was dependent on staff for toileting. -Resident #38 was incontinent of bowel and bladder. Review of Resident #38's most recent [NAME] +Pressure Ulcer Scale, dated 11/15/25, indicated Resident #38 scored an 11 (high risk of developing pressure ulcers). Review of Resident #14's Annual Bladder (incontinent) Functioning Assessment, dated 11/25/25, indicated the Resident was incontinent at all times. Review of Resident #14's Annual Bowel (incontinent) Functioning Assessment, dated 11/25/25, indicated the Resident was incontinent at all times. Review of Resident #38's active care plans indicated the following: -An Activities of Daily Living (ADL) care plan, initiated 2/22/22, with the following interventions: Toileting- Mod physical assist to toilet, start date 11/6/23. -An at risk for skin breakdown related to incontinence care plan, initiated 2/22/22 with the following interventions: Provide incontinent care every two hours and as needed and toilet every two hours and as needed. Review of the most recent skin assessment, dated 12/8/25, indicated, Resident #38 had redness to buttock bil (bilateral) legs and arms dry, right side of face self-inflicted scab (sic). On 12/09/25 at 7:45 A.M., Resident #38 was observed seated in the unit day room. The surveyor continued to make the following observations: -By 12:45 P.M., Resident #38 had not yet been offered toileting since the initial observation five hours earlier. On 12/11/25 at 7:36 A.M., Resident #38 was wheeled into the unit day room. The surveyor continued to make the following observations: -By 1:00 P.M., Resident #38 had not offered toileting since he/she was [NAME] to the day room, five and a half hours earlier. During an interview on 12/11/25 at 1:05 P.M., Hospice CNA #1 and CNA #5 said that residents should be checked for incontinence every two hours and changed at that time. During an interview on 12/11/25 at 1:08 P.M., Nurse Unit Manager #2 said residents should be checked for incontinence and changed every three hours and as needed. Nurse Unit Manager #2 said (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not providing incontinence care timely put the resident at risk for skin breakdown. During an interview on 12/11/25 at 1:17 P.M., Certified Nursing Assistant (CNA) #1 said that every resident should get incontinent care in the morning with morning care, after breakfast around 10-10:30 A.M., and then again after lunch. CNA #1 said that the CNAs know the level of care for each resident by looking at the Kardex and that the continence status of each resident is listed on their Kardex. CNA #1 said that each morning she gives the CNAs a verbal report of the resident care needs. CNA #1 said that it was very important to change a resident who is wet or soiled immediately to avoid skin break down and other complications and that Resident #38 should have been changed after breakfast each day but that the challenge was the CNAs need more support and that they consistently need five CNAs which they often don't get. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing said it was her expectation that staff provide incontinence care at least every two hours and as needed. The Director of Nursing said not providing timely care can put a resident at risk for skin breakdown. 3. Resident #77 was admitted to the facility in October 2024 with diagnoses including dementia and diabetes. Review of Resident #77's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 0 out of possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #77 was dependent on staff for toileting and section H of the MDS indicated the Resident was frequently incontinent of bowel and bladder. On 12/9/25 at 7:45 A.M., Resident #77 was observed sitting in the dining room. The surveyors observed the Resident in the dining room from 7:45 A.M. to 12:48 P.M., a total of five hours without any staff checking for incontinence or offering him/her to use the bathroom. On 12/10/25 at 8:06 A.M., Resident #77 was observed sitting in the dining room. The surveyors observed the Resident in the dining room from 7:45 A.M. to 12:34 P.M., a total of just under five hours without any staff checking for incontinence or offering him/her to use the bathroom. On 12/11/25 at 8:00 A.M., Resident #77 was observed sitting in the dining room. At 11:18 A.M., three hours later, Certified Nursing Assistant (CNA) #1 took Resident #77 to his/her room to provide incontinence care. The surveyor followed the Resident to his/her room and could smell a strong odor similar to urine. After the care was provided, the surveyor examined the Resident's incontinence brief which was moderately wet with a yellow liquid resembling urine. CNA #1 said Resident #77 had been incontinent of urine. The surveyor attempted to interview Resident #77, however, he/she was unable to participate in the interview. Review of the assessment titled, Bladder (Incontinent) Functioning Assessment), dated 9/13/25, indicated Resident #77 had total bladder incontinence for more than 12 months. Review of the assessment titled, Bowel (Incontinent) Functioning Assessment), dated 9/13/25, indicated Resident #77 had total bowel incontinence for more than 12 months. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #77's incontinence care plan last revised 10/1/25, indicated the following intervention: -toilet every two hours and PRN (as needed) containment program. Review of Resident #77's Kardex (a form indicating the level of assistance a resident required) indicated the Resident was incontinent of both bowel and bladder and he/she was dependent on staff for all toileting needs. Review of Resident #77's Norton Pressure Ulcer assessment dated [DATE], indicated Resident #77 had a pressure ulcer risk score of 7, indicating the Resident is a very high risk for pressure ulcer development. During an interview on 12/11/25 at 1:08 P.M., Nurse Unit Manager #2 said residents should be checked for incontinence and changed every three hours and as needed. Nurse Unit Manager #2 said not providing incontinence care timely put the resident at risk for skin breakdown. During an interview on 12/11/25 at 1:17 P.M., Certified Nursing Assistant (CNA) #1 said that every resident should get incontinent care in the morning with morning care, after breakfast around 10-10:30 A.M., and then again after lunch. CNA #1 said that the CNAs know the level of care for each resident by looking at the Kardex and that the continence status of each resident is listed on their Kardex. CNA #1 said that each morning she gave the CNAs a verbal report of the resident care needs. CNA #1 said that it was very important to change a resident who was wet or soiled immediately to avoid skin breakdown and other complications and that Resident #77 should have been changed after breakfast each day but that the challenge was the CNAs needed more support and that they consistently need five CNAs which they often don't get. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing said it was her expectation that staff provide incontinence care at least every two hours and as needed. The Director of Nursing said not providing timely care could put a resident at risk for skin breakdown. 4. Resident #78 was admitted to the facility in September 2019 with diagnoses including dementia. Review of Resident #78's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #78 was dependent on staff for all toileting needs and section H of the MDS said the Resident was frequently incontinent of both urine and bowel. On 12/9/25 at 7:45 A.M., Resident #78 was observed sitting in the dining room. The surveyors observed the Resident in the dining room from 7:45 A.M. to 12:15 P.M., a total of four and a half hours without any staff checking for incontinence or offering him/her assistance to the bathroom. At 12:19 P.M., Certified Nursing Assistant (CNA) #4 assisted the Resident to the bathroom. CNA #4 told the surveyor that Resident #78 had been incontinent of urine. He said he could not tell how long the Resident had been sitting on a soiled brief. On 12/10/25 at 8:06 A.M., Resident #78 was observed sitting in the dining room. The surveyors observed the Resident in the dining room from 7:45 A.M. to 12:34 P.M., a total of just under 5 hours without any staff checking for incontinence or offering him/her to use the bathroom. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/25 at 8:01 A.M., Resident #78 was observed sitting in the dining room. At 10:37 A.M., Resident #78 asked a CNA to take him/her to the bathroom. The CNA said, one second and walked away. Resident #78 was not toileted until 11:39 A.M., an hour later. The surveyor was present when incontinent care was provided and observed the Resident's incontinence brief to be saturated with urine. The surveyor attempted to interview Resident #78, however, he/she was unable to participate in the interview. Review of the assessment titled, Bladder (Incontinent) Functioning Assessment), dated 3/16/25, indicated Resident #78 had total bladder incontinence for more than 12 months. Review of the assessment titled, Bowel (Incontinent) Functioning Assessment), dated 3/16/25, indicated Resident #78 had total bowel incontinence for more than 12 months. Review of Resident #78's incontinence care plan indicated the following intervention: -toilet every two hours and as needed. Review of Resident #78's Kardex (a form indicating the level of assistance a resident required) indicated the Resident was incontinent of both bowel and bladder and he/she was dependent on staff for all toileting needs. Review of Resident #78's Norton Pressure Ulcer assessment dated [DATE], indicated Resident #78 had a pressure ulcer risk score of 8, indicating the Resident was a very high risk for pressure ulcer development. During an interview on 12/11/25 at 1:08 P.M., Nurse Unit Manager #2 said residents should be checked for incontinence and changed every three hours and as needed. Nurse Unit Manager #2 said not providing incontinence care timely put the resident at risk for skin breakdown. During an interview on 12/11/25 at 1:17 P.M., Certified Nursing Assistant (CNA) #1 said that every resident should get incontinent care in the morning with morning care, after breakfast around 10-10:30 A.M., and then again after lunch. CNA #1 said that the CNAs know the level of care for each resident by looking at the Kardex and that the continence status of each resident was listed on their Kardex. CNA #1 said that each morning she gives the CNAs a verbal report of the resident care needs. CNA #1 said that it was very important to change a resident who was wet or soiled immediately to avoid skin breakdown and other complications and that Resident #78 should have been changed after breakfast each day but that the challenge was the CNAs needed more support and that they consistently needed five CNAs which they often don't get. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing said it is her expectation that staff provided incontinence care at least every two hours and as needed. The Director of Nursing said not providing timely care can put a resident at risk for skin breakdown. 5. Resident #89 was admitted to the facility in February 2024 with diagnoses including stroke. Review of Resident #89's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident score a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated he/she had severe cognitive impairment. The MDS also indicated Resident #89 was dependent on staff for toileting and section H of the MDS indicated the Resident was frequently incontinent of both bladder and urine. On 12/9/25 at 7:30 A.M., Resident #89 was observed sitting in the dining room. The surveyors observed the Resident in the dining room from 7:30 A.M. to 12:15 P.M., a total of four hours without any staff checking for incontinence or offering him/her assistance to the bathroom. At 12:19 P.M., Certified Nursing Assistant (CNA) #2 assisted the Resident to the bathroom. CNA #2 told the surveyor that Resident #89 had been incontinent of urine. On 12/10/25 at 8:06 A.M., Resident #89 was observed sitting in the dining room. The surveyors observed the Resident in the dining room from 8:06 A.M. to 12:34 P.M., a total of four and a half hours without any staff checking for incontinence or offering him/her to use the bathroom. On 12/11/25 at 7:55 A.M., Resident #89 was observed sitting in the dining room. The Resident sat in the dining room until he/she was [NAME] to the bathroom at 12:37 P.M. The surveyor was present while incontinent care was provided and observed Resident #89's incontinent brief to be soiled with both urine and bowel and his/her groin area was reddened. The surveyor attempted to interview Resident #89, however, he/she was unable to participate in the interview. Review of the assessment titled, Bladder (Incontinent) Functioning Assessment), dated 1/10/25, indicated Resident #89 had total bladder incontinence for more than 12 months. Review of the assessment titled, Bowel (Incontinent) Functioning Assessment), dated 1/10/25, indicated Resident #89 had total bowel incontinence for more than 12 months. Review of Resident #89's incontinence care plan, indicated the following intervention: -provide incontinence care when toileting. Review of Resident #89's Kardex (a form indicating the level of assistance a resident requires) indicated the Resident was incontinent of both bowel and bladder and he/she was dependent on staff for all toileting needs. Review of Resident #89's Norton Pressure Ulcer assessment dated [DATE], indicated Resident #89 had a pressure ulcer risk score of 9, indicating the Resident was a very high risk for pressure ulcer development. During an interview on 12/11/25 at 1:08 P.M., Nurse Unit Manager #2 said residents should be checked for incontinence and changed every three hours and as needed. Nurse Unit Manager #2 said not providing incontinence care timely put the resident at risk for skin breakdown. During an interview on 12/11/25 at 1:17 P.M., Certified Nursing Assistant (CNA) #1 said that every resident should get incontinent care in the morning with morning care, after breakfast around 10-10:30 A.M., and then again after lunch. CNA #1 said that the CNAs know the level of care for each resident by looking at the Kardex and that the continence status of each resident was listed on their Kardex. CNA #1 said that each morning she gave the CNAs a verbal report of the resident care needs. CNA #1 (continued on next page)

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Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said that it was very important to change a resident who was wet or soiled immediately to avoid skin breakdown and other complications and that Resident #89 should have been changed after breakfast each day but that the challenge was the CNAs needed more support and that they consistently needed five CNAs which they often don't get. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing said it was her expectation that staff provide incontinence care at least every two hours and as needed. The Director of Nursing said not providing timely care can put a resident at risk for skin breakdown. 6. Resident #93 was admitted to the facility in December 2023 with diagnoses including Alzheimer's Disease. Review of Resident #93's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated he/she has severe cognitive impairment. The MDS also indicated Resident #93 was dependent on staff for all toileting needs and section H of the MDS said the Resident was frequently incontinent of both urine and bowel. On 12/9/25 at 7:30 A.M., Resident #93 was observed sitting in the dining room. The surveyors observed the Resident in the dining room from 7:30 A.M. to 12:48 P.M., a total of five hours without any staff checking for incontinence or offering him/her assistance to the bathroom. On 12/10/25 at 7:44 A.M., Resident #93 was observed sitting in the dining room. The surveyors observed the Resident in the dining room from 7:45 A.M. to 12:02 P.M., a total of just under four and a half hours without any staff checking for incontinence or offering him/her to use the bathroom. On 12/11/25 at 8:10 A.M., Resident #93 was observed sitting in the dining room. At 1:07 P.M., five hours later, a CNA brought Resident #93 to the bathroom. A surveyor was present while incontinent care was provided and the Resident's incontinence brief was observed to be saturated with urine. The surveyor attempted to interview Resident #93, however, he/she was unable to participate in the interview. Review of the assessment titled, Bladder (Incontinent) Functioning Assessment), dated 10/4/25, indicated Resident #93 had total bladder incontinence for more than 12 months. Review of the assessment titled, Bowel (Incontinent) Functioning Assessment), dated 10/4/25, indicated Resident #93 had total bowel incontinence for more than 12 months. Review of Resident #93's risk for skin breakdown due to incontinence care plan last revised 1/9/25, indicated the following intervention: -provide incontinence care every two hours and as needed. Review of Resident #93's Kardex (a form indicating the level of assistance a resident requires) indicated the Resident was incontinent of both bowel and bladder and he/she is dependent on staff for all toileting needs. Review of Resident #93's Norton Pressure Ulcer assessment dated [DATE], indicated Resident #93 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a pressure ulcer risk score of 10, indicating the Resident is a high risk for pressure ulcer development. During an interview on 12/11/2025 at 1:08 P.M., Nurse Unit Manager #2 said residents should be checked for incontinence and changed every three hours and as needed. Nurse Unit Manager #2 said not providing incontinence care timely put the resident at risk for skin breakdown. During an interview on 12/11/2025 at 1:17 P.M., Certified Nursing Assistant (CNA) #1 said that every resident should get incontinent care in the morning with morning care, after breakfast around 10-10:30 A.M., and then again after lunch. CNA #1 said that the CNAs know the level of care for each resident by looking at the Kardex and that the continence status of each resident is listed on their Kardex. CNA #1 said that each morning she gives the CNAs a verbal report of the resident care needs. CNA #1 said that it was very important to change a resident who was wet or soiled immediately to avoid skin breakdown and other complications and that Resident #93 should have been changed after breakfast each day but that the challenge was the CNAs need more support and that they consistently need five CNAs which they often don't get. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing said it was her expectation that staff provide incontinence care at least every two hours and as needed. The Director of Nursing said not providing timely care can put a resident at risk for skin breakdown.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure two Residents' (#89 and #77) maintained acceptable parameters of nutritional status out of a total sample of 30 residents. Specifically, 1) For Resident #89, the facility failed to a) ensure the Registered Dietitian's recommendations were implemented after a significant weight loss and b) ensure his/her nutritional supplement was provided during meals.2) For Resident #77, the facility failed to provide the Resident with his/her nutritional supplement during a meal. Findings include:Review of the facility policy titled, Resident Nutritional Policy & Procedure, reviewed 6/2025, indicated the following:Purpose: To promote optimal nutrition and provide mechanism to identify significant weight changes and implement corrective action as well as providing nutritional interventions for residents with pressure ulcers.Scope: To be followed by nursing, the Nutritional Coordinator, the Food Service Supervisor and Dietitian.Weights: the resident is weighed upon admission/re-admission according to the facility's weight monitoring policy.Weight Monitoring: Each resident is to be weighed upon admission, and thereafter, a minimum of once a month, or more frequently as medically necessary or as per physician order, by the Nutritional Coordinator (or other individual as designated by nursing). In order to maintain accurate weights, the resident should be weighed at approximately the same time each month. Weights are recorded directly on an individual in the EHR (electronic health record) or the Weights Sheet Form CN-052, to be used if EHR is unavailable, which are kept in a special weight book at the nurses' station.If a significant weight loss occurs, defined as five percent (5%) in one month, seven and one half percent (7.5%) in three months, or ten percent (10%) in six months, the Nutritional Coordinator (or designee) is to notify the Director of Nursing.Except in cases where the resident is on hospice services/comfort measure only and is contradicted by attending physician, a. The Director of Nursing will:1. Ensure that the attending physician is notified;2. Ensure physician orders are followed;3. Review significant weight changes through Case Management by utilizing electronic dashboard. The resident's care plan will be updated at this time.4. Ensure the family/next of kin/responsible party is notified regarding the significant change. b. The Nutritional Coordinator or designee shall: 1. Weigh residents upon admission and once a month to establish weight pattern. If the resident exhibits significant change, the resident must be re-weighed to assure accuracy. Once weight loss or gain is validated, the Nutritional Coordinator/designee will notify the Director of Nursing, Charge Nurse, MDS Nurse and Dietitian. c. The Dietitian shall: 1. Assess the resident's current nutritional status when a significant change is noted and document intervention. Some interventions may include feeding programs, supplementation of liquid or medication, lab work, consults (speech, psych, etc.,), alternate feeding plan, physician involvement, or any resident specific intervention which would benefit the resident in enhancing his/her nutritional status.Nutritional Assessment & Progress Notes: Nutritional progress notes are written for each resident by the dietitian and as necessary, according to the MDS schedule. The dietitian's notes are documented in the EHR. 1. Resident #89 was admitted to the facility in February 2024 with diagnoses including stroke. Review of Resident #89's most recent Minimum Data Set (MDS) assessment, dated 9/19/25, indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status exam which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #89 was dependent on staff for self-feeding and toileting and section H of the MDS indicates the Resident was frequently incontinent of both bladder and urine. Review of Resident #89's weight log indicated that on 9/17/25, Resident #89 weighed 135 pounds and on 12/12/25 weighed 122 pounds, a weight loss of 9.63%. On 12/9/25 at 1:44 P.M., Resident #89 was observed eating lunch. The meal ticket on his/her lunch tray indicated he/she was supposed to have a magic cup (a nutritional supplement). The Resident was never provided with a magic cup throughout the entirety of the meal. On 12/10/25 at 8:25 A.M., Resident #89 was observed eating breakfast. The meal ticket on his/her breakfast tray (continued on next page)

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	225548	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated he/she was supposed to have a magic cup. The Resident was never provided with a magic cup throughout the entirety of the meal. On 12/10/25 at 12:20 P.M., Resident #89 was observed eating lunch. The meal ticket on his/her lunch tray indicated he/she was supposed to have a magic cup. The Resident was never provided with a magic cup throughout the entirety of the meal. On 12/11/25 at 8:24 A.M., Resident #89 was observed eating breakfast. The meal ticket on his/her breakfast tray indicated he/she was supposed to have a magic cup. The Resident was never provided with a magic cup throughout the entirety of the meal. On 12/11/25 at 12:20 P.M., Resident #89 was observed eating lunch. The meal ticket on his/her lunch tray indicated he/she was supposed to have a magic cup. The Resident was never provided with a magic cup throughout the entirety of the meal. On 12/15/25 at 8:58 A.M., Resident #89 was observed eating breakfast. The meal ticket on his/her breakfast tray indicated he/she was supposed to have a magic cup. The Resident was never provided with a magic cup throughout the entirety of the meal. Review of Resident #89's physician orders indicated the following order:Diet: house no salt shaker breakfast, lunch, supper. Ground texture thin liquids. *lip plate, cup with handles and covers, built up utensils and magic cup at breakfast, lunch and dinner, initiated 6/29/25.Magic cup by mouth breakfast, lunch, supper with all meals, initiated 7/22/25. Review of the nutritional assessment dated [DATE] indicated the following:-Resident #89 had a 9.6% unintended weight loss in the past three months.-New recommendations for daily Ensure (a nutritional supplement), weekly weights, and to add Resident #89 to weekly at-risk meetings. On 12/17/25, the surveyor observed Resident #89's paper chart on the unit with a telephone order sheet flagged (raised up) out the top of the chart. The telephone order indicated an order, not yet signed off, for Ensure 237 ml (milliliters) 1x/day, written on 12/12/25. Review of Resident #89's nutritional care plan, last revised 1/6/25, indicated the following interventions:Provide dietary supplement as ordered.Provide diet as ordered.Notify physician of significant weight change. During an interview on 12/15/25 at 12:42 P.M., Nurse #11 said she was the nurse responsible for checking the meal trays at lunch this day. Nurse #11 said she did not check to ensure Resident #89 received his/her magic cup. Nurse #11 said she would have been the first staff member to realize the Resident needed a magic cup added to his/her tray but all other staff should have noticed as well. During an interview on 12/15/25 at 12:45 P.M., the Registered Dietitian said the kitchenette on the unit should be fully stocked with magic cups and the staff should provide the supplement to all residents who require one. Resident #89 was not able to participate in an interview during survey, and the surveyor attempted to contact the Resident's healthcare proxy without success. During an interview on 12/16/25 at 7:42 A.M., the Director of Nursing (DON) said any resident who is ordered a nutritional supplement with a meal should be provided with that supplement. The DON said nursing should ensure accuracy of all trays and that all ordered items are provided. The DON said if a resident were to lose weight, she would expect the Resident to be assessed by the dietitian immediately with nutritional interventions started as soon as possible to prevent further weight loss. The DON said she was unaware Resident #89 had a significant weight loss. During interviews on 12/15/25 at 1:42 P.M., and 12/17/25 at approximately 10:00 A.M., the Registered Dietitian (RD) said she works at the facility fulltime and is responsible for monitoring the residents' weights and implementing dietary interventions if a significant weight change occurs. The RD said a significant weight change would be a weight change of 2% in 1 week, 5% in 1 month, 7.5% in 3 months, and 10% in 6 months. The RD said when a significant weight loss occurs, she immediately makes recommendations for weight loss interventions and the physician needs to be notified so that he can review her recommendations, and they can be made into an order if he agrees. The RD said she was made aware that Resident #89's intake of meals had decreased and when looking at his/her weights, the RD noticed that Resident had a significant weight loss of over 9% from September 2025 to December 2025. The RD said that on 12/12/25 she wrote a recommendation for an order for an additional nutritional supplement of Ensure due to this weight loss and flagged it in the Resident's medical chart for the nurses to communicate the recommendation to the physician so the recommendation could be made into an active order. The RD said her expectation is that the nurses do (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this within 24 hours so that the dietary interventions can start immediately. The RD said that as of today, 5 days later, the nurses had not yet communicated her recommendations to the physician, and they have not yet been implemented. During an interview on 12/16/2025 12:10 P.M., Nurse Practitioner #1 said she was not aware of Resident #89's weight loss and would expect to have been notified by the facility. Nurse Practitioner #1 said she also expects all nutritional interventions, such as receiving supplements, to be followed by the nursing staff. During an interview on 12/17/25 at 1:22 P.M., Physician #1 said he was unaware of the recommendation from the Registered Dietitian made on 12/12/25. 2. Resident #77 was admitted to the facility in October 2024 with diagnoses including dementia and malnutrition. Review of Resident #77's most recent Minimum Data Set (MDS) assessment, dated 9/19/25, indicated the Resident scored a 0 out of 15 on the Brief Interview for Mental Status exam which indicated he/she had severe cognitive impairment. The MDS also indicates Resident #77 is dependent on staff for all mobility and self-care tasks. Review of Resident #77's physician orders indicated the following order:-Diet: house breakfast, lunch, supper Ground meat with regular sides. Thin mighty shake all meals. Review of Resident #77's nutritional care plan included the following interventions:-Provide diet as ordered.-Dietary supplement as ordered. Review of Resident #77's meal ticket that arrives on all of his/her meals and checked by the nursing staff for accuracy indicated mighty shake in the section of his/her diet. On 12/9/25 at 1:26 P.M., Resident #77 was given another resident's meal at lunch. The Certified Nursing Assistant (CNA) who provided the meal was observed telling another staff member she knew it was the wrong meal, however, proceeded to provide the meal to the Resident anyways. The lunch tray consisted of a meal and two drinks and nothing else on the tray. At 12:43 P.M., the surveyor asked the Nursing Administrative Assistant that was assisting Resident #77 if the meal belonged to Resident #77 and asked if the Resident had an order for a mighty shake. The Nursing Administrative Assistant said it was not Resident #77's tray and she believed the Resident did receive healthy shakes at meals, however, she was told by the CNA to just give the Resident this meal. Resident #77 finished the meal that was provided to him/her and was never given a mighty shake. During an interview on 12/9/25 at 12:47 P.M., Nurse #1 said Resident #77 should have been provided with her nutritional shake as ordered. During an interview on 12/10/25 at 2:42 P.M., the Director of Nursing (DON) said the nursing staff should be checking all trays to ensure accuracy and supplements are provided as ordered. The DON said that as soon as the nursing staff realized they had given Resident #77 the wrong tray, they should have removed the tray and obtained a new tray with the correct diet and nutritional supplements. The DON said a nurse should have ensured Resident #77 was given his/her nutritional shake to ensure all his/her nutritional needs were met. During an interview on 12/15/23 at 1:42 P.M., the Registered Dietitian (RD) said a risk of a resident getting the wrong tray or a meal without certain items is malnutrition. The RD said she would not want a resident to miss even one supplement if ordered for nutritional purposes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure drugs and biologicals were stored in accordance with acceptable professional standards of practice. Specifically,1.) The facility failed to ensure medications with short expiration were dated once opened according to manufacturer's guidelines in three out of three medication carts observed.2.) The facility failed to ensure medication and treatment carts were locked when unattended.Findings include: Review of the policy title 'Storage and Expiration Dating of Medications and Biologicals', dated 6/30/25, indicated the following: -Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened. -Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents or visitors. 1. On 12/10/25 at 6:39 A.M., the surveyor and Nurse #10 observed the following in the medication cart on the Two [NAME] Unit. 1 bottle of [NAME] eye drop opened and undated. 1 Flonase 50 (microgram) mcg opened and undated. During an interview on 12/10/25 at 6:45 A.M., Nurse #10 said eye drops and nasal spray should be dated when opened. On 12/10/25 at 6:50 A.M., the surveyor and Nurse #5 observed the following in the medication cart on the Two East Unit. 1 bottle of latanoprost 0.005% eye drop opened and undated. During an interview on 12/10/25 at 6:55 A.M., Nurse #5 said eye drops should be dated when opened. On 12/10/25 at 7:15 A.M., the surveyor and Nurse #6 observed the following in the medication cart on the One [NAME] Unit. 1 bottle of latanoprost 0.005% eye drop opened and undated. During an interview on 12/10/25 at 7:20 A.M., Nurse #6 said eye drops should be dated when opened. During an interview on 12/10/25 at 12:15 P.M., the Director of Nursing said medications with short expiration date like inhalers, nasal sprays and eye drops should be dated once opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) On 12/9/25 at 2:05 P.M., the surveyor observed that a medication cart on the Two [NAME] unit was unlocked without any staff within view of the medication cart. The surveyor opened the medication cart and observed multiple medications within the drawers. During an interview on 12/9/25 at 2:07 P.M., Nurse # 12 said she should have locked the medication because it was unattended but did not. On 12/10/25 at 2:06 P.M., the surveyor observed that a medication cart on the Two East unit was unlocked without any staff within view of the medication cart. The surveyor opened the medication cart and observed multiple medications within the drawers. There was a resident standing right next to the unlocked medication cart without any staff present. During an interview on 12/10/25 at 2:08 P.M., Unit Manager #2 came down the hallway and said the cart was not hers, but it should have been locked because it was unattended. During an interview on 12/10/25 at 2:12 P.M., Nurse #1 said it was her medication cart and she should have locked it because it was unattended while she was in a room down the hall but did not. On 12/15/15 at 9:55 A.M. to 10:05 A.M., the surveyor observed the Wound Nurse leave the treatment cart on the Two East unit, which the surveyor observed had contained both topical medications and treatment supplies, unlocked and unattended while she completed a dressing change in a resident room with the door closed. During an interview on 12/15/25 at 10:37 A.M., Nurse #1 said she should have locked the treatment cart when she was in the resident room with the door closed because it was unattended but did not. On 12/9/25 AT 2:05 P.M., the surveyor observed that a medication cart on the Two East unit was unlocked without any staff within view of the medication cart. The surveyor opened the medication cart and observed multiple medications within the drawers. During an interview on 12/16/25 at 11:18 A.M., Nurse #16 said he should have locked the medication cart because it wasn't within his view but did not. During an interview on 12/11/25 at 1:54 P.M., the Director of Nursing (DON) said medication and treatment carts should be locked when unattended by the nurse responsible for it.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interviews and test trays, the facility failed to provide meals that were palatable in temperature on three out of three units and texture in one out of one altered texture meal tested. Findings include:Review of the form titled, Daily Food Temperature Charting (Test Tray), undated indicated the following:-Service Standards (once tray arrives to unit) - Temperatures:-Hot entree, starches, vegetables: Goal: >/= (over or equal to) 130 degrees Fahrenheit, Acceptable: 125-129 degrees Fahrenheit, Unacceptable: 120-124 degrees Fahrenheit, unacceptable < (less than) 120 degrees Fahrenheit-Cold food & cold beverages: Goal: </= 45 degrees Fahrenheit, Acceptable: 48-50 degrees Fahrenheit, Unacceptable: 51-54 degrees Fahrenheit, Unacceptable >/= 55 degrees Fahrenheit.-Hot beverages: Goal 130-140 degrees Fahrenheit, Acceptable 120-130 degrees Fahrenheit, Unacceptable, <120 degrees Fahrenheit. A resident group meeting was held on 12/10/25 at 1:30 P.M. During this meeting, 8 out of 11 residents said the food at meals was often cold. The following test tray observation took place on 12/11/25 at 8:08 A.M., on the Two East Unit:The meal truck arrived on the unit at 8:10 A.M. and the last meal was passed out at 8:43 A.M., 33 minutes later.A test tray was conducted 8:43 A.M., with the following temperatures recorded: Eggs covered in cheese were 80 degrees Fahrenheit and tasted rubbery and lukewarm not hot. Bacon was 78 degrees Fahrenheit and tasted chewy and cool not hot. Toast was 74 degrees Fahrenheit and tasted cool. Oatmeal was 94 degrees Fahrenheit and tasted lukewarm not hot. The following test tray observation took place on 12/11/25 at 7:50 A.M., on the Two [NAME] Unit:The meal truck arrived on the floor at 7:55 A.M., and the last tray was passed at 8:08 A.M., 13 minutes later.A test tray was completed at 8:08 A.M., with the following temperatures recorded: Egg with cheese was 92 degrees Fahrenheit and tasted cool not hot.Toast was 93 degrees Fahrenheit and tasted cool. Oatmeal was 90 degrees Fahrenheit and tasted warm not hot.Apple juice was 58 degrees Fahrenheit and tasted warm not cold. A second test tray observation took place on 12/11/25 at 8:13 A.M., on the Two [NAME] Unit. Pureed toast was 130 degrees Fahrenheit and tasted warm, however, was thick and sticky and difficult to swallow. Oatmeal was 118 degrees Fahrenheit and tasted lukewarm not hot. The following test tray observation took place on 12/11/25 at 7:55 A.M., on the One [NAME] Unit:The meal truck arrived on the floor at 8:17 A.M., and the last tray was passed at 8:36 A.M., 19 minutes later.The test tray was completed at 8:36 A.M., with the following temperatures recorded: Egg with cheese was 105 degrees Fahrenheit and tasted cool. Toast was 100 degrees Fahrenheit and tasted cool and bland. Bacon was 97 degrees Fahrenheit and tasted cold. During an interview on 12/11/25 at 9:06 A.M., the Food Service Director said hot foods should temp at above 135 degrees Fahrenheit and cold foods should temp lower than 40 degrees Fahrenheit. The surveyor shared the results of the test tray with the Food Service Director and he said those temperatures were unacceptable and that trays sitting on the units for a delayed amount of time would cause unacceptable temperature ranges of foods when the residents are given their meals.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store and handle food in accordance with professional standards for food service safety. Specifically, the facility failed to:1) Ensure shelves on which food was stored were clean/free of possible contaminants, and that food was stored, labeled and dated properly in the main kitchen and in three of three unit kitchenettes. 2) Ensure staff did not handle ready-to-eat food with contaminated gloves. Findings include: 1. Review of the facility policy titled, Resident Personal Food Storage Policy & Procedure, dates 2/2025, indicated the following:-Resident food and beverage items stored in the unit kitchenettes must be clearly marked with the resident's name and the date the item was placed in the kitchenette. On 12/9/25 at 7:21 A.M. the surveyor made the following observations during the initial walkthrough of the main kitchen:A gray wispy substance present on the shelves in the walk-in refrigerator, there was food stored above and below the gray wispy substance.An undated pan containing yellow liquid in the walk-in refrigerator.An undated pan containing cooked green beans in the walk-in refrigerator.An undated take-out container with left-over macaroni and cheese in the walk-in refrigerator.A container labeled crab salad, dated 12/3/25, in the walk-in refrigerator.An undated pan of food consistent in appearance with tuna salad in the walk-in refrigerator.An undated container of macaroni salad in the walk-in refrigerator, the container was not wrapped or covered.Uncooked bacon open but undated in the walk-in refrigerator.A bag of mozzarella cheese open but undated in the walk-in refrigerator.An undated pan containing a thick yellow liquid consistent in appearance with egg in the walk-in refrigerator.Two open but undated containers of orange juice in the reach-in refrigerator.An open but undated container of nectar-thick juice in the reach-in refrigerator.Sliced ham open but undated in the reach-in refrigerator.Sliced turkey open but undated in the reach-in refrigerator. Two packages of open but undated sliced cheese in the reach-in refrigerator.A container of potato salad dated 12/3 in the reach-in refrigerator.A container of pudding dated 11/29 in the reach-in refrigerator.Dry pasta open but undated in the dry storage area.A package of undated hot dog buns in the dry-storage area.Three cans (mandarins, cranberry sauce and sweet potato) with significant dents stored on the can-rack in the dry storage area. During an interview on 12/9/25 at 7:54 A.M., the kitchen supervisor said that all food should be labeled and discarded after three days, that shelving in the walk-in refrigerator should be washed and that dented cans should be set aside and not placed on the can-rack. On 12/9/25 at 8:03 A.M. the surveyor made the following observations in the One [NAME] unit kitchenette refrigerator:An undated container of food with a Resident's room number and name written on it.An open container of cous-cous with a best-by date of 10/2/25.Four open but undated containers of cranberry juice.One open container of cranberry juice dated 11/24. On 12/9/25 at 8:19 A.M. the surveyor made the following observations in the Two East unit kitchenette:An undated half of a blueberry muffin.Three containers of active food thickener powder with expiration dates of October 2025.Three opened but undated thickened cranberry juices in the refrigerator.Two open but undated containers of cranberry juice in the refrigerator.One open but undated container of apple juice in the refrigerator.An undated creamy food substance wrapped in tinfoil in the refrigerator. On 12/9/25 at approximately 8:30 A.M. the surveyor made the following observations in the Two [NAME] unit kitchenette:An undated and unrefrigerated apple pie.Chocolate cake with a sell-by date of 12/8.An undated and unrefrigerated bacon egg and cheese bagel sandwich.An undated plastic tub containing hardboiled eggs in the refrigerator.An undated container of food consistent in appearance with cooked sweet potatoes in the refrigerator.An undated plastic bag containing leftover food in the refrigerator.French onion dip open but undated in the refrigerator. Two open but undated containers of apple juice in the refrigerator.One open but undated container of cranberry juice in the refrigerator.One container of thickened apple juice with an expiration date of 12/3/25 in the refrigerator. During an interview on 12/9/25 at approximately 8:35 A.M., Nurse #3 said staff must date Resident food and opened juices and that the bacon egg and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cheese sandwich should have been refrigerated. During an interview on 12/11/25 at 9:06 A.M., the Food Service Director (FSD) said that the walk in is cleaned weekly and the temperature of the walk-in had been too high, creating the gray substance on the shelves, which he believed was most likely mold. He said that food should not have been stored underneath this substance. The FSD said all food must be labeled when opened and discarded after three days, that dented cans should not be in rotation to be served and that any dented cans should be taken out of rotation. The FSD also said kitchenettes on the units were cleaned by the housekeeping staff but he is in charge of stocking the kitchenettes and maintaining inside of the refrigerators. The FSD said all food in the kitchenette also had to be labeled with a resident's name if it was personal food, and all food must be labeled when opened and discarded after three days. 2. The facility did not provide a policy for food handling to the surveyor. On 12/11/25 at 7:37 A.M., the surveyors observed the food preparation line with the following observations:The cook washed her hands, put on gloves, and touched the lid to the plate holder, the countertop and serving utensils, potentially contaminating her gloves. The cook then began to serve food using the same contaminated gloves and did not use a utensil to serve the toast, touching all pieces of the ready-to-eat toast served throughout meal. Using the same potentially contaminated gloves, the cook touched four pieces of bacon when placing them onto a resident's plate. In the middle of meal service, the cook took off her gloves, washed her hands and put on a new pair of gloves. She then touched the countertop, serving utensils and plates, potentially contaminating her gloves and then continued to use her gloved hands to serve the ready-to-eat toast. During an interview on 12/11/25 at 9:06 A.M., the Food Service Director (FSD) said that once gloves were put on, if the person touches any other surface than food, the gloves were contaminated, and the person should not handle food with those gloves.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain accurate medical records for two Residents (#111 and #32) out of a total sample of 30 residents. Specifically, 1) For Resident #11, the facility failed to accurately document the completion of a left heel wound treatment2) For Resident #32, the nurses documented the topical medication Flagyl (an antibiotic medication) inaccurately, when they documented that it was administered when it was not. Findings include:1. Resident #111 was admitted to the facility in March 2023, with diagnoses of dementia and chronic kidney disease. Review of Resident #111's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a score of 0 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #111 was dependent on staff for all functional daily tasks including bed mobility. Review of Resident #111's physician orders indicated the following order: L (left) heel stage 3 wound EVERY DAY ON DAY SHIFT, cleanse with vashe, apply iodsorb apply ABD pad (a sterile dressing) and wrap with gauze daily, [NAME] (as needed) for soiling, saturation, and accidental removal, initiated 11/12/25. Review of the Treatment Administration Record for December 2025 indicated Nurse #1 had marked the left heel wound treatment as completed on 12/9/25. On 12/10/2025 at 10:55 A.M., the surveyor observed the wound dressing changes for Resident #111's left heel wound with Nurse #1. The Resident's left heel had a dressing dated 12/8/25, two days prior. At the time of this observation, Nurse #1 said she is unsure of what the treatment orders are for the left heel. Nurse #1 said she also worked yesterday on 12/9/25 and took care of Resident #111. Nurse #1 said she did not complete the ordered wound treatments on 12/9/25. Nurse #1 said the facility has a wound nurse and she was told the wound nurse completes all wounds. Nurse #1 was unaware the wound nurse did not complete the wound treatment on 12/9/25. Nurse #1 said she should not have marked the order as completed if she had not actually completed the treatment. During an interview on 12/11/25 at 7:42 A.M., the Director of Nursing said a nurse should never document a treatment order as complete if they had not done the treatment. 2.) Resident #32 was admitted to the facility in September 2018 with diagnoses including dementia and malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/26/25, indicated Resident #32 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 3 out of 15. This MDS also indicated Resident #32 had an unstageable pressure ulcer. On 12/15/25 at 9:33 A.M., the surveyor observed the Wound Nurse complete the wound dressing change for Resident #32's coccyx pressure ulcer. After the Wound Nurse gathered dressing supplies, the surveyor observed her approach Unit Manager #2 requesting the Flagyl that was indicated to be used in active physician's order. Unit Manager #2 told the Wound Nurse the Flagyl had been (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discontinued the day prior, but she forgot to put the new order into the electronic medical record. The surveyor then observed the Wound Nurse complete Resident #32's wound dressing change without Flagyl. During a follow-up interview on 12/15/25 at 10:07 A.M., Unit Manager #2 said the Weekend Supervisor told her to discontinue the order yesterday, but she forgot to put it in the electronic medical record. Unit Manager #2 said she did not implement Flagyl in Resident #32's coccyx wound the day before (12/14/25), even though she documented that she had. During an interview on 12/15/25 at 10:43 A.M., the Weekend Supervisor said he asked Unit Manager #2 to follow-up regarding Resident #32's Flagyl order because it was input incorrectly in the electronic record, resulting in it not being sent by the pharmacy. The Weekend Supervisor said he was told by the nurses that there was no Flagyl available for Resident #32's wound treatment and that the Resident was not receiving the Flagyl as ordered by the physician. The Weekend Supervisor said he never personally contacted the pharmacy or a physician to clarify to order or notify them that they Flagyl was unavailable, but Unit Manager #2 was supposed to. Review of Resident #32's physician's orders indicated: Cleanse wound to coccyx with vashe (a wound cleanser), cleanse soak with vashe for 10 minutes apply hydrofera blue (an antibacterial foam wound dressing) to the wound secure with SAD (super absorbent dressing), change daily, initiated 12/15/25. Cleanse wound to coccyx with vashe cleanse soak with vashe for 10 minutes applying crushed Flagyl, hydrofera blue to the wound secure with SAD, initiated 12/2/25 and discontinued 12/15/25. Review of Resident #32's treatment administration record, dated 12/9/25 to 12/14/25, indicated the treatment to Cleanse wound to coccyx with vashe, cleanse soak with vashe for 10 minutes applying crushed Flagyl, hydrofera blue to the wound secure with SAD (super absorbent dressing), Change daily and PRN was documented as implemented as ordered: 12/9/25 by Nurse #7 12/10/25 by Unit Manager #2 12/11/25 by Unit Manager #2 12/12/25 by Unit Manager #2 12/13/25 by a nurse unable to be interviewed 12/14/25 by Unit Manager #2 During an interview on 12/15/25 at 11:43 A.M., Unit Manager #2 said she implemented Resident #32's coccyx wound dressing treatment on 12/10/25, 12/11/25, 12/12/25, and 12/14/25 but did not administer the Flagyl because it was unavailable. Unit Manager #2 also said even if there was Flagyl she couldn't have implemented it because the wound was so deep she would have to put Resident #32's leg over his/her head because the Flagyl wouldn't even fit in the wound. Unit Manager #2 said she never notified the provider but that she probably should have since it had not been implemented (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	since at least 12/10/25. Unit Manager #2 further said she should not have documented it as implemented since she did not implement it. During an interview on 12/15/25 at 11:55 A.M., Nurse #7 said she implemented Resident #32's coccyx wound dressing treatment on 12/9/25. Nurse #7 said she did not implement flagyl, even though it was a part of the physicians order, because it was not available. Nurse #7 said she passed along that it was unavailable in report, but she didn't personally notify the pharmacy or notify the physician because she did not have time. Nurse #7 further said she should not have documented it as implemented since she did not implement it. Review of Resident #32's medical record failed to indicate that flagyl was not implemented during the wound treatment, the flagyl was unavailable or unable to be administered, or that a provider was notified regarding any flagyl concerns. During an interview on 12/15/25 at 12:31 P.M., the Director of Nursing (DON) said Resident #32 should have had flagyl implemented in the wound daily. The DON said she contacted the Nurse Practitioner who said the flagyl should have been implemented since 12/2/25 and should not have been discontinued on 12/15/25. The DON said the Wound Nurse Practitioner had been on vacation since 12/9/25, and in her absence she would expect all nurses to contact the house Nurse Practitioner for wound concerns. The DON further said the nurses should not have documented it as implemented when they did not.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to develop, implement and maintain a Quality Assurance and Performance Improvement (QAPI) program which focuses on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility failed to ensure a QAPI plan was implemented and addressed concerns regarding Activities of Daily Living (ADL) care in the facility, when a.) staff identified the inability to provide the frequency of ADL care needed on the Dementia Specialty Care Unit (DSCU) and b.) nursing identified there was a problem with wound care. Findings includeReview of the policy titled Quality Assurance and Performance Improvement Procedure, dated 02/2025, indicated:PURPOSE: The facility will develop, implement and maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. Quality Assurance and Performance Improvement is a management process that is ongoing, multi-level, comprehensive and facility wide. It deals with full range care and services offered by the facility, including the full range of departments. It encompasses managerial, administrative, clinical, system of care, quality of life, resident choices and environmental services, as well as the performance of outside (contracted) providers and suppliers of care and services. The purpose is continuous evaluation of facility systems with the objective of:Keeping systems functioning satisfactorily and consistently including maintaining current practice standards.Preventing deviation from care processes arising, to the extent possible.Discerning issues and concerns, if any, with the facility systems and determining if issues/concerns are identified. Correcting inappropriate care processes.Focusing on quality of life and allowing resident choice to extent (sic) possible without compromised outcomes. Adverse event monitoring data review to develop activities to prevent adverse event. Create systematic approach to determine underlying causes of problems, impacting larger problems. On 12/17/25 at 12:40 A.M., the survey team met with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) to review the facility's QAPI program. The NHA said that the QAPI team meets quarterly, but should probably meet monthly. The DON said that she presently does not have a QAPI plan for Activities of Daily Living (ADL) care or wound care, but should. The DON said:a.) The lead Certified Nursing Assistant (CNA) #1 on the facility's Dementia Specialty Care Unit is a big resident advocate and that CNA #1 has expressed concern regarding the staff's ability to provide the needed ADL care, such as incontinence care, as often as they should, due to the number of CNAs and high care needs of the unit's residents. The DON said that her hands are tied with the facility's PPD (Patients Per Day=a metric used in nursing homes that measures the average number of patients cared for by staff on any given day. The PPD reflects the average number of patients per staff member). b.) She had a QAPI early in 2025 for skin but that it fell off for no particular reason. The DON said that the communication issues in the building are a big part of the problem and expressed that she feels very frustrated with the nurses because you can educate them till you are blue in the face and the issues persist. The DON indicated that a wound nurse was hired 9/2/25 due to significant concerns regarding wound care in the facility and that at that time that should have triggered her to start a wound QAPI. She said that the wound nurse has been communicating to her that she had concerns within the building regarding to the lack of communication from nurses regarding wounds and regarding staff competency for wound care. The NHA reviewed the active QAPI's and said that the facility had a QAPI between March and June 2025 regarding skin checks not being done. The DON added that a QAPI should have been in place to address these ongoing repeat issues that are not getting resolved with ADL care and wound care

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. Specifically,1a.) For Resident #111, the facility failed to implement enhanced barrier precautions.1b.) For Resident #66, the facility failed to implement enhanced barrier precautions.2.) The facility failed to ensure the nurse changed gloves between removing/handing a dirty dressing and applying a clean dressing to a pressure wound.3.) The facility failed to ensure staff performed hand hygiene before applying and after removing gloves during wound care.4.) The facility failed to ensure a nurse did not pour pills directly onto her laptop keyboard. Findings include: 1.) Review of the facility policy titled Enhanced Barrier Precautions, revised December 2024, indicated: Enhanced barrier precautions (EBP) apply when: a resident is NOT known to be infected or colonized with any MDRO (multi-drug-resistant organism), has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or maintained. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing linens, wound care. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE (personal protective equipment) required. 1a.) Resident #11 was admitted to the facility in March 2023 with diagnoses including a stage three pressure ulcer and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/10/25, indicated Resident #111 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 0 out of 15. This MDS also indicated Resident #111 had a pressure ulcer/injury. Review of Resident #111's Wound Nurse note, dated 10/28/25, indicated: Stage 3 open area to the back of outer left foot. Review of Resident #111's active physician's orders on 12/10/25 failed to indicate use of enhanced barrier precautions. Review of Resident #111's active plan of care on 12/10/25 failed to indicate use of enhanced barrier precautions. On 12/10/25 at 10:42 A.M., the surveyor entered Resident #111's room, there was no sign that indicated the need for any special precautions on or near the doorway. On 12/10/25 at 10:43 A.M., the surveyor observed Nurse #1 and Certified Nurse Assistant (CNA) #3 providing incontinence care to Resident #111. Nurse #1 said Resident #3 had multiple pressure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wounds. Nurse #1 and CNA #3 both had gloves on but were not wearing precaution gowns. On 12/10/25 at 2:10 P.M., the surveyor observed Nurse #1 and CNA #3 assisting Resident #111 with bed mobility. Nurse #1 and CNA #3 both had gloves on but were not wearing precaution gowns. During an observation of wound dressing change on 12/10/25 at 2:13 P.M., Nurse #1 gathered wound dressing supplies and then put on a precaution gown and gloves to enter the room. Nurse #1 said she needed to wear a precaution gown because enhanced barrier precautions are required for wound care. Nurse #1 said she didn't know why there was no sign or a physician's order for enhanced barrier precautions, but since other facilities would require it, she knew she should put on the precaution gown on to provide wound care. During an interview on 12/10/25 at 1:08 P.M., the Director of Nursing (DON) said residents with chronic wounds should be on enhanced barrier precautions while providing incontinence care, removing incontinence briefs, and/or repositioning in bed. During a follow-up interview on 12/11/25 at 11:07 A.M., the DON said Resident #111 should have been on enhanced barrier precautions but was not. 1b.) Review of the facility policy titled 'Handwashing/Hand Hygiene', revised October 2023, indicated: Hand hygiene is indicated: after contact with blood, body fluids, or contaminated surfaces, after touching a resident; immediately after glove removal. Resident #66 was admitted to the facility in April 2024 with diagnoses including obstructive and reflux uropathy. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/19/25, indicated Resident #66 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 14 out of 15. This MDS also indicated Resident #66 had an indwelling urinary catheter. During an interview on 12/10/25 at 6:59 A.M., Resident #66 was observed in his/her room with the urinary catheter drainage bag hanging from a trash can that was filled with trash. Resident #66 said staff put the catheter on the trash can and sometimes they put it on the floor if urine isn't draining adequately. Resident #66 said staff often does not wear precaution gowns while emptying his/her urinary catheter bag. Review of Resident #66's physician's order, initiated 9/4/24, indicated: Enhanced Barrier Precautions, every shift, for Foley (indwelling urinary) catheter. Review of Resident #66's plan of care related to infection risk r/t (related to) Foley (indwelling urinary) catheter, revised 9/3/25, indicated: Enhanced Barrier Precautions as appropriate to prevent and control transmission of infectious agents during care r/t foley catheter. On 12/9/25 at 9:06 AM, the surveyor observed a staff member kneeling on the floor emptying urine from a urinary catheter drainage bag. This staff member had gloves on but was not wearing a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precaution gown. On 12/10/25 at 7:01 A.M., Certified Nurse Assistant (CNA) #11 said she put the urinary catheter drainage bag on the trash can because the urine wasn't draining. CNA #11 was observed handling the urinary catheter bag with bare hands. CNA #11 touched the spout, where urine is drained from, and moved the urinary catheter drainage bag off the trash can and onto the bed frame. CNA #11 was not wearing a precaution gown or gloves. CNA #11 left room and began touching the laundry cart outside without performing any hand hygiene. During an interview on 12/10/25 at 7:16 A.M., Nurse #10 said the urinary catheter drainage bag or tubing should never be stored on the floor or hanging from a trash can because of risk of infection or injury from it pulling. Nurse #10 said the CNA should never put it on the trash can. Nurse #10 said staff should wear a precaution care when providing care to a urinary catheter. Nurse #10 said CNA should not have touched the urinary catheter drainage bag or spout without gloves, and further said she should have performed hand hygiene immediately after touching it and before leaving the Resident's room and touching the laundry cart. During an interview on 12/10/25 at 1:08 P.M., the Director of Nursing (DON) said residents with indwelling urinary catheters should be on enhanced barrier precautions while performing any urinary catheter care. The DON said staff should have been wearing a precaution gown while emptying Resident #66's indwelling urinary catheter drainage bag. The DON said the urinary catheter drainage bag should not have been hanging or touching a trash can. The DON further said the CNA should not have handled the urinary catheter drainage bag with bare hands and should have performed hand hygiene before leaving the Resident's room and touching the laundry cart. 2.) Review of the facility titled 'Dressings, Dry/Clean', revised September 2013, indicated: Steps in the Procedure: 6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. 9. Open dry, clean dressing(s) by pulling the corners of the exterior wrapping outward, touching only the exterior surface. 10. Label tape or dressing with date, time and initials. Place on clean field. 11. Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze). 12. Wash and dry your hands thoroughly. 13. Put on clean gloves. On 12/10/25 at 2:21 P.M., the surveyor observed Nurse #1 perform a dressing change to a stage three pressure wound on a resident's heel. Nurse #1 removed a dressing, which was soiled with brown drainage and cleansed the wound with a wound cleanser using gauze, contaminating her gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #1 did not remove/change her gloves or perform hand hygiene before continuing to apply a new clean dressing. During a follow-up interview on 12/10/25 at 2:25 P.M., Nurse #1 said she should have changed her gloves and performed hand hygiene after removing the dirty dressing and before applying the new, clean dressing. During an interview on 12/11/25 at 11:07 A.M., the Director of Nursing (DON) said Nurse #1 should have changed her gloves and performed hand hygiene after removing the dirty dressing and before applying the new, clean dressing. 3.) Review of the facility policy titled 'Handwashing/Hand Hygiene', revised October 2023, indicated: Hand hygiene is indicated: after contact with blood, body fluids, or contaminated surfaces, after touching a resident; immediately after glove removal. The use of gloves does not replace hand washing/hand hygiene. On 12/15/25 at 9:33 A.M., the surveyor observed the Wound Nurse perform a wound dressing change to an unstageable pressure ulcer on a coccyx. The Wound Nurse unfastened the resident's incontinence brief, which contained loose feces, and removed a dressing and an approximately six-inch-long thin strip of a white fabric-like material from inside the coccyx wound, both of which were soiled with brown drainage, contaminating her gloves. The Wound Nurse then removed gloves and did not perform hand hygiene prior to applying a new pair of gloves. The Wound Nurse then cleansed the wound with wound cleanser and gauze. The Wound Nurse then removed gloves and did not perform hand hygiene prior to applying a new pair of gloves. The Wound Nurse then rearranged dressing supplies, touched the bed remote control to adjust height of bed, and prepared dressing supplies. The Wound Nurse then again removed gloves and did not perform hand hygiene prior to applying a new pair of gloves. The Wound Nurse then cleansed the wound again and said this was because the feces present in the incontinence brief may have contaminated the wound. The Wound Nurse then removed gloves and did not perform hand hygiene prior to applying a new pair of gloves. The Wound Nurse applied a clean dressing to the wound. The Wound Nurse then again removed gloves and did not perform hand hygiene prior to applying a new pair of gloves. The Wound Nurse then refastened the incontinence brief, which contained loose feces, on the resident. The Wound Nurse then performed hand hygiene and left the room. The Wound Nurse did not perform any hand hygiene after removing gloves and before applying new ones during five glove changes. During a follow-up interview on 12/15/25 at 10:37 A.M., the Wound Nurse said she should have performed hand hygiene in between glove changes but did not. During an interview on 12/15/25 at 12:31 P.M., the Director of Nursing (DON) said the Wound Nurse should have performed hand hygiene before applying and after removing gloves during wound care. 4.) During an observation on 12/16/25 at 8:07 A.M., the surveyor observed Nurse #15 at her medication cart with pills popped onto the laptop keyboard in front of her. During an interview on 12/16/25 at 8:08 A.M., the Nurse #15 said that she should be popping the pills into a cup, not onto her keyboard. During the interview Nurse #15 was observed to use her bare hands to split the pills and empty the contents of the pills into a small plastic cup. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, record reviews and interviews, the facility failed to ensure one Resident (#36) out of a total sample of 30 residents did not self-administer medication without an assessment or physician's order.Findings include: Review of the facility policy titled Medication Administration/Self Administration policy, revised 7/2012, indicated the following:-Upon admission or upon request, the residents will be advised of their right to self-administer medications. The residents will review the implementation of self-medication and the self-administration of medication form #ADM-G26. Form is to be completed and added to the resident's record. Facility's case management team will determine upon completion of the nursing assessment form. Evaluation of Resident's Ability to Safely Self-Administer Medications. (Form #CN-070) whether the resident is safe in carrying out the self-administration practice.The decision of the case management team will be discussed with the resident and recorded on the self-administration of medications form and placed in the residence medical record. The physician's order will reflect the self-administration approval and practice. If the resident is able to self-medicate, the medications will be placed in a locked compartment at his/her bedside. The residents' care plan will be updated to reflect his/her ability to self-medicate. Resident #36 was admitted to the facility in October 2025 with diagnoses including chronic obstructive pulmonary disease and acute respiratory failure. Review of the Minimum Data Set (MDS) assessment, dated 10/28/25, indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam indicating intact cognition. On 12/9/25 at 8:19 A.M., the surveyor observed an Albuterol sulfate inhaler (used for treating respiratory diseases) on Resident #36's over the bed table. Resident #36 said the nurses knew he/she had the inhaler and that he/she would not give it to the nurses to keep in the medication cart as it is called a rescue inhaler for a reason. On 12/10/25 at 1:38 P.M., the surveyor observed the albuterol sulfate inhaler on Resident #36's over the bed table. On 12/11/25 at 2:08 P.M., the surveyor and Nurse #9 observed the albuterol sulfate inhaler on the over the bed table. Resident #36 told the nurse he/she was going to continue to keep it. Review of the medical record failed to indicate that Resident #36 had been assessed for the ability to self-administer medications. Further review of the medical record failed to indicate a physician order indicating the Resident could self-administer medication and store by bedside. Review of Resident #36's active care plan failed to indicate a plan of care for the self-administration of medications. During an interview on 12/11/25 at 2:10 P.M., Nurse #9 said residents who would like to keep medication by bedside require an assessment. She said she wasn't sure if Resident #36 had an assessment for self-medication administration. During an interview on 12/12/25 at 10:06 A.M., the Director of Nursing said residents who self-administered medications required an assessment and a physician order. During an interview on 12/12/25 at 10:23 A.M., Unit Manager #1 said if a resident wanted to keep medication by bedside for self-administration that an assessment would be done with the observation of return demonstration, a care plan would be initiated, and a physician order would be obtained. She further said she was aware Resident #36 had the albuterol inhaler by bedside and that the Resident gets very upset if anyone tries to take it away from him/her.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview the facility failed to ensure for one Resident (#3) out of a total sample of 30 residents, that the facility's abuse policy was implemented following an allegation of abuse. Findings include:The facility policy titled Abuse Prevention Policies and Procedures, dated 11/2024, indicates the following:Upon the observation/allegation/formed suspicion of resident abuse, the supervising staff ensure the safety of all residents and then initiates the investigation through recording known information on the Quality Assessment and Assurance Incident Report, and if an injury of unknown origin is identified, the Injury of Unknown Origin Investigation form.During the course of any investigation into allegations of resident abuse, it is the policy of the facility to protect residents from harm during investigations. Review of the policy titled Reporting Resident Neglect/Abuse, dated 2/2025, indicated:1.The Executive Director/Director of Nursing must investigate any suspicion of resident neglect/abuse.2.In the event that any staff member believes that a resident of the facility has been abused, mistreated or neglected, the individual is required to notify their direct supervisor who will notify the Executive Director/Director of Nursing.A. The Executive Director/Director of Nursing must investigate any allegation to determine the validity of the complaint. During this process, the accused individual may be suspended without pay until a formal determination is made. Review of the Quality Assurance and Performance Improvement, Procedural and Investigational Guide: Allegations of Resident/Participant Abuse, Neglect and Mistreatment, dated 2/2025, indicated the following:3. Conduct an interview of the accuser/alleged victim as soon as possible following the allegation. Consider utilizing a clinical staff member, nurse or social worker, with whom the resident has formed a trusting relationship. Document the interview in detail, using direct resident quotes if possible, on form CAD-066. More than one investigation of the resident may be required as the investigation develops.4. Identify staff who require interviews, and from whom statements should be obtained. More than one interview of staff members may be required as the investigation develops. Are all statements signed and dated, and on the Employee Statement Form, CAS-066.7. Create a folder which contains investigation documents:the schedule for the affected time periodcopies of the Nurse Aide Registry and proof of CORI check completed on hire for the accuseda current Nurse Aide Registry check for the accuseda printout of on-line learning system completed courses for the accuse, reviewed to ensure that the accused is current in Abuse Prevention and Reporting Procedures and Resident Rightsall written, signed and dated statements from staff, other witnesses, and/or from resident (s)staff interviews documented by managementFlash Drive (or reference to location of electronic file) of video related to the allegation, if available, and if used in determination of the investigation outcome.copies of emails, text messages, and/or other documents which contain communications and/or information relevant to the accusation, if available and if used in determining investigation outcomemedical record documentation including EHR reports and other documentation used or considered when determining the investigation outcomethe printed report submitted via the online reporting systemcopies of any disciplinary actions directly resulting from the eventcopies of re-in-servicing completed as a result of the event8. Verify that all documents within the folder are signed and dated by the author, and/or are dated for the date in which they were received by management. Resident #3 was admitted to the facility in July 2025 and has diagnoses that includes depression and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/19/25 indicated that on the Brief Interview for Mental Status exam Resident #3 scored an 11 out of a possible 15, indicating moderately impaired cognition. The MDS indicated Resident #3 had no behaviors. During an interview on 12/9/25 at 10:28 A.M. Resident #3 said he/she got slapped by the aide that was taking care of him/her, that the facility staff were aware because he/she had told everybody and that the police were called. During an interview on 12/9/25 at 12:33 P.M. Resident #3's spouse said that a few weeks ago Resident #3 had told the spouse that the staff member feeding him/her had slapped him/her but that Resident #3 could not remember who slapped (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/her. Resident #3's spouse said that he/she had told the nurse and social worker right away who then called the police. Review of the Activities of Daily Living care plan, initiated 7/1/25, indicated that for eating Resident #3 requires supervision with cueing to increase PO (by mouth) intakes. Review of the Advanced Directive care plan, initiated 8/1/25, indicates Resident #3 was his/her own responsible party. Further review of the care plan failed to indicate Resident #3 had impaired cognition. As well, the care plan failed to indicate Resident #3 had a behavior care plan in place until 11/19/25, the day after she made an allegation of abuse. At that time the record indicated a care plan for accusatory behavior toward staff was initiated. Review of the clinical record failed to indicate an allegation of abuse was made by Resident #3 on 11/18/25, or that the facility Social Worker was seeing Resident #3 or providing support following the allegation. Review of the facility's investigation regarding an allegation of abuse by Resident #3 included the following statements:A statement from Resident #3's Nurse #15 on 11/18/25. On 11/18/25 Nurse #15 wrote: After breakfast pt (patient) began crying stating CNA (Certified Nursing Assistant) staff member force fed him/her. Pt calmed down after asking him/her what happened. I let him/her know that CNA would not be allowed back into room to feed him/her (sic). During lunch time when husband came in Pt disclosed that CNA from morning feeding had 'slapped me across the face'. I did not hear or see any type of indication in regard to assault, nor was I present during meal time as I was on break during lunch feeding time. I reported the incident immediately to the DON. Pt did not present with any injuries.A statement dated 11/19/25, typed by the DON from the CNA (#17) assigned to Resident #3 on 11/18/25. The statement reads CNA #17 was assigned to care for Resident #3 on the day of the accusation. She fed him/her breakfast and reports that there were no issues during that meal. She stated she went to provide full care after breakfast and removed a small pillow (commemorative of a family member) from the bed so she could wash and dress Resident #3. When CNA #17 moved the pillow Resident #3 began to cry and become very upset. CNA nurse #9 had come into the room to care for the roommate. CNA #9 reported to the nurse that Resident #3 was upset. CNA #17 said that after this crying incident, she was reassigned and did not care for Resident #3 for the rest of the day. She did not provide him/her lunch, not did she have anything else to do with Resident #3 for the rest of the shift. The statement is unsigned.A statement dated 11/18/25, typed by the DON from CNA #9. The statement reads On this date, I conducted a phone interview with CNA #9 regarding the allegations made by Resident #3. Per CNA #9, CNA #17 was assigned to Resident #3 that day and as CAN #9 entered the room to care for the roommate, she noted that Resident #3 was being washed and care for by CNA #17 but that Resident #3 started crying and was upset. CNA #9 was not sure who fed Resident #3 breakfast and stated she herself did not feed her lunch. CNA #9 left early and was unaware of the accusation. The statement was unsigned. Review of the clinical record indicated that CNA #17 documented having provided care to Resident #3 throughout the entire shift on 11/18/25. CNA #17 documented that Resident #3 was dependent for eating that day. Review of CNA #17's timecard indicates that on 11/18/25 she worked from 7:01 A.M., to 3:43 P.M. During an interview on 12/17/25 at 8:04 A.M., the facility Social Worker (SW) said that on 11/18/25 she was informed that Resident #3 reported that he/she was slapped by his/her CNA. The SW said that she went up to speak to Resident #3 and his/her spouse. The SW said that Resident #3 reported someone had slapped him/her during breakfast but couldn't say who it was or give her details and that Resident #3 was very vague and very confused which is his/her baseline. The SW said that she reported what was told to her by Resident #3 to the Director of Nursing (DON) and then was out of the loop for the remainder of the investigation. The SW said that whenever a resident alleges abuse she sees the resident in the days following and documents it in the progress notes. SW cannot say why there were no notes in Resident #3's record but said that she followed up with him/her following the allegation and that she was recently referred to see a psych therapist due to apathy and potential depression. According to the SW Resident #3 had never made an allegation of abuse prior to the report on 11/18/25 and had not made one since.During an interview on 12/17/25 at 8:27 A.M., the DON said that the facility process when there was an allegation of abuse was:The (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure that the resident is safe.The police are notifiedIf there is an accused staff person, they obtain a statement from them, and then immediately suspend the staff person and send them home pending investigation.The SW interviews the resident, staff that are working and other residents She files an initial report within 2 hours of receiving the allegation to DPH The DON investigation she provided was reviewed. The DON cannot say:Why the CNA in question continued to work and provide care to Resident #3.Why other resident's were not interviewed. Why the Nurse did not immediately report the allegation to her on the morning of 11/18/25She said that she then was busy and did not submit her final report (front page summary that she provided) until 12/9/25 due to being busy and just catching up. The DON said that this must be due to her misunderstanding of the facts that day. She said that she had no additional statements or information related to the investigation than what had been provided to the surveyors. During a follow-up interview on 12/17/25 at 10:00 A.M., the DON said that in hindsight the facility's abuse policy and procedure was not followed when the CNA continued to work and provide care pending an abuse allegation / investigation regarding her. During an interview on 12/17/25 at 10:07 A.M., Nurse #15 said that on 11/18/25 she was Resident #3's nurse and that a little after breakfast, around 10:00 A.M., it was reported to her that Resident #3 was crying hysterically and had reported to other CNAs and the other nurse that his/her CNA #17 had force fed him/her breakfast that morning. Nurse #15 said that she went to see Resident #3 and Resident #3 said that his/her CNA that day was being mean to him/her and had force fed him/her breakfast. Nurse #15 said that the Resident could not tell her the CNAs name, so she looked at the assignment and spoke to the assigned CNA #17. Nurse #15 said that the CNA #17 said that she didn't feed Resident #3 that day, so she said to that CNA, and all the other CNAs working that day, that only CNA #17 was to feed or care for Resident #3 for the remainder of the shift. According to Nurse #15 around lunchtime Resident #3's husband came in and Resident #3 complained again, and the DON was notified of the allegation shortly thereafter. Nurse #15 could not say why she did not notify the DON when the allegation was initially made that morning. Nurse #15 said that Resident #3 was pleasant and alert with some occasional confusion but is able to voice his/her concerns and needs to staff and has made no further allegations since that time. During an interview on 12/17/25 at 10:55 A.M., the Nursing Home Administrator (NHA) explained the facility process when an allegation of abuse was made. The NHA said once the allegation was received, they have the SW interview the resident, they get two to three interviews from any staff that were there, document the information, and follow the facility's abuse policy for reporting and investigating. The NHA said that it was her expectation that the facility's policy and procedure for abuse be implemented immediately.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview that facility failed to develop a discharge summary that included a recapitulation of a stay for one discharged Resident (#130) out of 3 discharge records reviewed. Findings include: Resident #130 was admitted to the facility in October 2025 and has diagnoses that includes Alzheimer's disease and Chronic Obstructive Pulmonary Disease. Review of the clinical record:- Failed to indicate a discharge note or discharge disposition.- Failed to indicate a recapitulation of Resident #130's stay was documented.- Failed to indicate a Physician's order for discharge.- Failed to indicate a discharge note from the Physician or Nurse Practitioner. During an interview on 12/11/25 at 11:07 A.M., and 2:15 P.M., the Director of Nursing (DON) said that upon discharge the facility should have developed a discharge packet for Resident #130 that included a medication list and a Page one & two (a recapitulation of the Resident's stay) as well as written a discharge note by nursing. The DON said that she reviewed Resident #130's record and in this case that did not happen.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews and record review, the facility failed maintain professional standards in the managing and caring for urinary catheter devices for one Resident (#66) out of a total sample of 30 residents. Specifically, the facility failed to ensure the urinary catheter drainage bag was not placed directly on the floor or on a used trash can.Review of the facility policy titled 'Catheter Care, Urinary', revised August 2022, indicated:-Use aseptic technique when handling or manipulating the drainage system.-Be sure the catheter tubing and drainage bag are kept off the floor. Resident #66 was admitted to the facility in April 2024 with diagnoses including obstructive and reflux uropathy. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/19/25, indicated Resident #66 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 14 out of 15. This MDS also indicated Resident #66 had an indwelling urinary catheter. Review of Resident #66's physician's order, initiated 7/13/24, indicated:-Suprapubic catheter care, every shift. Review of Resident #66's plan of care related to indwelling urinary catheter, revised 9/3/25, indicated:-Relocate urine bag to hanging in proper locations and off the floor when Resident #66 puts it down on the floor. On 12/9/25 at 12:19 P.M., the surveyor observed Resident #66 sitting in a wheelchair with his/her urinary catheter drainage bag and tubing directly on the floor in front of him/her. This observation by the surveyor was made from the hallway. There were multiple staff members walking past his/her room delivering lunch trays. On 12/9/25 at 2:07 P.M., the surveyor observed Resident #66 sitting in a wheelchair with his/her urinary catheter drainage bag and tubing directly on the floor in front of him/her. This observation by the surveyor was made from the hallway. There were multiple staff members walking past his/her room. On 12/10/25 at 6:59 A.M., Resident #66 was observed in his/her room with the urinary catheter drainage bag hanging from a trash can that was filled with trash. Resident #66 said staff put the catheter on the trash can and sometimes they put it on the floor if urine isn't draining adequately. Resident #66 said he is concerned about how staff takes care of his/her urinary catheter system because it had blood in it yesterday and thinks he/she has another urinary tract infection. On 12/10/25 at 7:01 A.M., Certified Nurse Assistant (CNA) #11 said she put the urinary catheter drainage bag on the trash can because the urine wasn't draining. CNA #11 was observed handling the urinary catheter bag with bare hands. CNA #11 touched the spout, where urine is drained from, and moved the urinary catheter drainage bag off the trash can and onto the bed frame. CNA #11 also demonstrated how the urinary catheter bag should not be on the floor by placing the urinary catheter bag directly on the floor. During an interview on 12/10/25 at 7:16 A.M., Nurse #10 said the urinary catheter drainage bag or tubing should never be stored on the floor or hanging from a trash can because of risk of infection or injury from it pulling. During an interview on 12/10/25 at 1:08 P.M., the Director of Nursing (DON) said the urinary catheter drainage bag should not have been hanging or touching a trash can. The DON said its care planned that Resident #66 sometimes puts his/her catheter drainage bag on the floor, but that staff should have placed a barrier under it or moved it off the floor and it shouldn't have been on the floor without intervention for over an hour and a half.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, and record review, the facility failed to provide respiratory care services in accordance with professional standards of practice for two Residents (#36 and #61) out of a total sample of 30 residents. Specifically:1.) For Resident #36, the facility failed to ensure oxygen tubing and nebulizer tubing was changed/dated as necessary and that oxygen was implemented at the correct flow rate as ordered by the physician.2.) For Resident #61, the facility failed to ensure Resident #61's oxygen tubing was dated and that oxygen was implemented at the correct flow rate as ordered by the physician.Findings include:Review of the facility policy titled Oxygen Administration, revised October 2010, indicated: -Preparation: Verify there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. -Steps in the Procedure: 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. -Documentation: If the resident refused the procedure, the reason(s) why and the intervention taken. 1.) Resident #36 was admitted to the facility in October 2025 with diagnoses including, Acute Respiratory Failure with hypercapnia and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set assessment (MDS) assessment, dated 10/7/25, indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. On 12/9/25 at 8:15 A.M., the surveyor observed Resident #36 receiving oxygen from a nasal canula from an oxygen concentrator. The oxygen tubing was dated 11/30/25. There was a nebulizer tubing in a plastic storage bag dated 11/30/25. The oxygen was set at 2.5 liters. Resident #36 said he/she was supposed to be on three liters of oxygen. On 12/10/25 at 1:38 P.M., the surveyor observed Resident #36 receiving oxygen from a nasal canula from an oxygen concentrator. The oxygen tubing was dated 12/10/25. There was a nebulizer tubing in a plastic storage bag dated 12/10/25. The oxygen was set at 2.5 liters. Resident #36 said he/she is supposed to be on three liters of oxygen and that staff had changed the oxygen and nebulizer tubes in the morning. On 12/11/25 at 1:15 P.M., the surveyor observed Resident #36 receiving oxygen from a nasal canula from an oxygen concentrator. The oxygen tubing was dated 12/10/25. The oxygen was set at 2.5 liters. Review of Resident #36's active physician orders indicated the following: 10/1/2025: Every shift check o2 every shift continuous oxygen at 3l via nasal cannula. 10/2/25: Ipratropium bromide-albuterol sulfa albuterol sulfate/ipratropium bromide 3 mg/3ml-0.5mg/3ml solution. Give one vial inhalation 3x/day at 10am-2pm-6pm three times daily PRN for SOB and/or wheezing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/7/25: Night shift weekly on Sunday change nebulizer tubing and storage bag. Date tubing and storage bag. 11/7/25: Night shift weekly Sunday change oxygen tubing and storage bag. Date tubing and storage bag. Review of resident #36's Chronic Obstructive Pulmonary disease, Alteration in respiratory function care plan. initiated 10/1/25, indicated the following: Administer oxygen per physician order. Review of Resident #36's Treatment Administration Record (TAR), dated 12/7/25, indicated the nurse changed, labelled, and dated the oxygen and nebulizer tubing as ordered by the physician. During an interview and an observation on 12/11/25 at 2:08 P.M., the surveyor and Nurse #9 observed Resident #36's oxygen set at 2.5 liters. Nurse #9 said she did not check what setting the Resident's concentrator had been on throughout the shift. Nurse #9 said physician orders should be followed for oxygen setting. During an interview on 12/11/25 at 11:09 A.M., the Director of Nursing said physician's orders should be followed as ordered for oxygen flow settings. Oxygen and nebulizer tubing were changed weekly and should be dated, labelled and bagged. 2.) Resident #61 was admitted to the facility in March 2025 with diagnoses including chronic obstructive pulmonary disease (a lung and airway disease that restricts breathing) and chronic respiratory failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/12/25, indicated Resident #61 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 9 out of 15. This MDS also indicated Resident #61 received oxygen. Review of Resident #61's physician's order, initiated 3/23/25, indicated: -Continuous oxygen at 2L (liters) via nasal cannula, every shift. Review of Resident #61's plan of care related to respiratory status, dated 3/8/25, indicated: -Oxygen at 2 lpm (liters per minute) via nasal cannula. -Provide oxygen per MD (doctor) order. Review of Resident #61's plan of care failed to indicate Resident #61 was non-compliant or self-adjusted oxygen settings. On 12/9/25 at 8:35 A.M., the surveyor observed Resident #61 in bed with a nasal cannula in his/her nostrils with tubing connected to an oxygen concentrator with settings reading oxygen was being delivered at 3.5 liters per minute (lpm). The oxygen tubing was undated. Resident #61 said the nurses managed his/her oxygen and wasn't sure what flow rate it was supposed to be on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/25 at 12:17 P.M. and 2:03 P.M., and on 12/10/25 at 6:53 A.M., the surveyor observed Resident #61 in bed with a nasal cannula in his/her nostrils with tubing connected to an oxygen concentrator with settings reading oxygen was being delivered at 3.5 liters per minute (lpm). The oxygen tubing was undated. Review of Resident #61's nursing progress note, dated 12/8/25 to 12/10/25, failed to indicate any information related to oxygen not flowing at the physician ordered rate. During an interview on 12/11/25 at 6:54 AM, Certified Nurse Assistant (CNA) #13 said Resident #61 did not self-adjust oxygen settings and that the nurse was responsible for oxygen management. During an interview on 12/10/25 at 7:19 A.M., Nurse #10 said oxygen should be administered according to the physician ordered flow rate. Nurse #10 said nurses were responsible for checking oxygen settings every shift. Nurse #10 said he thought Resident #61's physician's order was for three lpm. Nurse #10 and the surveyor reviewed Resident #61's physician's orders and Nurse #10 said he was wrong and that the Resident's oxygen should have been set to 2 lpm but was not. Nurse #10 further said oxygen tubing should be dated. During an interview on 12/10/25 at 12:57 P.M., the Director of Nursing (DON) said oxygen should be administered according to the physician ordered flow rate, and if a different flow rate was required, they would need to obtain a new physician's order. Nurse #10 said nurses were responsible for checking oxygen settings every shift. During a follow-up interview on 12/11/25 at 11:09 A.M., the Director of Nursing said oxygen tubing should be dated because it needed to be changed weekly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews and policy review, the facility failed to ensure pharmaceutical services met the needs of the residents. Specifically, the facility failed to ensure insulin emergency kits were reordered and replaced by the pharmacy after being opened on two out of three units. Findings include: Review of the facility policy titled Emergency Medication Supplies (Emergency Kits), dated 11/15/24, indicated, but was not limited to, the following:-Facility staff may record the name of the nurse who accessed the emergency kit, the date and time the e-kit was accessed, and the serial number of the tamper evident lock or seal replaced on the emergency kit.-Fax the E-kit withdrawal communication form to the pharmacy. On 12/10/25 at 6:39 A.M., during the inspection of the medication room on the Two [NAME] unit the surveyor observed an insulin kit in the refrigerator; the kit was opened and some of the contents had been removed from the kit. There was no documentation indicating what had been removed, when it was removed or who had removed the items. There was no way to determine if the kit had been reordered from the pharmacy for a replacement kit. During an interview on 12/10/25 at 6:45 A.M., Nurse #10 said when the emergency kits are opened, they need to be reordered immediately. He further said he was not sure when the kit had been accessed or if it had been reordered. On 12/10/25 at 6:49 A.M., during the inspection of the medication room on Two East unit. The surveyor observed an insulin kit in the refrigerator; the kit was opened and some of the contents had been removed from the kit. There was no documentation indicating what had been removed, when it was removed or who had removed the items. There was no way to determine if the kit had been reordered from the pharmacy for a replacement kit. During an interview on 12/10/25 at 6:55 A.M., Unit Manager #2 said when the emergency kits are opened, nurses are to document what they took out and fax to the pharmacy. She said due to having a lot of agency nursing staff it was difficult to make sure the kits were replaced promptly as not all of the nurses call the pharmacy for a replacement kit. Unit Manager #2 said she was not sure when the kit was opened. During an interview on 12/10/25 at 12:15 P.M., the Director of Nursing said the emergency kits should be reordered when opened, and a form filled out indicating what medication was taken out, for whom and by which nurse.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to assess for side effects of an antipsychotic medication by completing the Abnormal Involuntary Movement Scale (AIMS) for one Resident (#12) out of a total sample of 30 residents. Findings include:Resident #12 was admitted to the facility in January 2024 with diagnoses including dementia and unspecified psychosis. Review of Resident #12's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 4 out of a possible 15 on the Brief Interview for Mental Status exam which indicated he/she had severe cognitive impairment. Further review of the MDS indicated Resident #12 was dependent on staff for all functional daily tasks. Review of Resident #12's active physician orders indicated the following order:-Olanzapine (an antipsychotic medication) 5 MG (milligrams) tablet by mouth every night at 9PM (night) bedtime, initiated 10/21/25. Review of the psychiatric nurse practitioner note dated 1/9/25 indicated the following:Resident #12 was prescribed Zyprexa (the brand name for Olanzapine) 5MG daily at hs (night).An AIMS assessment was completed during this visit with a score of zero. Review of Resident #12's medical record failed to indicate an AIMS assessment had been completed since January 2025, 11 months prior. During an interview on 12/15/25 at 12:25 P.M., Unit Manager #2 said she was Resident #12's primary nurse and that the Resident was prescribed an antipsychotic medication. Unit Manager #2 said she did not know what an AIMS assessment was, how often it should be done or who completed that assessment. During an interview on 12/16/25 at 7:40 A.M., the Director of Nursing (DON) said the AIMS assessment should be completed upon admission or start of antipsychotic medication and every six months after to assess possible side effects of the antipsychotic medication. The DON said the assessment was either completed by the nurses on the floor or the psychiatric provider. The DON said she was unsure if Resident #12's AIMS assessments have been completed and would look for them. During a follow-up interview on 12/16/25 at 7:51 A.M., the DON said she was unable to locate any completed AIMS assessments since January 2025 and had reached out to the psychiatric provider who confirmed an AIMS had not been completed. The DON said the facility did not have an AIMS policy, however, provided the surveyor with a list of expected assessments and the timeline for completion. Review of this timeline indicted the AIMS was expected to be completed on admission, every six months and if a resident were to have a significant change. During an interview on 12/16/25 at 12:10 P.M., Nurse Practitioner #1 said AIMS assessments were completed to ensure residents were not having adverse reactions to antipsychotic medications and that she would expect the facility to be completing them as indicated.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interviews, and record review, the facility failed to ensure one Resident (#39) was free from significant medication errors, out of a total sample of 30 residents. Specifically, a nurse administered insulin to Resident #39 when it was not indicated by the physician's order eight times.Findings include: Review of the facility policy titled Insulin Administration, revised March 2025, indicated:Preparation: The type of insulin, dosage requirements, strength, and method of administration are verified with the order on the medication sheet and the physician's order before administration.Steps in the Procedure (Insulin Injections via Syringe): Double check the order for the amount of insulin. Resident #39 was admitted to the facility in August 2025 with diagnoses including type two diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/7/25, indicated Resident #39 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 10 out of 15. This MDS also indicated Resident #39 received daily insulin injections. Review of Resident #39's physician's order, initiated 8/11/25, indicated:Humalog 100 u (units)/1 ml (milliliter) solution (Insulin Lispro, Recombinant) Give per sliding scale injection half hour before meals three times daily, 200-250 = 2 units, 25-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-450 = 10 units, above 450 notify MD (doctor)/NP (nurse practitioner), scheduled at 7:00 A.M., 11:30 A.M., and 4:00 P.M. Review of Resident #39's medication administration record, dated 12/1/25 to 12/10/25, indicated Nurse #13 administered Humalog insulin, when it was not indicated to administer Humalog insulin, at the following scheduled times:12/3/25 at 7:00 A.M., Nurse #13 administered one unit of Humalog insulin when blood sugar was 127.12/4/25 at 11:30 A.M., Nurse #13 administered one unit of Humalog insulin when blood sugar was 122.12/5/25 at 11:30 A.M., Nurse #13 administered one unit of Humalog insulin when blood sugar was 185.12/5/25 at 4:00 P.M., Nurse #13 administered one unit of Humalog insulin when blood sugar was 171.12/7/25 at 7:00 A.M., Nurse #13 administered one unit of Humalog insulin when blood sugar was 106.12/7/25 at 11:30 A.M., Nurse #13 administered one unit of Humalog insulin when blood sugar was 166.12/7/25 at 4:00 P.M., Nurse #13 administered one unit of Humalog insulin when blood sugar was 150.12/8/25 at 4:00 P.M., Nurse #13 administered one unit of Humalog insulin when blood sugar was 100. During an interview on 12/9/25 at 8:19 A.M., Resident #39 said he/she is unaware of how much insulin he/she receives because the nurses manage it. During an interview on 12/10/25 at 10:10 A.M., Nurse #13 reviewed Resident #39's physician's orders with the surveyor. Nurse #13 said she administered one unit of insulin to Resident #39 on 12/3/25, 12/4/25, 12/5/25, 12/7/25, and 12/8/25. Nurse #13 said that she thought the 1 ml in the physician's order for Humalog 100 units/1 ml meant to give 1 unit and was confused. During an interview on 12/10/25 at 10:21 A.M., Nurse #3 said she was often responsible for administering insulin to Resident #39. Nurse #3 reviewed Resident #39's physician's orders with the surveyor. Nurse #3 said no Humalog insulin should have been administered if Resident #39's blood sugar was less than 200. Nurse #3 said the Humalog 100 units/1 ml is the type of insulin, not the dosage that should have been administered. Nurse #3 reviewed the medication administration record with the surveyor and said Nurse #13 should not have administered one unit of insulin on 12/3/25, 12/4/25, 12/5/25, 12/7/25, and 12/8/25.During an interview on 12/20/25 at 10:33 A.M., the Director of Nursing (DON) reviewed the medication administration record with the surveyor and said Nurse #13 should not have administered one unit of insulin on 12/3/25, 12/4/25, 12/5/25, 12/7/25, and 12/8/25 because it was not indicated according to the physician's order.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide one Resident (#89) with adaptive equipment during a meal out of a total sample of 30 residents. Findings include: Resident #89 was admitted to the facility in February 2024 with diagnoses including stroke. Review of Resident #89's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident score a 3 out of a possible 15 on the Brief Interview for Mental Status exam which indicates he/she has severe cognitive impairment. The MDS also indicated Resident #89 required assistance from staff for self-feeding. Review of Resident #89's active physician orders indicated the following order:-Diet: House no salt at breakfast, lunch, supper. Ground texture thin liquids. Lip plate, cup with handles and covers, built up utensils. Magic cup at breakfast, lunch and dinner. Review of Resident #89's meal ticket served with each meal indicated the following:-2 handled cup, built-up utensil (1 each), inner lip plate (1 each). On 12/9/25 at 12:24 P.M., Resident #89 was provided with his/her lunch. The tray did not have any adaptive equipment on the tray. At 12:29 P.M., Certified Nursing Assistant (CNA) #2 was observed telling another staff member that she accidentally gave Resident #89 the wrong lunch tray. CNA #2 did not take the incorrect meal away from Resident #89 and instead gave another Resident #89's lunch tray. At 12:35 P.M., the surveyor asked CNA #2 and CNA #1 if Resident #89 required adaptive equipment to self-feed and they both responded yes and said the Resident should be given the necessary adaptive equipment. At 12:47 P.M., 25 minutes after Resident #89 was given his/her lunch, the staff had not yet obtained adaptive equipment for the Resident, and he/she had not yet eaten any of his/her meal. During an interview on 12/9/25 at 12:47 P.M., Nurse #1 was shown Resident #89's meal ticket and asked if the Resident required adaptive equipment for self-feeding. Nurse #1 said yes and then observed Resident #89's tray and said the Resident did not have the required adaptive equipment and would have expected the nurses or CNAs to have corrected the meal and obtained the adaptive equipment as ordered. Nurse #1 left the room and at 12:51 P.M., returned with a built-up fork. Nurse #1, or any other staff, never obtained a two-handled mug with cover or a lip plate for the remainder of the meal. During an interview on 12/10/25 at 2:42 P.M., the Director of Nursing (DON) said nursing should be checking the trucks and all meal trays for accuracy. The DON said if a CNA happened to make a mistake and give a meal to the wrong resident, the CNA should immediately remove the meal and order a fresh tray. The DON said Resident #89 required adaptive equipment for meals and the nursing staff needed to ensure the Resident received this equipment at every meal. During an interview on 12/15/25 at 1:42 P.M., the Registered Dietitian (RD) said all necessary adaptive equipment will be listed on the meal ticket. The RD staff should ensure the meals are checked for accuracy, contain the equipment ordered and was given to the correct resident.

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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. Based on record reviews and interviews, the facility failed to assess eligibility and offer pneumococcal and/or influenza vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations and facility policy for two Residents (#24 and #3) out of a total of five residents reviewed. Specifically:1.) For Resident #24, the facility failed to assess for eligibility and administer a pneumococcal vaccine after Resident #24 signed a consent indicating the Resident wished to receive the pneumococcal vaccine.2a.) For Resident #3, the facility failed to assess for eligibility and offer a pneumococcal vaccine to the Resident, as required.2b.) For Resident #3, the facility failed to ensure its staff offered the annual influenza vaccination to the Resident, as required. Findings include: Review of the facility policy titled Facility Vaccine Procedure, dated December 2024, indicated:Policy: The licensed nurse under the direction of the Director of Nursing will administer recommended immunizations vaccine to residents.Procedure: Obtain informed consent from each resident / responsible party to receive recommended vaccines. Resident / responsible party will sign Form ADM-G020 indicating their acceptance or declination of the vaccine.Procedure: The licensed nurse will distribute to the resident / responsible party information annually regarding risks/benefits or receiving any vaccine and document in the resident record receipt of educational information and appropriate informed consent/declination of vaccine.Procedure: The licensed nurse will administer the vaccine per physician order.Procedure: Document resident administration of vaccine in [electronic medical record] immunization template.1.) Resident #24 was admitted to the facility in August 2022.Review of the most recent Minimum Data Set (MDS) assessment, dated 10/3/25, indicated a pneumonia vaccine was not offered to Resident #24.Review of Resident #24's medical record included a pneumococcal vaccine consent form, dated 8/9/22, that indicated the Resident wished to receive pneumococcal vaccine. Review of Resident #24's physician order, dated 9/3/24, indicated:-May receive Pneumococcal vaccine with informed consent.Review of Resident #24's medical record failed to include documentation that the resident either received a pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.During an interview on 12/17/25 at 9:28 A.M., the Director of Nursing (DON) said Resident #24's medical record did not indicate he/she ever received or was screened for eligibility for pneumococcal vaccine but should have been. The DON and the surveyor reviewed the Massachusetts Immunization Information System (MIIS), which is a statewide, secure, computerized database that tracks immunization records for all Massachusetts residents, and the DON said there was no evidence that Resident #24 ever received any pneumococcal vaccine. The DON said Resident #24 should have had a pneumococcal vaccine administered because he/she signed consent that he/she wished to have one but did not. 2.) Resident #3 was admitted to the facility in July 2025.2a.) Review of the most recent Minimum Data Set (MDS) assessment, dated 9/19/25, indicated his/her pneumococcal vaccination was up to date, which it was not.During an interview on 12/17/25 at 10:43 A.M., the MDS Nurse said she coded the MDS incorrectly. The MDS Nurse said the MDS should have been coded differently as pneumonia vaccination not offered because based on CDC recommendations he/she was due for another pneumonia vaccine and was not up to date. The MDS Nurse said she would have to modify that assessment because it was inaccurate.Review of Resident #3's physician order, dated 7/24/25, indicated:May receive pneumococcal polysaccharide 23 (PPSV23) vaccine in accordance with CDC current recommended immunization schedule for adults, with documented informed consent, and if not otherwise contraindicated.Review of Resident #3's medical record failed to include documentation that the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; any informed consent forms; and that the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.During an interview on 12/17/25 at 9:28 A.M., the Director of Nursing (DON) said Resident #3's medical record did not (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicate he/she ever received or was screened for eligibility for pneumococcal vaccine but should have been. The DON and the surveyor reviewed the Massachusetts Immunization Information System (MIIS), which is a statewide, secure, computerized database that tracks immunization records for all Massachusetts residents, and the DON said there was no evidence that Resident #3 ever received any pneumococcal vaccine. The DON said this should have been assessed and the pneumococcal vaccine should have been offered when he/she was admitted in July but was not.During a follow-up interview on 12/17/25 at 10:38 A.M., the DON said based on CDC recommendations Resident #3 was not up to date for pneumococcal vaccination and should have been screened for eligibility and offered a pneumococcal immunization upon admission but was not. 2b.) Review of the most recent Minimum Data Set (MDS) assessment, dated 9/19/25, was completed prior to the current influenza season. Review of Resident #3's physician order, dated 7/24/25, indicated:May receive annual influenza vaccine with documented informed consent and if not otherwise contraindicated.Review of Resident #3's medical record failed to include documentation that the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; any informed consent forms; and that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindication or refusal.During an interview on 12/17/25 at 9:28 A.M., the Director of Nursing (DON) said Resident #3's medical record did not indicate he/she ever received or was screened for eligibility for influenza vaccine but should have been. The DON and the surveyor reviewed the Massachusetts Immunization Information System (MIIS), which is a statewide, secure, computerized database that tracks immunization records for all Massachusetts residents, and the DON said there was no evidence that Resident #3 ever received an annual influenza vaccine for 2025. The DON said this should have been assessed and the influenza vaccine should have been offered when he/she was admitted in July but was not.